Psychiatry in Israel at a Crossroads: What does the future hold?
CONTENTS / MAY 2012

Plenary Lecture Abstracts

PL1 The implications of social networks and generation Y on psychiatry
   Dr. Asher Idan 05
PL2 Does the bipolar spectrum exist?
   Prof. Nassir Ghaemi 05
PL3 Economic aspects of mental health – how much are we willing to invest in our health?
   Prof. Gabi Bin Nun 05
PL4 Why it has taken so long to convert biological psychiatry into clinical tests – and what to do about it?
   Prof. Shitij Kapur 05
PL5 Unmet needs in patients with first episode schizophrenia
   Prof. W. Wolfgang Fleischhacker 05
PL6 The size and burden of mental health in Europe
   Prof. Dr. Hans-Ulrich Wittchen 06
PL7 The Blue Brain Project: at the forefront of unlocking the secrets of the brain
   Prof. Idan Segev 06
PL8 Managing Sub-optimal Response To Initial Antidepressant Therapy: To Switch Or Not To Switch? A Debate
   Augmentation as a better practice - Prof. Stuart Montgomery
   Switching as a therapeutic option - Prof. Hans-Jürgen Möller 06

Symposia Abstracts

S1 Updates in Schizophrenia: genetic background, co-morbid obsessive compulsive disorder, brain plasticity -
   is it possible to predict schizophrenia?
   Chairpersons: Prof. Mark Weiser, Prof. Abraham Weizman 07
S2 From traumatic stress to PTSD
   Chairpersons: Prof. Ehud Klein, Prof. Talma Hendler 08
S3 Bipolar disorders across the age Spectrum: implications for the clinician
   Chairpersons: Prof. Leon Grunhaus, Prof. Y. Levkovitz 10
S4 Psychiatry and Gender
   Chairpersons: Dr. Zippi Dolev, Prof. Hanan Munitz 11
S5 Scientific publishing: Meet the editors
   Chairperson: Prof. Zvi Zemishlany 12
S6 A window to neuromodulation and neurostimulation in psychiatry
   Chairpersons: Prof. Y. Levkovitz, Prof. Leon Grunhaus 13
S7 Psychotherapy in the psychiatric setting: beyond the common
   Chairpersons: Dr. Shlomo Mendlovic, Dr. Ilana Kremer 15
S8 Attention deficit disorder: updates and controversy
   Chairpersons: Dr. Iris Manor, Prof. Shmuel Tyano 17
S9 Eating disorders and obesity
   Chairpersons: Dr. Eitan Gur, Prof. Dan Stein 18
S10 Transcultural aspects of mental health
   Chairpersons: Dr. Nimrod Grisaru, Prof. Eliezer Witztum 20
Plenary Lecture Abstracts

PL1  THE IMPLICATIONS OF SOCIAL NETWORKS AND GENERATION Y ON PSYCHIATRY

Dr. Asher Idan
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According to a recent AMA study, which also cites a study by the Pew Internet Research Group, in 2011 nearly 80% of all internet users, or 60% of all adults, have searched online for health information. 50% of the world’s population is under 30. They do not communicate via e-mail or telephone. Generation Y considers e-mail passé. They prefer social networks. A recent survey by the National Research Corporation found that 41% of patients look for medical content from social media sites, and 94% of those patients turn to Facebook. Social networks, and especially medical social networks such as http://www.patientslikeme.com/, http://www.sermo.com/ and http://www.patientopinion.org.uk/ enable psychiatrists to work with three technologies:

1. Social Intelligence: Engaging platform for collaborative decision making.
2. Intuitive User Interface: Easy-to-use, rich visualization to make powerful information simple.
3. Automated Insights: Intelligent engines that learn to automatically generate relevant insights by understanding user behaviors.

Medical Intelligence 3.0 (MI 3.0) is a term that refers to new tools and software, which enable contextual discovery and more collaborative decision making. MI 3.0 is socially enabled, which keeps it in line with the popularization of social media technologies and the demand for more intuitive self-service. MI System, is context aware so it anticipates needs and automatically pushes relevant information in real time.

PL2  DOES THE BIPOLAR SPECTRUM EXISTS?

Prof. Nassir Ghaemi
Mood Disorders Program at Tufts Medical Center in Boston

PL4  WHY IT HAS TAKEN SO LONG TO CONVERT BIOLOGICAL PSYCHIATRY INTO CLINICAL TESTS – AND WHAT TO DO ABOUT IT?

Prof. Shitij Kapur
Section on Schizophrenia, Imaging and Therapeutics, Institute of Psychiatry, King’s College London

Patients with mental disorders show many biological abnormalities which distinguish them from normal volunteers; however, few of these have converted into tests with clinical utility. Why is this the case? There are several reasons for this, but, particularly: lack of a biological ‘gold standard’ definition of psychiatric illnesses; a profusion of statistically significant, but minimally differentiating, biological findings; ‘approximate replications’ of these findings in a way that neither confirms nor refutes them; and a focus on comparing prototypical patients to healthy controls which generates differentiations with limited clinical applicability. Overcoming these hurdles will require a new approach. Rather than seek biomedical tests that can ‘diagnose’ DSM-defined disorders, the field should focus on identifying biologically homogenous subtypes that cut across current psychiatric classifications (thereby side-stepping the issue of a gold standard). To ensure clinical relevance and applicability, the field needs to focus on differences which have clinically meaningful effect sizes in relevant populations, rather than chasing p-values versus normal controls. Validating these new biomarker-defined subtypes will require longitudinal studies with standardized measures at a scale and standardization not previously attempted by biological psychiatry – but, that is what has been required for success in other medical disciplines and that is what psychiatry must do. To achieve such sizes, we will need to share individual patient-data across studies – thereby overcoming the problem of significance chasing and approximate replications. Such biological psychiatry derived clinical tests, and the subtypes they define, will exist, at least for the foreseeable future, side-by-side DSM-like diagnoses. However, they will provide a natural basis for new therapeutics and if this venture is successful, it will give rise to a ‘stratified psychiatry’ that will improve clinical outcomes across conventional diagnostic boundaries.

PL3  ECONOMIC ASPECTS OF MENTAL HEALTH – HOW MUCH ARE WE WILLING TO INVEST IN OUR HEALTH?

Prof. Gabi Bin Nun
Department of Health Systems Management, Guilford Glazer Faculty of Business and Management, Ben-Gurion University of the Negev

PL5  UNMET NEEDS IN PATIENTS WITH FIRST EPISODE SCHIZOPHRENIA

Prof. W. Wolfgang Fleischhacker
Department of Psychiatry at Innsbruck Medical University, Austria
The Size and Burden of Mental Health in Europe

Prof. Dr. Hans-Ulrich Wittchen
Institute of Clinical Psychology and Psychotherapy and Center of Clinical Epidemiology and Longitudinal Studies (CELOS) Technische Universität Dresden

In a 3-year pan-European study covering 30 countries and a population of 514 million people, over a hundred experts jointly with the European College of Neuropsychopharmacology (ECNP) and the European Brain Council (EBC) has examined for the first time comprehensively the size and burden and cost of mental and other “disorders of the brain” across the full age span. Findings:

- Each year, 38.2% of the EU population (64.8 million people) suffers from a mental disorder.
- With variation by gender and age group the most frequent disorders are anxiety disorders (14.0%), insomnia (7.0%), major depression (6.9%), somatoform disorders (6.3%), alcohol and drug dependence (>4%), attention-deficit and hyperactivity disorders (ADHD, 5% in the young), and dementia (30% among 85 and above).
- No indications were found for increasing rates, except for dementia.
- The treatment situation remains highly deficient. Only 1/3 of all cases affected receive treatment, those receiving treatment do so with considerable delays of several years and rarely with appropriate, state-of-the-art therapies.
- Additionally, many millions of patients suffer from neurologic disorders such as stroke and Parkinson’s disease, cases that may add on top of the above estimates.
- As the result of the high prevalence, early onset, a persisting recurrent or chronic course and poor treatment, mental disorders are the largest contributor to the EU’s total morbidity burden, accounting for over 26% of the total disease burden. The four most disabling conditions were depression, addiction, dementia and stroke.
- The total cost burden is immense (approx 800 billion €), mainly due to indirect costs. The low direct (treatment) cost proportion is unique to mental disorders and markedly different from other prevalent somatic diseases (e.g. cancer, diabetes).

The study also identified the critical challenges to improved care, such as: disciplinary fragmentation, marginalisation and stigmatisation, lack of awareness about the full range of mental disorders and insufficient research funding. The study concludes that “Concerted priority action is needed at all levels, including substantially increased funding for research in order to identify better strategies for improved prevention and treatment for disorders of the brain as the core health challenge of the 21st century.”

The Blue Brain Project: At the Forefront of Unlocking the Secrets of the Brain

Prof. Idan Segev
Institute of Life Sciences, Dept. of Neurobiology and Interdisciplinary Center for Neuro Computation, David & Inez Myers Chair in Computational Neuroscience Edmond Safra Campus, Givat Ram

Managing Sub-Optimal Response to Initial Antidepressant Therapy: To Switch or Not to Switch? A Debate.

Augmentation as a better practice
Prof. Stuart Montgomery
Emeritus Professor, Imperial College University of London

Switching as a therapeutic option
Prof. Hans-Jürgen Möller
Psychiatric University Hospital, Ludwig-Maximilians-Universität München

Insufficient response of depressive patients to treatment with antidepressants is a frequent problem in daily clinical practice. About 20-30% of patients do not achieve a satisfying therapy result in terms of response (i.e. at least 50% improvement of the depression score) to the administered antidepressant. In terms of remission criteria the frequency of unsatisfying therapy results is even higher. To improve the therapy results there are several medicinal possibilities, such as sequential therapy approaches, where different antidepressants are administered in monotherapy or in combination. Other proven approaches are augmentation with thyroid hormones or lithium. In recent years, add-on therapy with antipsychotics has gained increasing significance after several studies proved the effectiveness of this strategy. Quetiapine has recently been approved for this indication and enriches respective therapeutic possibilities since then. In case of non-response/non-remission or not sufficient response the question arises whether to switch from one antidepressant to another, to switch from one antidepressant to another of a different pharmacological class, or whether combination/augmentation (antidepressant plus another antidepressant or lithium or an antipsychotic) is the best strategy. Regarding the general perspective this has to be discussed in the framework of evidence-based medicine. As to the individual patient a personalised approach has naturally to be combined with EBM related guidelines.
S1 UPDATES IN SCHIZOPHRENIA: GENETIC BACKGROUND, CO-MORBID OBSESSIVE-COMPULSIVE DISORDER, BRAIN PLASTICITY - IS IT POSSIBLE TO PREDICT SCHIZOPHRENIA?

Chairpersons: Prof. Mark Weiser, Prof. Abraham Weizman

S1.1 THE GENETICS OF SOCIAL BEHAVIOR FROM PAIR BONDING TO SCHIZOPHRENIA

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2 Hadassah Hospital Jerusalem

More than a decade of translational research that began with an attempt to understand the molecular architecture of the remarkable social behavior of a small rodent in the Western USA, the vole, has subsequently led to a deeper understanding of how oxytocin and its close relative arginine vasopressin modulate human social cognition in both healthy subjects as well as in psychopathology. Accumulating evidence demonstrates than oxytocin, the parturition hormone, molds the social brain in humans. A variety of strategies has been employed towards unraveling the role of this nonapeptide in human social behaviors including pharmacology, imaging, molecular genetics and neuroeconomics. In humans oxytocin has been associated foremost with trust behavior in the trust game, and also with psychological resources, social support, mind reading, empathy, maternal - infant bonding & parenting, altruism, mirror neuron activity and emotional support seeking. In particular, our own studies have shown genetic association between the oxytocin receptor and autism. Recently CD38, aka ADP-ribosyl cyclase, has been shown to mediate release of oxytocin in the brain and we have shown association between tagging SNPs in this gene and autism. Recently CD38, aka ADP-ribosyl cyclase, has been shown to mediate release of oxytocin in the brain and we have shown association between tagging SNPs in this gene and autism. Finally, we are currently genotyping a substantial sample of Russian schizophrenic patients and their families for oxytocin-arginine vasopressin neural pathway genes. Altogether we have 764 samples from schizophrenic patients and 461 from healthy controls. Many of the subjects have been inventoried for mind reading and other measures of social cognition. Results from this study will be reported in the May symposium.

S1.2 OBSESSIVE-COMPULSIVE SYMPTOMS IN SCHIZOPHRENIA: CLINICAL SIGNIFICANCE AND TREATMENT

S1.3 FAILURES OF CORTICAL PLASTICITY IN SCHIZOPHRENIA: RELATIONSHIP TO COGNITIVE DYSFUNCTION AND TARGET FOR TREATMENT

Michael Poyurovsky
Tirat Carmel Mental Health Center affiliated to the Rappaport Faculty of Medicine, Technion, Israel Institute of Technology

Although obsessive-compulsive symptoms are not considered primary features of schizophrenia, they are prevalent, independent of psychosis, and substantially modify clinical characteristics, course, treatment and prognosis of schizophrenia patients. The presenter will highlight the clinical significance of obsessive-compulsive symptoms in schizophrenia, provide diagnostic criteria and treatment options for “schizo-obsessive” patients. Findings of recent studies pertaining to the rate of occurrence of OCD in schizophrenia and the clinical characterization of the schizo-obsessive subtype will be presented. In the absence of evidence based data, tentative therapeutic approaches in this difficult-to-treat patient subgroup as well as management of antipsychotic induced OCD will be suggested.

Daniel C. Javitt
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Schizophrenia is a severe disorder associated with persistent neurocognitive dysfunction reflecting underlying brain pathology. Deficits are diffusely distributed throughout sensory, cognitive and motoric brain regions, leading to a generalized pattern of cognitive dysfunction consistent with predictions of N-methyl-D-aspartate [NMDA] models of schizophrenia. Also, as predicted by NMDA models, patients not only show cross-sectional cognitive deficits, but also highly impaired ability to benefit from training and experience. These impairments limit the ability of patients to benefit from remediation approaches and are, of themselves, an important target of treatment. This presentation will focus on recent research investigating causes and potential treatment approaches for cortical plasticity failures in schizophrenia based upon studies in the auditory and motor modalities. In the auditory system, patients show severe deficits in ability to match tones following brief delay, which correlate highly with impairments in higher level processes such as emotion recognition and prosodic detection. In an auditory plasticity task, in addition to showing elevated tone matching thresholds to unique tones, patients failed to show expected improvement in performance following tone repetition. This failure in plasticity correlated with impairments in reading ability, suggesting that cortical plasticity deficits...
contribute significantly to cognitive dysfunction in schizophrenia. In the motor system, individuals normally improve accuracy and speed of sequential finger movements following prolonged sequence repetition. As in the auditory system, patients failed to benefit from repetition, suggesting impaired cortical plasticity. Motor plasticity can be modulated by localized direct current stimulation applied over motor cortex. In addition, plasticity may be enhanced by agents that potentiate NMDA receptor mediated neurotransmission. Both pharmacological and brain stimulation approaches, therefore, represent potential targets for reversal of brain plasticity deficits in schizophrenia.

S1.4 IS IT POSSIBLE TO PREDICT SCHIZOPHRENIA BEFORE THE ONSET OF PSYCHOSIS

Mark Weiser
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In the early 1990s, the perception that second generation antipsychotics improved the risk/benefit ratio of anti-psychotic treatment was the impetus for investigators to attempt to diagnose and treat the illness before the appearance of full-blown psychosis. In order to identify these future patients, diagnostic criteria for this prodromal phase of the illness were developed, and initial results indicated that 40% of patients who met these criteria transitioned to full-blown psychosis within a year. However, as time went on, the rates of transition from prodrome to psychosis dropped below 15-20%. A recent paper by Addington et al followed “prodromal” patients who did not receive antipsychotic medication, and did not transition to full-blown psychosis over two years. It turns out that the clinical status of the majority of these patients was improved, with fewer positive symptoms and somewhat better functioning. One reason that this strategy does not work is that attenuated psychotic symptoms (APS) are quite frequent in the non-treatment seeking general population, and about 10% of persons in the community endorse having APS, which are often transient, generally do not cause great distress nor lead to treatment seeking. Hence, persons with APS might be misclassified as being in the prodromal phase of the illness. Other aspects of early intervention will be discussed.

S2 FROM TRAUMATIC STRESS TO PTSD

Chairpersons: Prof. Ehud Klein, Prof. Talma Hendler

S2.1 PREVENTION OF PTSD: DOES A WINDOW OF OPPORTUNITY EXIST?

Joseph Zohar
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The medical concept of golden hours is well-established in situations like CVA and MI. PTSD might benefit from this approach as, like in those disorders, the time of onset is clear. To date, several interventions have been explored, including debriefing, and administration of benzodiazepines, propranolol, morphine, cortisol and SSRI. Several studies of debriefing suggest that it might interfere with the robust and potent process of spontaneous recovery. Intervention with benzodiazepines also had a potential risk of interfering with spontaneous recovery. The underlying mechanism of benzodiazepines – deactivation of the HPA axis – may be linked to its adverse activity in the first few hours after exposure to trauma. A large multicenter, double-blind study conducted recently in Israel examined the efficacy of SSRI (escitalopram) in preventing PTSD, beginning treatment within one month of the traumatic event. Preliminary results, as well as a discussion of the methodological issues involved in recruitment and follow-up for this type of study, will be presented. Cortisol – the “stress hormone” is a cornerstone in the normal response to traumatic events. An animal model using rats with hyper-reactive HPA axis (the Fischer strain), or hypo-reactive (the Lewis strain), showed that plasticity of the HPA axis is critical for recovery from a traumatic event. Furthermore, normal hyper-secretion of cortisol following exposure to a traumatic event was associated with a reduction in the amplitude of the memory-fear associated with the exposure. This has aroused interest in the potential use of a medium dose [100-140mg] of intravenous cortisol. A small preliminary study has shown the potential benefit of this approach. Changing the focus from treatment to secondary prevention of PTSD in the “window of opportunity” – the first few hours after exposure to a traumatic event – has opened the door to new exciting possibilities in PTSD research and treatment.

S2.2 B-ENDORPHIN DEGRADATION AND INDIVIDUAL REACTIVITY TO TRAUMATIC STRESS

Alexandra Kavushansky1*, Milli Kritman2, Mouna Maroun1, Ehud Klein1, Gal Richter-Levin1, Hui Koon-Sea3, Dorit Ben-Shachar1
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Introduction: Reactivity to traumatic stress varies between individuals, and only a minority of those exposed to trauma develops Post-Traumatic Stress Disorder (PTSD). The endogenous opioid system has been extensively implicated in anxiety and stress management, but the specific alterations of the system in individual reactivity to traumatic stress are yet to be delineated. We investigated in rats the role of the opioid-degrading enzymes,
specifically insulin degrading enzyme (IDE), which degrades β-endorphin, in vulnerability/resilience to acute traumatic stress. Materials and Methods: Rats were exposed to traumatic foot-shock stress and categorized according to their behavioral responses to responders - showing extreme anxiety, and non-responders - not differing from the non-stressed rats. Blood levels of β-endorphin and corticosterone, as well as brain levels and activity of opioid-degrading enzymes were estimated. Effects of slowing down β-endorphin degradation following exposure to stress on behavioral and hormonal responses were tested as well. To that end we exposed rats to elevated-platform stress, and after categorization to responders or non-responders, exposed them to foot-shock stress, while they received intra-amygdalar insulin or saline prior to foot-shock. Reduced β-endorphin degradation by insulin was verified in-vitro. Results: Pre- and post-trauma levels of serum corticosterone, and post-stress plasma β-endorphin concentration differentiated between the responders and the non-responders. Liquid Chromatography-Tandem Mass Spectrometry (LS-MS/MS) analysis of hippocampal and amygdalar β-endorphin degradation rates suggested enhanced activity of IDE in responders. Brain metabolism of β-endorphin correlated with anxiety, whilst the peripheral measures correlated with rats’ locomotion. Amygdalar β-endorphin degradation rate was reduced after exposing the amygdala to insulin. Insulin application to the amygdala prior to exposure to traumatic stress reduced post-stress anxiety and serum corticosterone levels specifically in the responders. Conclusions: Slowing down β-endorphin degradation rate may constitute an integral part of the normal stress-response, upon a failure of which an extreme anxiety develops. IDE and insulin may thus present potential novel targets for pharmacotherapy intervention in stress-related disorders.

S2.3 DECODING THE NEURO-BEHAVIORAL TRAJECTORY OF HUMAN VULNERABILITY TO STRESS RELATED PSYCHOPATHOLOGY

Talma Hendler*, Roee Admon, Gadi Lubin
Functional Brain Center; Wohl Institute for Advanced Imaging, Tel Aviv Sourasky Medical Center, & Departments of Psychology and physiology, Tel Aviv University

It is yet unclear why potentially traumatic events (PTEs) lead only some individuals to suffer debilitating, chronic psychopathology while others to adaptively cope. We aimed to decode vulnerability to trauma by identifying risk markers that predict long-term outcome, while focusing on stress related brain processes. In specific, we examined early and later aspects of the response to stress via changing reward value and context of stimuli, respectively. A prospective three-point brain-imaging (fMRI) and DTI assessment was applied on a-priori healthy soldiers serving in a combative unit in the Israel Defense Forces. PTSD related symptoms were recorded, and brain imaging data were collected, prior to exposure to combative activity and two times following it (during deployment and following discharge). This unique design enabled at the individual level to disentangle between neural vulnerability factors related to predisposition (e.g. the amygdala) from those related to responsiveness to traumatic occurrences (e.g. nucleus accumbens and hippocampus). This regional plasticity corresponded to reduced functional connectivity with the medial PFC as well as with reduced anisotropy in the uncinate fiber tract. Together our finding suggests that vulnerability to traumatic stress is composed of both initial predisposing neural hypersensitivity as well as the reduced capacity for adaptive neural plasticity following exposure. These aspects of vulnerability accordingly, point to early and late therapeutic approaches with respect to the traumatic exposure.

S2.4 A RAT MODEL OF PTSD - REACHING TO REFLECT REALITY

Gal Richter-Levin
The Institute for the Study of Affective Neuroscience (ISAN), University of Haifa

Mental disorders are the cause of immense human suffering, with tens of millions of people suffering from schizophrenia, mood and anxiety disorders. Despite impressive progress in neuroscience in general, animal models have so far practically failed to promote our understanding of the neural basis of psychiatric disorders. Pharmaceutical companies’ difficulties in developing new effective compounds for psychiatric illness have been attributed to the shortcomings of animal models that have failed to be predictive in decision-making for such compounds. There is a significant difference between the way a psychiatric disorder is diagnosed in humans (based mainly on verbal interaction with a psychiatrist, and on adhering to DSM-based clusters of symptoms), and the way it is conducted in the animal models (in which diagnosis is based on very few, mostly a single physiological or behavioral measure). Employing such an approach in animal models leaves no room for the expression of individual differences in these models, and thus hampers its relevance to the human pathology. We aim to develop a novel approach for setting up rat models of psychiatric disorders, which is based on establishing complex, yet quantifiable models, combined with a novel diagnostic methodology that brings closer together the human psychiatric diagnosis and its heterogeneity and the animal model approaches. We have already demonstrated that employing this methodology is effective, both in demonstrating the richness, complexity and individual variability of the rat emotional behavior, and in revealing features of the human disorder that were not possible to detect in the rat with the traditional animal model approach. This may be demonstrated by the following example: In humans, the diagnosis of PTSD made only if an individual exhibits a certain number of symptoms from each of three quite well-defined symptom-clusters over a certain period of time, yet animal studies, irrespective of the study design/model or of the stress paradigm, the results were presented, discussed and conceptualized as involving the entire exposed
population versus controls, although in practice the exposed animals displayed a diverse range of responses. In order to more closely approximate the animal model approach to contemporary understanding of the clinical condition, Cohen et al (Cohen et al. 2003; Cohen and Zohar 2004; Cohen et al. 2005) conceived a novel approach that enabled segregating the study animals into groups according to the degree of their response to the trauma. Employing a version of that novel analysis approach (Cohen et al, 2004) we were able to demonstrate a similar individual dissociation in animal models, as in humans, to those animals that demonstrate more anxious symptoms and those that exhibit more depressive symptoms [Tsoory and Richter-Levin, 2006; Tsoory et al, 2007, Horovitz et al, 2011]. This enables us, for the first time, to examine whether differential neurobiological alterations are associated with such a categorization to Depression, PTSD and Post-traumatic depression.

S2.5 DISCUSSION: THE PATH FROM TRAUMATIC STRESS TO POST-TRAUMATIC STRESS DISORDER

Ehud Klein
Department of Psychiatry Rambam Medical Center, Rappaport Faculty of Medicine, Technion Institute of Technology

Most human beings encounter throughout their lives traumatic events that could lead to the development of stress related psychopathology in general and PTSD in particular. Yet, only a fraction of exposed individuals will eventually develop a clinical syndrome, the reasons for that remaining unclear. Moreover, the possibility to intervene during what might be a critical time window, to protect individuals at risk from developing PTSD, attract much interest among clinicians. Studies from recent years, both in humans and in animals, have shed light and furthered our understanding on neuro-pharmaco-behavioral mediators that determine individual trajectories of the path from traumatic stress to PTSD. The presentations in this symposium highlight some of these findings, bringing together imaging, animal behavior, neurochemical and therapeutic intervention studies. Insights from these studies and their implications for our understanding of these critical issues will be addressed in the commentary.

S3 BIPOLAR DISORDERS ACROSS THE AGE SPECTRUM: IMPLICATIONS FOR THE CLINICIAN

Chairpersons: Prof. Leon Grunhaus, Prof. Y. Levkovitz

S3.1 EPIDEMIOLOGY OF BIPOLAR DISORDERS IN ISRAEL

Raz Gross

S3.2 PEDIATRIC BIPOLAR DISORDER – FACTS AND MYTH

Shoshana Arbelle
Soroka University Medical Center, Beer-Sheva

Over the past 20 years, the evidence regarding pediatric bipolar disorder (PBD) has increased substantially. In contrast to increasing diagnoses in clinical settings, prevalence in epidemiological studies has not changed. Some reasons for that might be the ambiguity in the diagnostic criteria for mania and how they may apply to children with functionally impairing irritability. It is of clinical importance to address how those BP children could be distinguished from those with chronic irritability and severe mood dysregulation, although the two groups also have some shared deficits. BP spectrum conditions among youth are highly impaired and there is a high risk for conversion to BP-I and BP-II. Compared to adults, youth with BP have more mixed symptoms, more changes in mood polarity, are often symptomatic and seem to have worse prognosis. The course, clinical characteristics and comorbidities of BP among children and adolescents are in many ways otherwise similar to those of adults with BP. Nonetheless, many youth with BP receive no treatment and most do not receive BP-specific treatment. Simultaneous concern remains regarding missed or inaccurate diagnoses of BP, leading to inadequate or inappropriate treatment respectively. Despite increased evidence supporting the validity of pediatric BP, discrepancies between clinical and epidemiologic findings suggest that diagnostic misapplication may be common. Simultaneously, low rates of treatment of youth with BP suggest that withholding BP diagnoses may also be common. Unique family based psychosocial treatment models will be discussed.

S3.3 MAJOR DEPRESSION IN BIPOLAR DISORDER

Leon Grunhaus
Jerusalem Mental Health Center, Hadassah Medical School, Hebrew University of Jerusalem

Extensive clinical research in recent years has shown that “not all depressions are equal” especially when considering depression in bipolar disorder. It has been demonstrated that common clinical practices are not sufficient when approaching the care of patients with bipolar disorder. Longitudinal studies have demonstrated that patients with bipolar disorder have a more reserved prognosis than patients with major depression. This worse prognosis is seen in: 1- more episodes of illness, 2- more weeks of manic and depressive symptoms during follow-up, 3- treatment-emergent mood changes, 4- not responding to usual antidepressant care. In this presentation we will discuss the relevance of bipolar disorder, the need to include evaluations of previous history of mania or hypomania during
the evaluation of a depressive episode, the need to include collateral information during the clinical evaluation, and the particular treatment needs of this population.

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**S3.4 **BIPOLAR DISORDER IN THE ELDERLY

Yoram Barak
Abarbanel Mental Health Center, Bat-Yam

Bipolar disorder is a chronic disorder of mood which leads to episodes of either elevated mood or depression in a sizable number of adults in the community (1%). Though the prevalence rates in the elderly are lower in the community (up to 0.1%), there is significantly higher morbidity in protected environments like care homes and hospital settings where prevalence rates may be as high as 10%. Bipolar disorder in the elderly is probably heterogenous and its etiopathogenesis is complex. Bipolar disorder may be divided into two distinct subtypes, the late onset bipolar (LOB) and the early onset bipolar (EOB) groups. LOB patients tend to have a milder illness in terms of manic severity but they have higher medical and neurological burden. They also have lower familial burden of bipolar illness as compared to EOB patients. There is an increased risk of dementia and stroke in patients with late life bipolar disorder (and there may be a protective effect of lithium in preventing dementia). White matter changes, as seen by increased white matter hyperintensities on neuroimaging, are also increased, providing further evidence of cerebrovascular disease. Treatment of late life bipolar disorder is currently based on guidelines drawn up for younger bipolar disorder patients. Unfortunately, there is a considerable dearth of literature involving evidence-based clinical practice guidelines and randomized controlled trials in elderly individuals with bipolar disorder. Available options for the treatment of bipolar disorder [including those for mania, hypomania, depression, or maintenance] in the elderly include lithium, antiepileptics, antipsychotics, benzodiazepines, antidepressants, ECT, and psychotherapy. The data for the treatment of LOB disorder are limited, but the available evidence shows efficacy for some commonly used treatments. Good quality intervention studies are needed to estimate the possible protective effect of cognitive enhancers and/or vascular prevention strategies. We suggest that late life bipolar disorder, particularly LOB disorder, is probably a distinct diagnostic entity compared to the younger bipolar patients as it has a different presentation, etiology and hence perhaps needs different treatment strategies.

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**S3.5 **EARLY ONSET OF ANTIDEPRESSANT ACTION: TRUTH OR FICTION

Boris Nemets
Beer Sheva Mental Health Center, Ben-Gurion University of the Negev, Beer Sheva

Most of the available treatment guidelines for major depressive disorders recommend the continuous use of antidepressants for 4 to 8 weeks based on the idea of a delayed onset of response to these drugs. Contrary to this conventional belief, the recent data indicate that antidepressants start to exert their effects within 2 weeks and early nonresponse could predict a subsequent unfavorable outcome. Conclusions: These findings suggest the need of revisiting the timing of an antidepressant switch for early nonresponders, whereby switching could be commenced in as early as 2 weeks. If prospective studies corroborate this strategy, early switching will shorten the duration of illness and in turn reduce the burden on patients and their families.

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**S3.6 **BIPOLAR DISORDER: SHIFTING PARADIGM

Y. Levkovitz
The Emotion-Cognition Research Center, The Shalvata Mental Health Center, School of Medicine, Tel Aviv University

High rates of misdiagnosis, delayed diagnosis, and lack of recognition and treatment of comorbid conditions often lead patients with bipolar illness to have a chronic course with high disability, unemployment rates, and mortality. Despite the recognition that long-term outcome of bipolar disorder depends on systematic assessment of both inter-episodic dysfunctional domains and comorbid psychiatric and medical conditions, treatment of bipolar disorder still focuses primarily on alleviation of acute symptoms and prevention of future recurrences. Medical and research findings, along with health economic data, support a more modern view of bipolar disorder as a chronic, progressive, multisystem disorder. New comprehensive framework should guide the search to identify biomarkers and etiologic factors and should help design a new policy for health care, including prevention, diagnosis, treatment, and training. We will review the evidence offering a modern view of bipolar disorder defined as a chronic and progressive multisystem disorder.

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**S4 **PSYCHIATRY AND GENDER

Chairpersons: Dr. Zippi Dolev, Prof. Hanan Munitz

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**S4.1 **GENDER ASPECTS OF INSOMNIA

Zippi Dolev
Private Practice, Women’s Mental Health, Herzliya

Insomnia is considered both a symptom and a subjective clinical condition that is associated with significant impact on multiple life dimensions including mental and physical functions. No satisfactory correspondence has been established between the common complaints of sleep quality, and sleep laboratory parameters. In line with the lack of such correspondence, the diagnosis of poor sleep quality is based on subjective assessments as is the evaluation of treatment effects on sleep quality. Insomnia is
mostly treated with benzodiazepines, non-benzodiazepine hypnotic drugs, and with off label use of antidepressant and antipsychotics (that were not developed to treat insomnia). Women have better sleep quality compared to men, with longer sleep times, shorter sleep-onset latency and higher sleep efficiency. Despite this, women have more sleep-related complaints than men. The amount of slow-wave sleep decreases with age in men and women. Normal physiologic periods, including puberty, menstruation, pregnancy and menopause, are associated with alterations in sleep patterns. Gender differences in normal sleep may underlie the observed differences in risk of sleep disorders. Studies of insomnia support a female predominance, with increased divergence of prevalence between men and women with older age.

S4.2 GENDER AND PSYCHOPHARMACOLOGY

Hanan Munitz
Clalit Health Services

The epidemiology of gender is heavily influenced by gender. Females suffer more from depression, anxiety, borderline and narcissistic personality disorders, whereas males suffer more from PTSD, sociopathy and addictions. It is also known that females manifest schizophrenia at a slightly older age. Some psychiatric conditions are specific to females, for example, postpartum depression. There are several variables which are female specific and affect treatment. These include slower gastric emptying, lower basal gastric acid, lower blood volume, higher fat content all this affect drug bioavailability, drug clearance rate, peak levels of the medication and serum concentration. These variables influence efficacy and side effects. There are several female specific issues - these include changes in pharmacological variables during the menstrual cycle, changes due to pregnancy and teratology. It is important for anyone prescribing psychotropics to be aware of the above facts.

S4.3 ARE THERE “MALE” AND “FEMALE” BRAINS?

Daphna Joel
Department of Psychology, Tel-Aviv University

The currently prevailing paradigm is that human brains can take on of two forms, male or female, and that the differences between these two forms underlie sex differences in personality, cognition, emotion, behavior and neuro/psychopathology. I will review data demonstrating that although sex plays an important role in neuropsychiatric disorders, a division of human brains into “male” and “female” is useless when discussing other important aspects of being human, i.e., personality, cognition, emotion and behavior.

S4.4 THE HIDE AND SEEK GAME OF THE GENDER IN OCD

Doron Todder
Beer Sheva Mental Health Center

Obsessive-compulsive disorder (OCD) is a neuro-psychiatric illness. The role of gender in this disorder is evasive. In a cursory look it seems there is no prominent gender difference, but an in-depth examination reveals that gender does play a role in this relatively chronic and hard to treat disorder. The lecture will introduce research findings of gender impact on several dimensions of OCD such as tics, clinical presentations, age of onset etc. The importance of sex hormones will be discussed. All these findings will also be shown in relation to evolutionary psychiatry.

S5 SCIENTIFIC PUBLISHING: MEET THE EDITORS

Chairperson: Prof. Zvi Zemishlany

S5.1 UNDERSTANDING THE CURRENT REVOLUTION IN SCIENTIFIC PUBLISHING

Bernard Lerer
Biological Psychiatry Laboratory, Department of Psychiatry Hadassah – Hebrew University Medical Center, Jerusalem; Founding Editor in Chief, the International Journal of Neuropsychopharmacology (Cambridge University Press).

Scientific journals are the traditional medium whereby researchers and clinicians bring their scientific discoveries and key clinical observations to the attention of colleagues. A key role of journals is as arbiters of the quality of scientific papers and the findings they report. By accepting a paper for publication a journal assigns it a mark of quality. The more prestigious the journal (as determined almost solely by its impact factor) the more prestigious its mark of quality. The traditional paper format of journals has almost ceased to exist. Most of us rarely see a journal in print or even as a single electronic entity. We access articles of interest directly via databases and download or read them online. The only thing that really remains of a journal is its mark of quality, a very valuable resource that allows the name of the journal to continue to exist and be recognized. Journals as electronic entities will eventually disappear as have their paper predecessors and will be replaced by online portals. In parallel, scientific papers can be expected to evolve from their current format to more dynamic online entities. There is no point in repeating introductions and background statements or in detailing methods already presented when these can be accessed with the click of a mouse. An important question is whether papers will remain “fixed in time” as they are now or be updatable with new findings. One may also anticipate changes in the use of citations as the sole arbiter of the quality of scientific work and the journals that publish them.

Note: Prof. Lerer founded the International Journal of Neuropsychopharmacology in 1998 and served as Editor in Chief for 10 years. During this time the journal was among the top 10 journals in psychiatry with an impact factor greater than 5.
S5.2 WHO NEEDS A LOCAL JOURNAL? THE CASE OF THE ISRAEL JOURNAL PSYCHIATRY

David Greenberg
Herzog Hospital, Jerusalem, Editor in Chief, Israel Journal of Psychiatry and Related Sciences

As the IJP approaches its 50th volume since it first appeared in 1963, it is appropriate to consider the role of this "local" journal in the modern world of medical publishing. There are two viewpoints to consider: the reader and the author. For the reader, major developments in practice, whether pharmacological, psychological or rehabilitation, will be sought in leading or specialized journals. However, there are matters that are inevitably local, including mental health laws, and particularly provision of services, where the "actual" available in Israel should be presented and the "ideal" sought. A local journal is the natural place for Israeli mental health workers and researchers to pressure for change. Practically, however, these issues would not fill a quarterly journal. For the potential author, Israeli psychiatrists are prolific in publishing in the many international specialized journals of psychiatry. Despite increasing political isolation and calls for academic boycotts, effects of avoiding Israeli authors are hopefully minimal, and would be an unfortunate justification for a local journal. I have long cherished the wish that trainee mental health workers and junior researchers would turn to the IJP for their initial trial at publishing, where the editors should be sensitive and encouraging, providing a positive learning experience. Finally, as the journal of the IPA in the State of Israel, many mental health workers around the world wish to express their connection, and would be an unfortunate justification for a local journal. I have long cherished the wish that trainee mental health workers and junior researchers would turn to the IJP for their initial trial at publishing, where the editors should be sensitive and encouraging, providing a positive learning experience. Finally, as the journal of the IPA in the State of Israel, many mental health workers around the world wish to express their connection, and many are happy to publish in the IJP. This ambassadorial role of the IJP is now even more potent, as the journal enters its eighth year freely available online.

S5.3 DISCUSSION

Yehuda Shoenfeld
Editor in chief: Autoimmunity Reviews, Israel Medical Association Journal (IMAJ), Harefuah. Co-editor: Journal of Autoimmunity

Hans-Jürgen Möller
Editor in Chief of the European Archives of Psychiatry and Clinical Neuroscience

Chairpersons: Prof. Y. Levkovitz, Prof. Leon Grunhaus
1The Emotion-Cognition Research Center, The Shalvata Mental Health Center, School of medicine, Tel Aviv University
2Jerusalem Mental Health Center, Eitanim-Kfar Shaul Hospital.

MDD is a chronic and incapacitating condition with a high prevalence; therefore clinicians should consider all the treatment options including invasive and non-invasive stimulating approaches. Brain stimulation represents a new discipline in psychiatry focused on using magnetic or electrical energy to improve brain function. These techniques are used both for research and for treatment in major psychiatric disorders that do not always respond fully to conventional treatments, such as medication or psychotherapy. Stimulation with electrical or magnetic energy interacts with neurons, causing them to release chemicals called neurotransmitters, and possibly also helping form more healthy synapses, or connections, between nerve cells. Brain stimulation therapy uses both traditional and brand new methods of applying energy. It is not a replacement for medications, but it may be added onto medications to improve outcome. As with other treatments, brain stimulation has a risk of side effects that should be discussed thoroughly with the doctor before making a decision. Stimulating the brain as a potential therapy is currently undergoing a profound and fertile expansion. Several new techniques are working their way into clinical use. In this symposium we will focus on new information on electroconvulsive therapy (ECT). We will present new data about recent advances with TMS and tDCS methods with a relative benign profile of side effects; however, while TMS effects are comparable to antidepressant drugs for treating MDD; further research is needed to establish the role of tDCS. DBS is another invasive strategy with a possible role in treatment-resistant depression.

S6 A WINDOW TO NEUROMODULATION AND NEUROSTIMULATION IN PSYCHIATRY

Y. Levkovitz
The Emotion-Cognition Research Center, The Shalvata Mental Health Center, School of medicine, Tel Aviv University

Over the past 20 years we have seen how neurostimulation and neuromodulation for severe mental disorders has progressed from an experimental treatment based upon a clinical theory to being on the threshold of becoming a standard of medical practice. While new devices are implanted every year, the mechanism of action still evades complete understanding. Nevertheless, technological improvements have been considerable and the current neurostimulation and neuromodulation devices are safe and reliable. Unlike most conventional treatments, neurostimulation cannot be restricted to one specialty as its clinical applications ignore the boundaries of medical specialties. Conditions such as major depression, auditory hallucination, post-traumatic stress disorder, addiction etc. are likely to respond to brain stimulation. Even though the evidence for efficacy remains unsatisfactory, the field of neurostimulation has developed remarkably in terms of looking for new technologies to improve efficacy in patients who have failed conventional medication. The development, the
technicalities and the most important clinical applications of recent findings in the field of neurostimulation will be reviewed.

S6.2 ECT: NEW ADVANCES IMPROVE SAFETY AND MAINTAIN EFFICACY

Bernard Lerer*, Renana Eitan
Biological Psychiatry Laboratory, Department of Psychiatry Hadassah – Hebrew University Medical Center, Jerusalem

Although more than 70 years have elapsed since electroconvulsive therapy (ECT) was first introduced into psychiatry, it remains the most effective treatment for major depression and the treatment of choice for patients whose illness is resistant to antidepressant drug treatment. More recently introduced brain stimulation therapies such as transcranial magnetic stimulation and vagus nerve stimulation, although approved by regulatory authorities in the USA for the treatment of depression, have not supplanted ECT from its unique position. Over the decades several modifications have been introduced that have improved the safety of ECT including anesthesia, muscle relaxation, use of brief pulse rather than sine wave stimulation, right (non-dominant) unilateral [RUL] electrode placement and stimulus dosing based on seizure threshold. From the perspective of efficacy, a lingering concern has been that UL electrode placement may not be as effective as bilateral (BL) stimulation. This can be resolved by insuring a stimulus dose sufficiently in excess of seizure threshold (typically 5x). Recently, right unilateral, ultra brief stimulation [RUL-UB, 0.3 ms at 6x seizure threshold] has been introduced with support from two randomized controlled trials. In the first trial [Sackeim et al.2008] RUL-UB ECT was superior in efficacy to ultra-brief bilateral ECT and standard pulse width BL and RUL ECT. In the second trial (Loo et al, 2008), RUL-UB was equivalent to standard pulse width RUL in terms of efficacy. In both trials RUL-UB induced markedly less cognitive impairment than any of the other modalities. Our clinical impression from a series of patients with resistant depression treated at Hadassah – Hebrew University Medical Center supports these findings from the perspective of efficacy and lack of significant cognitive impairment. We suggest that RUL-UB should be adopted as the standard treatment for medication-resistant, unipolar depression. Use in bipolar depression and in catatonia remains to be further explored.

S6.3 TRANSCRANIAL MAGNETIC STIMULATION. STATE OF THE ART AND FUTURE DIRECTIONS

Leon Grunhaus
Jerusalem Mental Health Center, Hadassah Medical School, Hebrew University of Jerusalem

Transcranial Magnetic Stimulation (TMS) was approved by the FDA in the USA in 2008 for treatment resistant depression. Since then, several other countries in the world have issued similar approvals. As a consequence the clinical use of TMS has accelerated throughout the world although relevant questions regarding its efficacy and technical application remain open. Additionally TMS has spurred major interest in brain stimulation techniques and has opened the door for a variety of other methodologies that include wave modifications in TMS, deep TMS, theta burst stimulation, low-intensity focused ultrasound stimulation, optogenetics, optical stimulation techniques and more. In this presentation the state of the art of the clinical use of TMS will be discussed. The presentation will center on its use in treatment resistant depression but also in other clinical applications like PTSD, bipolar disorder, schizophrenia, Parkinson’s disease, and more. With a view towards the future, the presentation will also include developments in the area of magnetic stimulation that in the view of the presenting author will impact the clinical use of this modern methodology. Finally, the presentation will include recommendations for the continued development of brain stimulation in neuropsychiatry in Israel.

S6.4 DEEP BRAIN STIMULATION (DBS): A NOVEL TREATMENT IN PSYCHIATRY AND A NEW WINDOW ON THE BRAIN

Renana Eitan*, Zvi Israel1, Hagai Bergman3
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2Department of Neurosurgery, Hadassah-Hebrew University Medical Center
3Department of Medical Neurobiology, Institute of Medical research Israel-Canada (IMRIC), Faculty of Medicine, The Hebrew University

Deep brain stimulation (DBS) involves the insertion of thin wires (<1.5mm diameter) to carry electric current to parts of the brain. DBS surgery is now routine for patients with advanced Parkinson’s disease (PD), treatment refractory tremor and many forms of dystonia, and is being actively investigated for intractable depression and OCD. In contrast to a lesion surgery, DBS is a reversible, nondestructive and adjustable mode of neuromodulation. Although the overall published experience with DBS for psychiatric indications is limited, the reported results are encouraging. Behavioral changes followed by DBS were observed in PD patients and provide evidence for a possible limbic function of the subthalamic nucleus (STN). To better understand the motor and limbic roles of the STN we have moved the patient’s limbs and played emotional voices during and with synchronization of microelectrode recording (MER) of the STN on 9 PD patients that underwent DBS surgery. Our results reveal double dissociation of motor and emotional responses in the human subthalamic nucleus. The dorso-lateral oscillatory region (DLOR) of the STN was associated with motor stimulations and less with emotional ones. In contrast, the ventro-medial non-oscillatory region (VMNR) of the STN was associated with emotional stimulations and less...
Transcranial direct current stimulation (tDCS) is a non-invasive method of brain stimulation in which a weak direct electrical current is applied to the cerebral cortex through a pair of sponge electrodes placed on the scalp. It differs from other brain stimulation techniques as ECT, TMS by not inducing rapid depolarization required to produce action potentials in neural membranes, but modifies spontaneous neuronal excitability by tonic de- or hyperpolarization of resting membrane potential of neurons underlying the anode or cathode consequently. So it is more accurate to consider tDCS as a neuromodulatory rather than neurostimulatory intervention. A wide variety of brain functions has been shown to be modulated by tDCS, including effects in motor cortex, visual cortex, somatosensory cortex, mood and cognition. Its effects can be modulated by combination with pharmacological treatment and it may influence the efficacy of other neurostimulatory techniques. Therapeutic effects have been demonstrated in clinical trials of tDCS for a variety of psychiatric and neurological conditions including depression, post-stroke motor deficits, fibromyalgia, migraine, epilepsy, drug dependence, Parkinson’s disease. Multisensory environmental intervention (Snoezelen) is an innovative treatment method based on exposure to high-tech multisensory environment, which includes music, light from fiber optic strands and calming image projections, vibrations of bubbles tubes and soothing smells. The use of multi-sensory environmental intervention has been proven to be an effective intervention in the closed psychiatric ward for calming agitated patients and for reducing the number of seclusions and restraints (Teitelbaum A. and all, Harefuah, 2007). It can be postulated that enhanced sensory stimulation through exposure to multisensory environment, as a kind of gentle brain stimulation, may provide some therapeutic effect on psychiatric patients. Conclusions: tDCS and Snoezelen could be promising noninvasive, simple to use and safe tools for gentle brain neurostimulation, however more research evidence is necessary.
resources (e.g., constructed dialogue, metaphors, self- and rhetorical questions, pronouns, and syntactic structures), L. was able to relate to the doctor’s questions, position coherent dimensions of herself, and define her disorder at the beginning of each encounter. When, however, she became entangled in the narration of painful experiences retrieved from memory, she did not cohere thematically, temporally and/or causally. The paper highlights theoretical, methodological and clinical aspects of the study and illustrates them with examples.

S7.2 THE DEPARTMENT FOR INTENSIVE LONG-TERM PSYCHOANALYTIC PSYCHOTHERAPY: A UNIQUE INITIATIVE IN PUBLIC MENTAL HEALTH

Henry Szor
Abarbanel Mental Health Center; Sackler Faculty of Medicine, Tel-Aviv University

S7.3 THE ROLE OF GROUP PSYCHOTHERAPY IN THE REHABILITATION DEPARTMENT OF A MAXIMUM SECURITY UNIT IN A PSYCHIATRIC HOSPITAL

Galina Povar, Irit Schattner Zanany, Tali Lindenbaum, Orit Ne’eman-Nagur, Alexander Grinshpoon
Sha’ar Menashe Mental Health Center

In this era, the rehabilitation framework is extremely complex. On the one hand community rehabilitation that allows rapid discharge from the hospital to the community is developing. On the other hand, inpatients, such as those in our department, who alongside their severe psychiatric disorders also committed crimes, require a very long and complex preparation process before returning to society. Taking this into consideration, the department staff regards individual and group psychotherapy as key components in the preparation of these patients to deal with the community. Irvin Yalom specified eleven key components of the therapeutic experience, beginning with instilling hope, developing social skills and finally existentialist components. From among these, in the various types of psychotherapy we emphasized the development of social competence and interpersonal relationships as essential targets in the rehabilitation process of the mentally ill. In the framework of the activities of the rehabilitation department of the maximum security unit, we chose to present group psychotherapy, based on the belief that it constitutes the very essence of the rehabilitation process. In the rehabilitation department there is a variety of psychotherapy groups that deal with various issues in the rehabilitation process; the individual’s coping with his illness and his actions and learning and practicing social skills. Through various psychotherapy groups the patients are given the opportunity to identify their core difficulties with mirroring and feedback from other group participants. By identifying with others’ difficulties they increase their own motivation to search for appropriate solutions. The interpersonal interaction in the group is the focus of the therapeutic rehabilitation program. We focus on the “here and now” and work together to develop behaviors appropriate to the demands of reality, to enable integration into the community.

S7.4 MINDFULNESS IN A PSYCHIATRIC HOSPITAL

Oded Arbel
Beer Sheva Mental Health Center

In recent years, there has been a significant rise in popularity and interest in mindfulness-based therapies, both in theory and practice. As opposed to the past, where such therapies were considered esoteric and unconventional, if not unacceptable, nowadays, mindfulness-based therapies are entering into the core of conventional therapies and are receiving much positive feedback and validity. Research shows the effectiveness of mindfulness-based therapies for help dealing with anxiety, depression, personality disorders, ADD, as well with both in-patients and hospitalized psychiatric populations. Mindfulness-based therapies are carried out both individually and in group settings and are based on the learning and practicing of active, sitting meditation) the development of awareness and attention, active movement and body awareness, as well as a psychosocial and a cognitive elements. This lecture will discuss the relevancy of these techniques with different mental disorders and will explore the how these techniques can be integrated to mental health. In addition, participants will have a chance to hear about the pioneering work being carried out at the mindfulness unit at Bé’er Sheva Mental Health Center.

S7.5 THE EFFECT OF PERSONAL COACHING PROCESS ON THE REHABILITATION AND QUALITY OF LIFE IMPROVEMENT IN MENTALLY ILL PATIENTS

Yael Sne, Ilan Rubinstein
The Faculty of Management, Ben Gurion University

Psychiatric illnesses are a most common serious health problem in Israel and around the world, second only to heart disease. One in four people in the world is likely to have psychiatric symptoms during the course of his life. Psychiatric illnesses constitute a third of all mental illnesses in the world, measured by premature death and by the number of years a patient lives with his handicap, as the result of such a disease. In the last decades significant developments have taken place concerning the treatment and the rehabilitation of people who suffer from mental illnesses, among them the much acclaimed “Al Missud” Process – a process in which the psychiatric treatment is taken out of the hospitals and institutions and being transferred to
within the community framework (Anthony 1993, Saraceno 1997, Priebe & Mc Cabe 2000). In the year 2000 a new law was drafted in Israel under the title: “The Community’s Mentally Handicapped Rehabilitation Law”, with the aim of rehabilitating and integrating those people in their community so they may be able to achieve a degree of functional independence and a certain quality of life, while upholding their self-esteem in the spirit of the basic law of man’s dignity and freedom. The concept of Psychiatric Rehabilitation has a number of varied models and practices in its fold. Among others it concerns with reintegrating the patient in his community, by supporting and developing his capabilities and by focusing on his needs and goals in the time when he moves from the concentrated and focused care in the hospital to the more open care in the community.

S8 ATTENTION DEFICIT DISORDER: UPDATES AND CONTROVERSY

Chairpersons: Dr. Iris Manor, Prof. Shmuel Tyano

S8.1 PRESCHOOL ATTENTION-DEFICIT/HYPERACTIVITY DISORDER: THE STATE OF THE ART

Miriam Peskin*, Sara Spitzer1,3, Iris Manor2,3
1Day Care Preschool Department, Geha Mental Health Centre, Petach Tiqva, Israel
2Attention-Deficit/Hyperactivity Unit, Geha Mental Health Centre, Petach Tiqva, Israel
3Sackler Faculty of Medicine, Tel-Aviv University, Tel-Aviv, Israel

Attention-deficit/hyperactivity disorder (ADHD) is a common, chronic, and impairing neurodevelopmental disorder that frequently begins between 2 to 4 years of age. It is estimated that about 5% of preschool children have ADHD. Gender differences are less pronounced in preschool children than in older children, with a ratio of boys to girls of 2:1. The prevalence rates of ADHD subtypes in young children are markedly different from those in school-aged children, with high predominance of the hyperactive-impulsive and combined types. Clinically referred preschool children with ADHD are considerably impaired in their daily functioning. They often exhibit disruptive behaviors that may lead to expulsion from daycare education settings, accidental injuries and safety concerns. They often have significant social and learning difficulties that may lead to poor social adjustment and poor academic performance. Preschool-onset ADHD is currently understood as a strong risk factor for persistent behavior, social and academic problems, substance abuse and depression. Early diagnosis and intervention in young children with ADHD are strongly recommended. ADHD-specific rating scales, subscales on behavioral checklists, and structured psychiatric parent interviews have been shown to be reliable in assessing preschool children for ADHD. The treatment of ADHD during the preschool period is still a relatively controversial topic. Psychosocial treatment with parent training is considered a suitable first-level treatment for young children presenting with signs of ADHD. Methylphenidate appears to be efficacious in the treatment of this group of children, with effect sizes of decrease in ADHD symptoms smaller than in school-aged children. Side effects are usually mild, but the frequency and severity of them are greater than in school-aged children. Side effects as social withdrawal and decreased appetite are a matter of concern in the rapidly developing preschool child. All the aspects of preschool ADHD will be reviewed and updated during the presentation.

S8.2 ARE NAMES OF CHILDREN WITH ATTENTION-DEFICIT HYPERACTIVITY DISORDER MORE “HYPERACTIVE”?

Gal Shoval*, Iris Manor1, Eitan Nahshoni1, Abraham Weizman1,2, Gil Zalsman1
1Child and Adolescent Division, Geha Mental Health Center Psychiatry Department, Sackler Faculty of Medicine, Tel Aviv University, Israel
2Felsenstein Medical Research Center, Sackler Faculty of Medicine, Tel Aviv University, Petach Tiqva, Israel

Background: The role of the meaning of given names has been noted in psychotherapy as well as in everyday life. This study aimed to investigate the possible association between the nature of given names of children and ADHD diagnosis.

Methods: A total number of 134 given names of children and adolescent patients diagnosed as having ADHD were compared with an age and gender-matched randomly chosen control group from the general population. The first names of the two cohorts were compared with regard to the following: the literal meaning of their names, whether the name constitutes a verb, the prevalence of each name and their length (number of syllables).

Results: The meaning of first names of children and adolescents with ADHD combined type, were rated by referees as expressing significantly more activity and containing less syllables than the names of controls. In addition, the prevalence of their names was significantly lower than names used in the general population. The first names of the two cohorts were compared with regard to the following: the literal meaning of their names, whether the name constitutes a verb, the prevalence of each name and their length (number of syllables).

Conclusions: Our findings demonstrate an intriguing relationship between children’s given names and ADHD diagnosis. Given name may serve as possible predictor of later diagnosis of ADHD. Clinicians should be more attentive to given names in the context of child psychiatric evaluation and therapy.

S8.3 METADOXINE – A NOVEL EXTENDED-RELEASE NON-STIMULANT DRUG FOR TREATING ADHD

Iris Manor1, Rachel Ben Hayun2, Miriam Peskin1, Dana Salumi1, Yaron Daniely1, Dalia Megiddo1, Judith Aharoni1, Avraham Weizman1
1Geha Medical Health Center, Sackler Faculty of Medicine, Tel-Aviv University, Israel
2Rambam Medical Center, Haifa, Israel
3Alcobra Ltd, Israel
**Background:** Although ADHD is largely thought of as a childhood disorder, it is now known that symptoms can persist into adolescence in 80% of cases, and into adulthood in at least 50% of cases causing significant lifelong impairments in academic, career, and social functioning. Metadoxine (pyridoxol L-2-pyrrolidone-5-carboxylate) has been preliminarily shown to improve cognitive function in our previous studies. This trial examined the safety and efficacy of Metadoxine in adults by evaluating improvements in core ADHD symptoms and associated functional outcomes/Quality of Life.

**Methods:** Adult males and females (aged 18-50 years old, inclusive) who met DSM IV criteria for ADHD (via the Adult ADHD Clinician Diagnostic Scale [ACDS] v1.2) were randomly assigned in a 1:1 ratio to one of two treatment groups, MG01CI (extended-release Metadoxine, 1,400 mg) and matching placebo, for a 6-week double-blind parallel treatment period. The primary efficacy measure was the Conners’ Adult ADHD Rating Scale-Investigator Rated: Screening Version Total ADHD Symptoms score (CAARS –Inv:SV) with adult ADHD prompts, to assess core ADHD symptoms. The Adult ADHD Quality of Life-29 (AAQOL-29) scale evaluated functional outcomes in various domains. Other assessments included the Clinical Global Impression-Severity (CGI-S) scale, and the Test of Variables of Attention (TOVA). Pre-specified statistical analysis included the median test for the primary endpoint and ANCOVA for secondary endpoints, with adjustments for age, gender and site. Subjects also underwent safety assessments including laboratory evaluations, neurological and physical exams, 12-lead ECG and weekly assessments on the Columbia-Suicide Severity rating scale (C-SSRS).

**Results:** Significant improvements in CAARS Total ADHD Symptoms Score (11.02±1.50 vs. 5.71±2.13, p<0.01) were observed in the MG01CI group as opposed to the placebo group, respectively. Improvements in CAARS and TOVA were statistically significant over placebo after 2 weeks. Sub-analysis of subjects with ADHD inattentive type (n=48) showed an even greater improvement in CAARS scores over placebo (-13.4±1.9 vs. -6.3±1.4, p<0.05). MG01CI was associated with a favorable safety profile, comparable to Placebo. Mild nausea was observed only in MG01CI and may be considered an anticipated TEAE in future research.

**Conclusion:** MG01CI resulted in a significant improvement in ADHD symptoms compared to Placebo, with possible differential effects on inattentive/executive function symptoms, as reflected by relatively greater improvement in CAARS inattention and TOVA scores, and in subjects’ quality of life.

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**S8.4 TRANSCRANIAL MAGNETIC STIMULATION (TMS) AS A TREATMENT IN ADHD**

Yuval Bloch
Shalvata Mental Health Center

Transcranial magnetic stimulation (TMS) is a non-invasive tool that was developed for studying the nervous system and showed promising findings of having the capability of favorably affecting neural plasticity. The high safety profile combined with the specificity it has [effecting specific brain areas and not others] have probably contributed to a rise in rTMS use as a therapeutic tool for different neuropsychiatric disorders. It is currently approved by the FDA as a second line treatment for depression. In using rTMS there have been recurrent reports on improvement in attention. This is probably not surprising since rTMS affects dopaminergic secretion in the prefrontal cortex. Attention deficit hyperactivity disorder (ADHD) had been suggested to involve dopaminergic prefrontal abnormalities. We recently conducted a crossover double blind randomized, sham-controlled pilot study, patients diagnosed as having adult ADHD received either a single session of high-frequency rTMS directed to the right prefrontal cortex (real rTMS) or a single session of sham rTMS. The post-real rTMS attention score improved significantly (M=3.31, SD=.5), t(12) = 2.235, p < .05. TMS had no effect on measures of mood and anxiety. The sham rTMS had no effect whatsoever. We will discuss these findings and future possibilities.
on weight maintenance. 3. Failure to lose weight or maintain weight loss during treatment or suffering from severe medical complications, combined with good cooperative efforts: Bariatric surgery. Preliminary results: 1. All patients achieve weight loss during intensive inpatient intervention. 2. Most patients continue to cooperate with the program throughout the second stage (day treatment program) and achieve 5%-15% weight loss with significant improvement in medical complications. 3. Patients remaining at the program during the follow-up stage, maintain their weight loss. Drop-out patients return to their initial weight.

Until now few patients required bariatric intervention. Future aims: 1. To compare the characteristics of patients and families in the three groups. 2. To assess the effectiveness and outcome of our interventions with a focus on the different treatment stages: engagement, weight loss, maintenance. 3. To study the impact of preoperative and post-operative preparation and follow-up of patients undergoing the Sleeve Procedure.

## S9.2 COGNITIVE REMEDIATION THERAPY FOR PATIENTS WITH ANOREXIA NERVOSA

I. Vorgaft, S. Bercovich.

Child & Adolescent Psychiatric unit, Eating disorder – day care unit, Ziv Medical Center, Safed

Anorexia Nervosa (AN) is a severe mental illness characterized by rigid thinking and rigid eating behaviors. Neuropsychological studies have shown that patients with AN have difficulties in cognitive flexibility. Specifically, neuropsychological deficits such as set shifting difficulties and weak central coherence, measured by a variety of neuropsychological tasks, were present in people with eating disorders. The key for understanding the link between these cognitive dysfunctions and rigid thinking may be the cognitive interiorization process. Cognitive interiorization process is the cognitive ability to assimilate information and to transform it to autonomous and usable. Internalized information is represented in the human mind by words, symbols, icons etc. Deficient interiorization process is manifested by rigidity, difficulty in transferring the cognitive principle to a new task, difficulty to detach oneself from the minor or concrete details [weak central coherence] and low efficiency of the cognitive processing. In our day care center for eating disorders, we managed to demonstrate deficient interiorization processes in adolescents suffering from AN in comparison to healthy controls. Cognitive Remediation Therapy (CRT) is a novel clinical intervention based on these findings, which aims to use cognitive exercises to improve performance on flexibility tasks. In our day care center for eating disorder, in Ziv hospital, we implemented short term (ten sessions) CRT intervention for adolescents suffering from AN, based on our understanding and the encouraging data supporting the use of CRT in patients with AN by Tchanturia and colleagues. Some preliminary results will be presented.

## S9.3 FACTORS ASSOCIATED WITH THE RATE OF WEIGHT GAIN DURING INPATIENT TREATMENT OF FEMALE ADOLESCENTS DIAGNOSED WITH ANOREXIA NERVOSA

Shimrit Ziv, B. Kochavi, A. Toledano, D. Stein

The Safra Children’s Hospital, The Chaim Sheba Medical Center, Tel Hashomer, affiliated with the Sackler School of Medicine, Tel Aviv University, Tel Aviv, Israel

The aim of the present study was to evaluate relevant clinical and psychometric factors potentially influencing the rate of weekly weight gain of female adolescents hospitalized because of anorexia nervosa (AN). This was done with a retrospective analysis of the medical files and self-rating questionnaires of 84 adolescent females hospitalized in an adolescent inpatient department because of AN in a period of 8 years. Of all parameters assessed, the following were found to be associated with greater weekly weight gain: lower minimal body mass index, greater difference between minimal weight and weight at discharge from hospitalization, shorter duration of hospitalization, less use of SSRIs and atypical neuroleptics during hospitalization, and a greater willingness and ability to protect one’s body according to the Body Investment Scale. These findings suggest that whereas it might be easier for very low-weight malnourished AN patients to gain weight during inpatient treatment, at least during the earliest weeks of hospitalization, greater severity of the AN illness, as reflected by the need for longer hospitalization and for psychotropic treatment, and by a less favorable attitude toward the body, is associated with lower weekly weight gain.

## S9.4 INVOLUNTARY TREATMENT OF ADULTS SUFFERING FROM ANOREXIA NERVOSA: THE CURRENT LEGAL REGULATION AND PROPOSALS TO RE-EXAMINE IT FROM A CLINICAL CAREGIVER’S POINT OF VIEW

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The question of involuntary treatment of adults suffering from anorexia nervosa does not leave the public agenda. Unfortunately descriptions of anorexia nervosa patients who do not receive proper care and family members who are desperate for forced intervention frequently hit the headlines of both the printed and the broadcast media. Many times the multi-disciplinary team that treats these patients is caught in the tension between the world of medicine and the world of law, with complicated medical and ethical dilemmas, which become even more complex because of the impression that the legal regulations...
(legislation, rulings and establishment of health policies) in Israel is not commensurate with current psychiatric clinical knowledge and practice. This lecture will examine the current existing situation in Israel concerning the legal regulation of involuntary treatment of anorexia nervosa patients, while relating to the new research ideas in Israel and around the world. First, we will describe the formal legal regulation, which evolved following legal interpretation of the laws (which are not unique for anorexia nervosa patients), which allow involuntary treatment – and we will put this regulation to the test through real cases in Israel, which have not yet been published. Next, we will examine the considerations, from the clinical caregiver’s point of view, which seem central to us in the creation of appropriateness between the legal regulation and the accepted evidence based psychiatric treatment. Finally, we will examine the proposals which are on the table today for the reform in the legal regulation of involuntary treatment of anorexia nervosa patients, while comparing to what is customary around the world, and examine the reference - if it exists - to the central considerations mentioned above. We hope that this lecture will present this important issue from a new point of view and will be a basis for discussion, research and cooperation between all those involved in the field from both sides medical and legal as one.

S9.5 ALIVENESS AND WEAROUT IN THE INTENSE TREATMENT OF EATING DISORDERS

Micha Weiss M. Eitan Gur
Department of Eating Disorders, Sheba Medical Center, Tel-Hashomer

In the following presentation the authors will assess the various factors that are involved in the working experience of the staff of the Department of Eating Disorders for adults in Tel-Hashomer Hospital. The current perspective is extracted through the lens of the dialectics of Aliveness and Wearout that the presenter believes to be a central tension in the working experience of the personnel. The treatment of eating disorders is known to be a tedious effort. Among the patients, about 50% are known to proceed into variations of a chronic ‘career’, creating the ‘round-door’ effect on the ward, while returning for treatment periods again and again. Eating disorders are known to be a rigid malaise, often a part of wider syndrome consisting of personality disorders and other disorders. This produces stress on the treating personnel, creating prorness for the burnout of the staff. On the other hand, the effort of curing is seemingly undamaged, and many times able and talented persons, usually women, arouses the therapists’ rescuing fantasies, enlivening their sense of mission. It is within this dialectical tension that this presentation intends to surf, looking into its various effects on the work in the department.

S10 TRANSCULTURAL ASPECTS OF MENTAL HEALTH

Chairpersons: Dr. Nimrod Grisaru, Prof. Eliezer Witztum

S10.1 SUICIDAL BEHAVIOR AMONG IMMIGRANTS FROM THE FORMER SOVIET UNION IN ISRAEL

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Presented is a study that explored the association between suicidal behavior and immigrant status among immigrants from the former Soviet Union (FSU) in Israel. Data on suicide ideations, plans and attempts was obtained from the Israeli component of the World Mental Health Survey (INHS). The INHS sample included Israel-born Jews (n = 2114) and immigrants from the FSU who arrived in the country since 1990 (n = 814). Data on completed suicides were extracted from the countrywide report of the Ministry of Health. The controlled lifetime rates of suicidal behavior among FSU immigrants were significantly higher than among their Israel-born counterparts. A higher risk was found in the first years following immigration among young adults with higher education and without a spouse. Completed suicide rates were also higher among the FSU immigrants than in the general Israeli population. The largest risk for completed suicide was found among young-adult immigrant men. These findings are consistent with previous studies and are discussed in the context of suicide rates in the country of origin and migratory stressors. They are also compared with findings on Ethiopian immigrants in Israel. Preventive measures are suggested.

S10.2 A REVIEW OF MENTAL DISORDERS AMONG THE ARAB POPULATION IN ISRAEL

Nabil N. Geraisey
Health Office, Ministry of Health

The epidemiological data regarding mental health problems in the Arab countries and among the Arab minority in Israel are scant, but have recently increased. The “Israel National Health Survey” (INHS) is part of the international mental health survey that was planned and coordinated by experts from the WHO and Harvard University. The survey included 28 countries. It explored the prevalence rates of selected mental disorders among the adult non hospitalized general population. The INHS examined the prevalence rates of the common mental disorders in the total Israeli population: Depression (severe, mild and moderate
episodes), Bipolar Affective Disorders and Dysthymia, Panic, Agoraphobia, Generalized Anxiety and Posttraumatic Stress Disorder. In addition Drug and Alcohol Dependence were examined. This report focuses on the relationship between mental disorders and socio-demographic traits and various risk factors, patterns of referrals to mental health services and attitudes toward mental health treatment. In addition to the data from the National Health Survey we will report on other recent research studies e.g., Emotional Distress among the elderly Arab population, Eating Related Attitudes and Psychological Traits among adolescent girls, Suicidal Behaviors, Emotional Distress and treatment lag among first time patients attending Outpatient Mental Health Clinics. The implications for clinical care will be discussed.

S10.3 MENTAL HEALTH TREATMENT IN ISRAEL: DOES THE MELTING-POT POLICY WORK?

Anne-Marie Ulman MD*
Beer-Yaacov Mental Health Center, Sackler Faculty of Medicine Tel-Aviv University

In today’s world of globalization, mental health workers are confronted with a new type of psychiatric pathology consequent to the process of migration. Like in the world, Israeli mental health workers are required to adapt their practice and develop new skills in order to treat a mosaic population. The objective of this presentation is to explore what has been accomplished to date concerning psychiatric practice, as described in the literature. We will review how Canada implemented a mental health policy allowing efficient treatment in a multicultural context. We will also explore Tobie Nathan’s ethnopsychiatric setting whose function is to overcome the deleterious consequences of the split existing between the two cultural referents (host and origin) in which migrant/patients live. Canadian studies have shown importance of cultural barriers, as well as the importance and impact of culturally sensitive mental health service implementation. Canada has also illustrated and documented the fact that migrant populations are subject to more psychiatric pathology than the host population but are reluctant to turn to mental health practitioners. Fear from prejudices and cultural misunderstanding were found to be not only a source of delay in consultation, but also a cause of inappropriate treatment. Tobie Nathan’s ethnopsychiatric setting enables mental health workers to understand new psychological disorders by understanding and manipulating traditional therapy concepts. Thus tools can be found to understand the patient while addressing modernity. This approach enables mental health workers to cope with complexity and efficiency in the field of psychotherapy. In conclusion, practice of psychiatry in a multidisciplinary context makes possible the use of the patient’s cultural background as a source of information and a tool to the understanding of pathology. Cultural differences should not be a reason for cultural discrediting, but rather a meeting point for the establishment of new type doctor/patient therapeutic relationship embedded in the society’s conception of human relationships.

S10.4 INTIMATE PARTNER HOMICIDE AND SUICIDE AMONG ETHIOPIAN MEN IN ISRAEL

Arnon Edelstein
Academic Adviser and Senior Lecturer for Youth at Risk Department, Kaye Academic College of Education, Beer Sheva, Israel; Lecturer in Criminology for I.D.F students, Sapir Academic College, Sederot, Israel

Ethiopian immigrants account for the vast majority of cases of intimate partner homicide (IPH) in Israel, whether or not the murderer commits suicide. Explanations of the risk factors for IPH among Ethiopians emphasize their transition from a patriarchal culture to a modern one and husband/wife role reversal. Risk factors are insufficient causes; we must identify the triggers that escalate risk factors for IPH. In order to explore these triggers among Israeli men, in general, and Ethiopian men, in particular, an empirical research examined more than five thousand legal documents on IPH from all the courts in Israel, 1985-2010. Three main triggers for IPH among Ethiopian men were found: a woman’s request to separate from her partner (50%); a formal complaint lodged against the man for abusive behavior (13%); and real or imagined infidelity by the woman partner (37%). Fifty percent of the Ethiopian murderers tried to/succeeded in committing suicide, a ratio parallel to that of women requesting separation. Contrary to the myth that suicide is a result of guilt felt after uxoricide (wife murder) or IPH, suicidal tendencies were found to precede the decision to commit murder. Distress, despair and the feeling that there is nothing more to lose are the main motives for suicidal behavior among Ethiopian men. The unhealthy rationale behind IPH followed by suicide is to eternally preserve the relationship as it was prior to the woman’s will to separate by both their deaths. When the separation trigger impacts on a personality suffering from prior psychological disorders, such as abandonment anxiety, high dependency, acculturation stress, and other immigration-related factors, the result is often IPH.

S10.5 WHEN THE SYMPTOMS ARE PSYCHOTIC AND THE PATIENT IS NOT; THE PSYCHIATRIC STATUS IN A DIFFERENT CULTURE. THE ETHIOPIAN EXAMPLE

Nimrod Grisaru, Eliezer Witztum
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The ethnographic Ethiopian definition for health is “a state of equilibrium between the physiologic, spiritual, cosmologic and ecologic powers surrounding the human being”. The influence
of the supernatural powers is much more emphasized with regard to mental health. In order to provide psychotherapy to patients from a different culture the therapist needs to obtain both a specific cultural competence and a good general knowledge. The cultural competence is mandatory in order to reach the right diagnosis and in order to provide psychotherapy in an acceptable way. Pharmacotherapy is also part of the process. During this presentation I will present two examples of situations which can easily lead to an erroneous diagnosis. 1. A representative case of an Ethiopian patient suffering from KN-KN with apparently psychotic symptoms is misdiagnosed by his culture as suffering from a mixed anxiety and depression disorder. This is well-known and acceptable condition in the Ethiopian culture, treated by ‘shenbeko’ and ‘mirta’ by a special healer. In our cross cultural clinic I would suggest a combined western, cultural and placebo treatment. 2. A representative case of ‘Colle’, an Ethiopian Spirit possession with a full apparently psychotic phenomenology and symptomatology. Patients have been erroneously diagnosed as suffering from psychotic conditions, including schizophrenia and treated with antipsychotics. Zar (or Colle) is a well-known phenomenon included in the DSM-TR IV but is not considered to be pathologic at all in the local culture. In several cases people from the community appealed to western clinics with a dual diagnosis usually due to stress. In both cases the idiom of distress and the explanatory model of the culture are the cultural tools needed in order to reach the right diagnosis and to provide psychotherapy in an acceptable way.

S11 WORKSHOP FOR RESIDENT PSYCHIATRISTS: DILEMMAS DURING THE RESIDENCY PROGRAM - QUESTIONS OF IDENTITY

Chairpersons: Dr. Shlomo Mendlovic, Prof. Y. Levkovitz, Dr. Ilana Kremer

The residency program of psychiatry in Israel is complicated. It has different components, some (either openly or hidden) conflicting with each other. These components have a direct effect on the future identity of the psychiatrist in terms of the theoretical, clinical, ethical and systematical conception of psychiatry. In addition, since these components concern the practice of the resident, they can influence the way the future psychiatrist will act, in practice, in the therapeutic field. The symposium will examine the different components of the psychiatric residency program. In order to clarify these components we will conduct four debates. In each debate, two residents will represent two opposing approaches towards a chosen dilemma. Each debate will last ten minutes and will be conducted by a senior psychiatrist. Later, 10-minutes will be dedicated to a discussion with the audience. After the debates, we will conduct a discussion with the general assembly concerning the integration of the different components of the developing psychiatric intern identity.

S12 THE ISRAEL CONSORTIUM FOR POSTTRAUMATIC STRESS DISORDER CELEBRATES ITS 10TH ANNIVERSARY

Chairpersons: Prof. Joseph Zohar, Prof. Ze’ev Kaplan

S12.1 TENTH ANNIVERSARY OF THE ISRAELI NATIONAL CONSORTIUM ON PTSD (INCP): MILESTONES, INSIGHTS AND ROADMAPS

Joseph Zohar*, on behalf of the INCP (Avi Bleich, Dan Dolfin, Miki Doron, Ze’ev Kaplan, Ehud Klein, Moshe Kotler, Mooli Lahad, Avi Ohry, Arieh Shalev, Zeev Weissman)

Sackler School of Medicine, University of Tel Aviv

The INCP dedicated its first four years (2001-2005) to a comprehensive survey of all veterans who were diagnosed with any mental disorder, with a specific emphasis on PTSD. The survey found that about 50% of veterans who approached MoD for mental disorders had a primary diagnosis of PTSD. Based on these findings, the consortium built a guideline for treatment of PTSD (see www.ptsdil.info). The guidelines are unique for five reasons: Multidimensional, including as integral parts not only medical dimensions, but social, marital, family, sexual, and rehabilitation axes. They make specific reference to treatment taking into account the time axis, specifying the first month, two years, five years, ten years, 15 years, etc.

The starting point is response so far to treatment, using this as a base for the next step.

This is a web-based guideline. The therapist enters the medical, psychological, family, occupational history of the patients, and gets the relevant suggestions from INCP. It focuses on the patient rather than a method or a prescribed step. After filling in details of the patients, including past history, time of traumatic events, etc, the therapist gets, via the algorithms, the recommended next step.

The system has the capacity to monitor a given patient, through repeated assessment with selected severity scales. This also allows comparison of performance of different methods/therapists/centers over time, and consequently centers of excellence were identified whose methods could be disseminated to other centers. The INCP also developed a structured “Entrance Gate” system. The concept is that every “newcomer” will undergo a detailed, comprehensive, structured evaluation (including specific validity and exacerbation index).

Based on this specific treatment program will be tailored to the patient, offering 12-18 months intensive treatment, provided before a disability claim is filed.
S12.2 CHANGES IN ISSUES OF RECOGNITION AND TREATMENT OF THE MENTALLY DISABLED CASUALTIES OF IDF: PROFESSIONAL AND PERSONAL PERSPECTIVES

Avi Bleich
Lev-HaSharon MHC, affiliated to the Sackler faculty of Medicine, Tel-Aviv University, and NATAL (The Israel Trauma Center for Victims of Terror and War)

Following the first Lebanon War (1982), soldiers who suffered post traumatic distress were offered therapy in the Mental Health Department of the army. Thus, for the first time, eligibility for treatment was no longer dependent on a disability claim. Indeed, cumulative clinical experience revealed that most soldiers seek treatment (preferably provided by the army) rather than disability compensations. Studying the characteristics and needs of the casualties led to various psychotherapeutic modalities, an advanced psychopharmacology clinic, an innovative therapeutic project “KOACH” [strength], and recognition of the need to treat the spouses as well. During the 1990’s, the Rehabilitation Department of the Ministry of Defense re-evaluated the issue of recognition of the mentally disabled casualties in the IDF. A professional steering committee was appointed and its recommendations for multi-disciplinary evaluation, including defined functional parameters, were implemented. A study that accompanied the process revealed that: PTSD was the most common diagnosis among those who seek recognition as disabled veterans; levels of psychiatric symptoms and distress were high and were related to functional impairment and the total degree of disability; The estimated levels of disability were on the average higher than those previously “accepted” among mentally disabled veterans. A survey of the Israeli PTSD consortium in the last decade revealed: a steady increase in the number of mentally disabled due to PTSD [that currently constitute about half of all of the mentally disabled in the IDF], a discouraging course from initial recognition with a lack of functional improvement and recurrent claims for higher degrees of disability and, at the same time, a reduction in adherence to therapy and in the rate of those in therapy among the disabled. These trends can be accounted for by the increased number of wars and terror attacks, by social trends, and also by inherent problems in the policy of compensation and rehabilitation of the disabled. Ongoing efforts are necessary to swing the pendulum from over-involvement with the disabled status to focusing on appropriate therapeutic modalities as well as creative rehabilitation policies.

S13 DRUG ADDICTION – THE ROLE OF MEDICAL MARIJUANA IN MENTAL HEALTH

Chairpersons: Dr. Yehuda Baruch, Dr. Arturo Lerner

S13.1 PRIVATE TREATMENT FOR OPIATE ADDICTION IN ISRAEL

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1 Hebetim Clinic, 5 Brenner St. Tel-Aviv
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5 Eitanim Mental Health Center, Outpatient Clinic, Jerusalem

Opiate addiction patients for whom detoxification treatment was unsuccessful routinely receive psychopharmacological treatment with either Methadone or Sub-Lingual Buprenorphine. For the
past six years, Hebtem Clinic has offered a pioneer program in an ambulatory private setting, for the administration of Sublingual Buprenorphine to over 1200 patients. Five hundred of the patients continue to receive daily treatment with monthly follow-up visits. Treatment is provided at low cost and in an empathic environment. Treatment is primarily medical, and psychotherapy is optional, offered for a fee, at private clinic rates. The clinic operates at four locations; Tel Aviv, Kfar Saba, Ashdod and Gedera. Additional providers offer similar services throughout Israel. The model has proved to be an acceptable method for delivering this essential treatment to large numbers of patients, and can be regarded as a preferred alternative to Methadone clinics in terms of efficacy, safety and psychosocial benefits. The model enables quick and smooth initiation of treatment parallel to occupational rehabilitation without the constraints of daily visits to a Methadone clinic. The main obstacle to widespread implementation of the model is the total absence of support from the Israeli Government though in many western countries Sub-Lingual Buprenorphine is provided free of charge. Based on our data, official government support would significantly advance the treatment of this difficult-to-treat population. Data will be presented and our model will be described in detail.

S13.2 CANNABIS USE- RISKY ASPECTS IN THE MENTAL HEALTH DOMAIN

Emi Shufman
Director of Jerusalem Institute for Treatment Substance Abuse and Comorbidty-Ministry of Health, 1987-2010

More than a few physicians including psychiatrists have a moderate approach toward Cannabis use as a soft drug. This approach is dictated by the Media and has been accepted by society. In this lecture I will bring evidence based facts against the above misconception, especially in mental health aspects. The facts are based on my long clinical experience and especially upon many studies that have been published in the important medical literature. I will depict prospective studies which prove that using Cannabis causes high frequency of psychoses and detrimental effects on affect, stability and cognition.

S13.3 REGULATION OF MEDICAL GRADE CANNABIS (MGC) IN ISRAEL AND THE WORLD: CURRENT SITUATION

Assaf Shelef
Abarbanel Mental Health Center, Bat Yam, and Sackler Faculty of Medicine, Tel Aviv University, Israel.

In the last several years there is increased demand and use of medical grade cannabis (MGC). Regulation of cannabis growth, use and distribution has been a subject for many discussions in the Israeli medical system, parliament and the media. The increased demand for this kind of treatment which is considered to be safe and effective for various indications caused increased interest in the MGC approval mechanisms. There are certain countries that built regulation and control mechanisms for MGC. The United Nations Convention, 1961, defines the medical legal use of narcotic substances. The convention demands full governmental control of the narcotic substances stock, including cannabis. In Holland there is full control according to the United Nation’s convention. MGC is prescribed in Holland and supplied by a pharmacist as a regular drug. In Canada after a long legal struggle, patients pressed the government to begin a federal program of MGC. In the United States of America there is a gap in cannabis authorization policy between some of the states and the federal government which is against MGC use. Today in Israel, the Ministry of Health general manager appoints a representative who certifies MGC. MGC is directly supplied by the marijuana growers. This is a problematic model which lacks separation between the growers and the patients. Another problem is that the United Nations requirements are not fulfilled. The first certificate was given in 1993, and in the year 2010 there were 5000 MGC users. The number of certificates is growing as a result of increased awareness of the general public to this subject and according to the various indications. Until lately, Israel has not implemented the United Nation’s convention and has not established a governmental agency which controls MGC.

In August 2011 the Israeli government decided to establish a governmental MGC agency in the Ministry of Health. This agency is supposed to regulate and control MGC in Israel.

S13.4 MEDICAL CANNABIS: PAST, PRESENT AND FUTURE

Yehuda Baruch
Abarbanel Mental Health Center, Bat Yam, Israel

Dr. Shelef will speak about the medical benefits of medical cannabis or MGC (Medical Grade Cannabis). I will focus on the indications for use and the dosages to be administered. The indications for use in Israel are: chronic pain, cancer patients in chemotherapy treatment, HIV patients with more than 10% weight loss or CD4 ≤ 400, inflammatory bowel dis. (as opposed to irritable bowel syndrome), and MS patients suffering from spasticity. One must remember that for all indications MGC is the last line of treatment and not the first, and the physician must show the full list of medications administered to the specific patient prior to MGC treatment. There is an option for treating patients with conditions not included in the list of recommended indications, in the event that the physician can produce a letter from the director of the hospital or the clinical division in the Health Fund stating that he is convinced that in the specific case there is justification for prescribing MGC therapy even though the patient does not meet the specific criteria in the guidelines for MGC treatment. Dosing - We begin with 20 gr per month which
is about 0.66 gr per day. We start low and progress slowly, and 70% of the patients are satisfied with a regimen of 0.5 gr * 2 a day or less. A dosage of 1.33 gr of cannabis with a 16% of THC is enough to occupy more than 90% of the CB receptors and this without taking in to account other cannabinoids that compete on the same receptors. The maximal dose is 100 gr per month. Restrictions – Patients should refrain from driving for up to 6 hours after the intake of cannabis. Patients using MGC 3 times per day or more should not drive at all.

**S14 PROFESSIONAL AND ECONOMIC ASPECTS OF MENTAL HEALTH IN THE PUBLIC SECTOR**

Chairpersons: Dr. Alexander Grinshpoon, Dr. Marnina Swartz

**S14.1 MENTAL HEALTH SERVICES IN ISRAEL ARE AT A CROSSROADS**

Igor Barash  
Ministry of Health, Jerusalem

When the national health insurance law was passed in 1994, mental health was excluded from the services that the HMOs were responsible for, leaving the Ministry of Health responsible for Mental Health Services. At that time the Ministry of Health, decided on a structural reform, by reducing the number of inpatient psychiatric beds, with the plan being to implement the insurance reform within a year or two. 17 years have passed with ongoing debates regarding the future of health insurance reform in mental health services. The Ministry of Finance estimates the reform will cost 400-450 million NIS, over a five year period. There are currently government run mental health clinics that operate as satellite services of the psychiatric hospitals, mental health clinics operated by the HMOs and ambulatory services /clinics that are outsourced and funded by the Ministry of Health. There are 3,150 inpatient psychiatric beds (42 per 100,000 persons) and psychiatric hospitals operate at 120%-105% capacity. Is it necessary to increase the number of inpatient beds in psychiatric hospitals or in general hospitals? How many beds should be allocated for adults, children age 0-12 and adolescents age 12-18? How many beds are needed to treat individuals with eating disorders or with dual diagnosis (Mental illness and substance abuse or mental illness and mental retardation)? In recent years the Ministry of Health developed a residential program for serious and persistently chronically mentally ill adults who no longer needed acute care. There are now 650 beds on the campuses of psychiatric hospitals or in the community operated by service providers by tenders. The cost per day of inpatient care in an acute unit is 950 NIS, long term stay is 750 NIS and Intensive Residential Care is between 250-300 NIS a day. The time has come to give serious thought to the future of mental health in Israel, in light of the delay of the insurance reform.

**S14.2 FUNCTIONAL ASSERTIVE COMMUNITY TREATMENT (FACT) IMPROVES BOTH THE QUALITY OF LIFE AND LEVEL OF CARE FOR SMI-PATIENTS LIVING ON THEIR OWN IN THE COMMUNITY**

Dan Cohen, Michiel Bahler, René Keet  
Department of Severe Mental Illness, Mental Health Organization North-Holland

FACT, functional assertive community treatment, is a Dutch version of ACT that provides multidisciplinary outpatient care for all patients with severe mental illness within a certain catchment. The FACT-team is responsible for ACT-care as long as the patient lives in its catchment area, irrespective of the level of psychiatric care needed. Besides rare exceptions, patients are not discharged but remain within the responsibility of the FACT-team: once a patient has been admitted, the FACT-team is responsible. When low intensity care is needed, the level of care is intensified, even up to phone calls or house visits. The FACT-team does not discharge patients, unless a patient has been stabilized for 2 years or longer. Other characteristics are: 1. High inpatient/outpatient ratio: out of the in total 900 severely mentally ill patients, 800 are outpatients and about 100 are inpatients. 2. Decentralized assertive community treatment. Every team has its own catchment area with between 150-200 outpatients per team. 3. A high staff-patient ratio: 1 fulltime psychiatrist for every 150-200 patients. 4. Apart from moving to another catchment area, dying or referral to the GP (1 or 2 patients per team per year at most), there is no way to escape our assertive psychiatric care. 5. Intensive case management: case managers have a maximum caseload between 15-20 patients. 6. Multidisciplinary approach: a FACT-team a mean of 6 case managers, 2-3 social psychiatric nurses, one fulltime psychiatrist and halftime psychologist, a peer-specialist, an individual placement & support worker.

**Results:** a. Very low drop-out rate: apart from the 3 causes mentioned above below 5% b. Very low number of acute coercive admissions to the hospital c. Drop in hospital bed occupancy d. Increased patient satisfaction

**S14.3 COMORBIDITY AND GENDER IN SEVERE MENTAL ILLNESSES IN A TWO MILLION MEMBER HEALTH ORGANIZATION IN ISRAEL: FINDINGS FROM A COMPUTERIZED REGISTRY OF PSYCHIATRIC PATIENTS**

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Disease registries can provide good-quality information relating
to individual patients as well as for epidemiological monitoring and service planning. However, little is known about the potential of a computerized registry of severe mental illness (SMI) to improve the clinical patient follow-up and identification of medical co-morbidity and the reduction of complications and death. Maccabi Healthcare Services (MHS), the second largest HMO in Israel, has recently established a registry of SMI patients. Using this registry, we investigated the prevalence of SMI, medical co-morbidity and mortality in correlation to age and gender in schizophrenia and bipolar affective disorder adults, compared with the general population of MHS members. We identified 8,848 schizophrenia patients (crude prevalence rate of 5 to 1000) and 5,732 bipolar patients (crude prevalence rate of 3 to 1000). 1 year incidence rates were 4.2 and 2.4 per 1000 for schizophrenia and bipolar disorder accordingly. On average an 8 years earlier onset of schizophrenia was observed among males vs. females. Life expectancy was 12 and 9 years shorter for schizophrenia and bipolar disorder patients accordingly, compared with the general population. Higher medical co-morbidity rates were observed among SMI patients, in particular diabetes mellitus with age and sex adjusted odds ratio of 1.9 and 1.6 for schizophrenia and bipolar disorder patients accordingly. The current study demonstrates the potential of using large automated medical and administrative databases to determine the epidemiology of chronic diseases, such as SMI. The presented information is important for the development of good medical practice and the installation of prevention plans for bridging the gap between mental and physical patient’s health care. To our knowledge, this is one of the largest and most comprehensive studies assessing the epidemiology of SMI patients, regarding gender, medical co-morbidity, and life expectancy using a computerized registry.

S14.4 INTEGRATING A PSYCHIATRIST TO THE HOME-TREATMENT UNIT’S TEAM IN THE NORTHERN DISTRICT OF MACCABI HEALTHCARE SERVICES

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1Maccabi Healthcare Services, Tel Aviv, Israel
2Department of Community Mental Health, Haifa University, Haifa, Israel
3Faculty of Health Sciences, Ben-Gurion University of the Negev, Beer Sheva, Israel

The purpose of the unit for home treatment in Maccabi Healthcare Services in the northern district is to give medical services to the insured clients that are restricted to their homes. In addition to their medical conditions, the prevalence of psychiatric diagnosis in that specific patient group was found to be higher compared to the general population matched for age. In many cases the psychiatric disorder aggravates the prognosis of the underlying physical condition and can even lead to a higher rate of mortality. These features called for the integration of a psychiatrist to the multi-disciplinary team. In the beginning of 2010 a psychiatrist joined the team group. He provides home visits to the unit’s patients and participates in the team’s meetings and consultations. Today the unit’s team includes: Primary physicians (family, internist, geriatric), nurses, social workers and a geriatric psychiatrist. The unit treats a 1,500 patients caseload, and performed approximately 400 house calls during an 18 month period. All medical data for the patients including: diagnosis, evaluations, laboratory results, medications, treatments, documentation, imaging tests are documented in the patients’ electronic files, so that all the members of the team can see and update the data. In the presentation we will specify those patients that were evaluated by the psychiatrist regarding the consumption of psychiatric medications, the common reasons for the psychiatric evaluation, demographic data and common medical conditions. We will examine the advantages of multi-disciplinary team work, in particular the optimization of complex and diverse physical and mental medical treatment.

S15 ORGANIZATIONAL, LEGAL AND EDUCATIONAL ASPECTS OF PSYCHIATRIC SERVICE IN RUSSIA AND ISRAEL

Chairpersons: Prof. N. Neznanov, Dr. A. Teitelbaum

S15.1 ORGANIZATIONAL AND LEGAL ASPECTS OF PSYCHIATRIC CARE IN RUSSIA (LECTURE IN RUSSIAN)

N. Neznanov

Every year, the population of Russia decreases by 800 000 persons, among whom about 600 000 persons are of able-bodied age. Every year, over 7.8 million people, i.e. over 5.2% of the population of Russia, seek psychiatric and addiction aid at the treatment facilities of the country. Psychiatric morbidity in the Russian Federation is: in adults - 2833.6; in all age groups - 2967.4; in adolescents - 3318.6 patients per 100 000 population. Diagnostic structure of the mental disorder cohort in the Russian Federation includes non- psychotic mental disorders – 2 101 226 (50.3%), Mental retardation – 993 165 (23.7%), Psychoses and dementia states – 1 085 691 (26.0%). Somatic patients without depressive disorders are 23.8%, with depressive states - 30.3% with depressive spectrum disorders - 45.9% and without somatic disorders - 10% in the total number of patients seeking aid for different somatic diseases at the general somatic care network. Persons with mental disabilities are about 900 000, 89% among them - persons with 1st and 2nd degrees (groups) of disability, 95% - persons under 40 years of age. Total number of hospital beds - 11.6 per 10 000 of population,
of beds in day hospitals - 1.1 per 10,000 population. There are 275 mental hospitals, 170 psychoneurological dispensaries, 12 psychotherapeutic centres. Number of psychiatrists - 1.56 and psychotherapists - 0.13 per 10,000 population. Direct expenses of mental disorders - 0.4%, indirect expenses - 1.5% of Gross Domestic Product. Antipsychotic drugs in the treatment of the mentally ill in Russia are: atypical antipsychotics – to 9%, traditional antipsychotics – to 91% of patients. The model of continuous quality improvement in psychiatric care provides outcome management by means of improving the treatment-and-diagnosis process technology. The essential principles comprise process analysis; orientation on continuous improvement of treatment-and-diagnosis processes; involvement of entire personnel in management; gradual reduction of inspection control in favour of work technology control on the part of performers on the basis of psychiatric care provision standards; and strategic planning with the regard for the future needs of the population in terms of the nature and scope of medical care as well as with the regard for psychiatric care quality indicators. Measures that are necessary to realize the national priority project in the field of public health with the regard for new personnel, administrative and financial potentialities are discussed.

**S15.2 THE STRUCTURE AND THE LEGAL ASPECTS OF MENTAL HEALTH IN ISRAEL**

Igor Barash  
Department of Mental Health, Ministry of Health, Israel

We will discuss and describe the mental health system in Israel, in patient services, ambulatory care and rehabilitation services. We will discuss the Ministry of Health as a regulator, insurer and service provider. The trends and developments within the Department of Mental Health; the structural reform, preparations prior to the insurance reform, services for substance abusers and the treatment of individuals with dual diagnosis. The lecture will also focus on the legal aspects of mental health; laws pertaining to the treatment of mentally ill, involuntary civil hospitalizations and the relationship between laws, judicial system and psychiatry, the role of the District Psychiatrist and his responsibilities, the legal representation of clients in courts and in the distinct psychiatric committees. In Israel today there are 10 psychiatric hospitals, 8 are operated by the government, 2 that are owned and operated by Clalit, the largest Health Maintenance Organization (HMO). These hospitals have 3150 inpatient beds that service a total population of 7,700,000,2,200 are acute care beds, with an average length of stay of 32 days. The remaining beds are for long stay patients, hospitalized for over a year. Ambulatory services are provided in clinics that are satellites of the hospitals, other clinic services are provided by the HMOs, or by independent professionals who have an arrangement with the HMOs. Rehabilitation services are included in mental health services. Ten years ago the Israeli Parliament passed the Rehabilitation of the mentally ill in the Community Law, which outlines the entitlements of persons with a recognized mental illness: supportive housing, vocational services, home care, peer counseling. The state invests more than 100 million dollars each year in these services.

**S15.3 TRAINING IN PSYCHIATRY: PROBLEMS AND PROSPECTS**

N. Petrova  
Saint-Petersburg State University

Reorganization of the health care system, the formation of concepts of mental health, the internationalization of education, changes in approaches to diagnosis and treatment of mental disorders, the relevance of de-stigmatization of mental health, the increase of mental disorders in general practice determine the need to improve all levels of training in psychiatry, including higher medical education with the expansion of training in psychosomatics, addiction, psychotherapy, postgraduate training with the development of continuing professional education, the introduction of modern methodological approaches in teaching, the change of certification of personnel, establishment of training for mental health to other specialists. The issues of quality of training and model of continuing professional education are carried out. The place and role of the professional community are determined in the sphere of teaching through learning, development of normative documents, regulation of professional education, development and implementation of rating training, professional criteria, quality assessment, educational programs, continuing education, creation of tolerant public attitude to psychiatry.

**S15.4 THE MAKING OF A PSYCHIATRIST: A VIEW FROM ISRAEL**

Sergey Raskin, Moshe Abramowitz  
Jerusalem Mental Health Center Klar Shaul-Eitanim

In Israel there are five medical schools. Approximately 700 medical students are accepted a year. Many of those who are not accepted locally choose to study abroad. Those fortunate enough to be accepted in Israel are 2–3 years older on average than their counterparts in other countries, since most men and some women at the age of 18 are drafted into military service. Upon their discharge they embark on a rigorous 6-year journey of intensive studies: 3 years preclinical and the remainder rotating clerkships through medical and surgical departments, including a 5-week clinical rotation in psychiatry during the fifth year. Upon completing their formal education they must pass state board examinations and then do a year of internship in order to qualify for a medical license before starting a residency. As a young struggling nation,
Israel took pride in its early years in investing energy to build the state and to take positive action in dealing with problems such as the absorption of new immigrants and fighting disease. Acknowledgement of personal difficulties and open discussion of emotions were frowned upon. Thus, psychiatry began to receive recognition only after the ‘basic needs’ of the country were met. A residency in psychiatry in Israel was not considered desirable 30 years ago. An important contribution was made by immigrant psychiatrists from Latin America with a traditional psychoanalytic orientation. Things have changed in the course of the past 20 years. Close to a million immigrants arrived in Israel from the former USSR during the 1990’s, including medical students, doctors and psychiatrists. Immigration has changed the profile of the Israeli psychiatrist. Studies that examined professional preferences of medical students in Israel in recent years show that more students considered psychiatry as an option. This can be seen as an encouraging finding, if the proper funding for sufficient job slots can be provided by the government.

### S16 WHO IS RESPONSIBLE FOR OUR HEALTH?
THE BOUNDARIES OF RESPONSIBILITY OF CAREGIVERS AND THE MENTALLY ILL

Chairpersons: Dr. Shmuel Hirschmann, Prof. Zvi Zemishlany

#### S16.1 BOUNDARIES OF RESPONSIBILITY IN THE MANAGEMENT OF SUICIDAL PATIENTS

Zvi Zemishlany
Geha Mental Health Center

Psychiatrists cope with an unfounded and almost mythical perception of their ability to predict and prevent suicide. According to commonly accepted public opinion and even in the judicial system, suicide is an irrational act performed by individuals who are not responsible for their actions and are victims of circumstances or of psychiatrists’ negligence. The responsibility of the patient who has the capacity for judgment and reality testing is ignored. Three examples of lawsuits for financial compensation for alleged negligence demonstrate this issue: 1. A man, 44, married + 3 daughters, M.Sc in Geography, applied to an out-patient clinic and was diagnosed with an adjustment disorder due to a decrease in his employment and income as a tour guide. After an evaluation he was referred to psychotherapy, and refused antidepressant treatment offered to him. While on therapy he was working part time as a teacher. 4.5 months later he committed suicide. 2. A man, 32, married + 2, an engineer in a prestigious project, 3 years in psychotherapy, was diagnosed correctly by his GP as suffering from a major depressive episode, did not even fill his antidepressant prescription. Three months later he visited his GP again with the same complaints. The GP referred him to a psychiatrist who changed the medication. A day later he committed suicide. 3. A single woman, 30, with a long history of admissions due to borderline personality disorder and Munchausen’s syndrome jumped from the stairs protesting against the intention to discharge her from hospital and was injured. A lawsuit for high compensation was filed. The Patients’ Rights Law (1996) empowers the patient as a partner in therapy and is conceived as the termination of physicians’ paternalism. The personal responsibility of the non-psychotic patient should apply, as well, to their decisions and actions including compliance with therapy and suicide.

#### S16.2 PROFESSIONAL BOUNDARIES: THE ERA OF TAKING RESPONSIBILITY

Yuval Melamed
Deputy Director, Lev Hasharon Mental Health Center, Netanya, Israel and Clinical Associate Clinical Professor, Sackler Faculty of Medicine, Tel-Aviv University

Today, it is common to avoid taking responsibility, in hit and run accidents the driver explains that he was in shock, was frightened, and does not take responsibility for his actions, and those close to him give the impression that the behavior is legitimate. Social observations turn to the “responsible adult” to take responsibility for the deeds of the individual. The family doctor stands trial because the patient did not follow the instructions the doctor gave concerning treatment for diabetes and the patient suffered from complications and did not take responsibility for his lack of compliance. In yet another case the attending physician was charged with not reporting exacerbation of a patient’s epileptic condition to the road safety commission. A mental health patient committed a terrible deed and harmed his family, and the blame was immediately pointed towards the medical and welfare agencies. These are not cases of patients who are not responsible for their actions, and the system expects the doctor to function beyond what is required of the patient himself. It seems that there is an exaggerated trend towards transferring responsibility from the patient to the therapist, without reason. A balance must be reached between positive paternalism, when necessary and social responsibility for those unable to care for themselves, and protection of the autonomy and responsibility of the patient for his actions.

#### S16.3 THE BOUNDARIES OF CRIMINAL RESPONSIBILITY OF CAREGIVERS AND THE MENTALLY ILL AND VALIDATION OF THE PSYCHIATRIC EXPERT TESTIMONY WITH A POLYGRAPH EXAMINATION

Shmuel Hirschmann, Ilana Guzner
Sha’ar Menashe Mental Health Center affiliated to the Rappaport Faculty of Medicine, Technion, Israel Institute of Technology

There is increasing demand for psychiatric expert testimony in
criminal proceedings. In Israel there are about 60,000 indictments every year, and in about 3% of the court cases the accused is referred to inpatient psychiatric evaluation. A person is responsible for his actions unless he is subject to the penal code, Section 34h, insanity. Some individuals referred for psychiatric evaluation have psychiatric diagnoses, and others do not. Mental illness is not sufficient to determine insanity; it must be proven that the patient did not understand what he had done, did not comprehend the inappropriateness of his actions: or could not have avoided performing the deed. Naturally, these cases are emotionally loaded and color psychiatry with negative connotations. Opponents argue that the expert testimony is not scientific and not professional and alternatively that the mentally ill avoid responsibility even when there is no connection between the illness and the offense. The lecture will examine the validity of the psychiatric expert testimony and second, the appropriate boundary for determining criminal responsibility when there is a mental disorder. The polygraph examination is an important instrument for confirming credibility of the testimony but it has not yet been thoroughly investigated in the field of psychiatry. Psychiatric status is the basis for expert testimony and identification of delusions will ultimately determine criminal responsibility. In the lecture we will present research data for the validation of psychiatric expert testimony using the polygraph. We will present our view regarding determination of the appropriate standards for criminal responsibility.

**S16.4 BALANCING THE PSYCHIATRIST’S PROFESSIONAL RESPONSIBILITIES**

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The Patients’ Rights Act establishes the right of a patient to receive proper medical care, both from professional conduct and quality perspectives (Section 5). He also has the right to be informed before consenting to treatment (Sec. 13). On the other hand the Mental Illness Treatment Act limits the patient’s rights under this Law to provide treatment for medical reasons only (Art. 35). The psychiatric patient cannot always consent to medical care and to make informed decisions about his or her needs, hence it is not always possible to draw an analogy between this type of patient or medical treatment. Furthermore, therapy used in psychiatric care could be enforced treatment and is authorized without limitations, notwithstanding patient’s rights. Our discussion will emphasize the duty of the psychiatrists within the boundaries of legal situations drawn from the conflicting laws. We shall present the case of a patient diagnosed with paranoia and schizophrenia followed by a suicide attempt who was hospitalized under a court order after he threatened to kill his therapists using a gun purchased online. During compulsory treatment with psychiatric drugs he suffered from serious side effects due to the large dosage of drugs he was forced to take, that significantly increased his blood pressure. According to a second opinion received from another expert, if he would continue receiving the medications he could suffer irreparable damage and risk his health. The case raises questions about the limits of professional responsibility of the psychiatrist in psychotherapy in general and in particular with regard to involuntary therapy. Can the treating psychiatrist be sued in a medical malpractice claim for breach of duty of care if the patient suffered damage to his health? What is the relationship between the doctor’s duty of care towards the patient under general tort law and the duty of care of a psychiatrist in regard to the provisions of Section 35(c) of the treatment of the mentally ill act? What is the relationship between patients’ rights to receive proper medical treatment on the one hand versus the duty to reduce the damage?

**S17 PSYCHOTHERAPY IN THE AGE OF NEUROBIOLOGY**

Chairpersons: Dr. Shlomo Mendlovic, Dr. Ilana Kremer

This symposium will be held as an expert panel, conducted by Dr. Shlomo Mendelowicz and Dr. Ilana Kremer. It will raise a debate whether psychiatric settings need to combine various psychotherapy techniques in this age of neurobiology and how it is possible to maintain psychotherapy and psychotherapy training in the age of short hospitalizations in crisis-oriented psychiatric settings. The panel will focus on the role of psychotherapy and psychotherapy training in the daily life of a psychiatric ward. Prof. Dov R. Aleksandrowicz will refer to this topic in general, Dr. Patrick Bantman, Head of the Department of Psychiatry in Hopital Esquirol St. Maurice in France will discuss family therapy in the context of severe psychopathologies, and the chairpersons will invite leading psychologists and psychiatrists working and teaching in psychiatric settings to debate the feasibility, the role and the importance of widely conducting psychotherapy in public psychiatric settings and of investing in developing psychotherapeutic approaches, teaching and supervision in these settings.

**S17.1 PSYCHOTHERAPY IN THE AGE OF NEUROBIOLOGY**

Dov R. Aleksandrowicz
10 Harel St., Ramat Gan, Israel

The 21st century has been described as the “the century of the brain”; the invention of advanced means for the study of the living brain and the decoding of the human genome have revolutionized behavioral neurobiology and behavioral genetics. Moreover, the development of potent psychoactive medications has entirely changed the course of psychiatric illnesses. The success of pharmacotherapy has led many practitioners of psychotherapy...
to question whether their discipline will gradually become irrelevant. I wish to argue that, in the long run, neurobiology will buttress the claims of psychotherapy and other non-medical environmental interventions. The nervous system evolved to control the response of the organism to its environment in a way favorable to survival and reproduction. The mammalian brain, the most advanced control system in nature, evolved to make use of the intimate relationship between the newborn and its mother, and the architecture of the immature brain reflects that purpose. In addition, in social mammals (and in man especially) the brain evolved to optimize lifelong interaction between individuals. The result is that the human brain is closely attuned to interpersonal interactions, which include verbal messages, body language (including pheromones), the emotional atmosphere, and complex environmental variables such as the therapeutic contract. These stimuli interact directly with neural circuits related to interpersonal interaction. In the case of an intense therapeutic relationship, the circuits shaped by the early infant-mother relationship are also, presumably, activated. To modify maladaptive behavior patterns most reliably, one needs to “plug in” to those circuits (and “reprogram” them). Therefore, some crucial therapeutic goals, such as a change of cognitive configuration or resolution of a psychic conflict, especially an unconscious one, cannot be achieved by a chemical or physical intervention. The only danger to psychotherapy is that we become so beguiled by the spectacular success of pharmacotherapy that we ignore the latter’s limitations.

S17.2 FAMILY THERAPY IN THE CONTEXT OF SEVERE PSYCHOPATHOLOGIES IN FRANCE

Patrick Bantman
Department of Psychiatry, Hospital Esquirol StMaurice 94413

In a first perspective, family therapy cannot be applied as such with families of psychotic patients or other severe psychopathologies. The difficulty comes from the fact that meeting the family often occurs in the context of a crisis corresponding to a decompensation associated with the psychotic disorder and to the reactions of the patient’s family and friends. The family’s request is to be « relieved » of this situation which has been evolving for many years and a therapy can only be entered upon once this often intolerable situation has first been taken into account. At the second stage, outside of the hospital, family therapy can be initiated. One of the characteristics of families of psychotic patients is a reduced capacity to anticipate. In these families time is interrupted by pathology, the symptoms and the events. In comparison to the psychoanalyst the family therapist underlines the competences inherent in the family in order to give them maximum leverage. This work of restoration is probably as essential for the family therapist as is thinking of how the family and social groups organize themselves around the illness.

S17.3 TEACHING PSYCHOTHERAPY TO RESIDENT PSYCHIATRISTS - WHAT DOES ONGOING EXPERIENCE TEACH US?

Henry Szor
Abarbanel Mental Health Center, Sackler Faculty of Medicine, Tel-Aviv University

S17.4 FACILITATING UNDERSTANDING AND COMMUNICATION: THE ROLE OF GROUP ANALYTICALLY ORIENTED SUPERVISION IN PSYCHIATRIC WARDS

Ido Peleg
Mazra Mental Health Center, Akko and Rappaport faculty of Medicine, Technion IIT
Following group analytic thought, psychiatric wards are conceptualized as communication networks that include patients and staff. Therapeutic work consists of facilitation of open, pluralistic and empathic discourse between patients and staff alike, standing at times in sharp contrast to coercive forces inherent to this environment. This may help isolated, secluded patients to resume communication with others, helping them resume their role as respected members of society. Facilitating communication in the ward entails the working through of feelings of alienation, silencing and rage. These are expressed as outbursts, controlling interactions and splits between patients, patients and staff and in the staff group itself. Their working through is achieved by regular group supervision meetings about group therapy for all of the ward’s professionals. This lecture will address aspects of this work, illustrated with vignettes.

S17.5 INDIVIDUAL PSYCHOTHERAPY (“TALKING THERAPY”): A SURVEY OF RESIDENTS’ & PSYCHIATRISTS’ ATTITUDES, ISRAEL 2010-2011

Orit Levi Shachar*, Shlomo Mendlovic1,2, Ido Lurie1,3
1Sackler School of Medicine, Tel Aviv University, Tel Aviv, Israel
2Shalvata Mental Health Center, Hod-Hasharon, Israel
3Abarbanel Mental Health Center, Bat-Yam, Israel

Individual psychotherapy is an important option in psychiatric treatment. This form of treatment may be delivered to many patients in different settings. Over the years, several evidence-based studies have demonstrated the efficacy of psychotherapy treatments. At present, psychotherapy is considered an integral part of psychiatric treatment, and is recommended in guidelines for several psychiatric disorders. Nevertheless, it seems that as opposed to psycho-pharmacological treatments, the status of “talking therapy” among mental health experts is still obscure. In parallel, over the years, along the decrease in psychotherapy delivered by psychiatrists, there has been a trend of increase in prescription of psychotropic medications. Surveys conducted in different settings have shown that most psychiatry residents

30
consider psychotherapy as part of their training. Up until now, a survey regarding psychiatrists’ views of psychotherapy in Israel has never been conducted.

**Objective:** To explore and map the attitudes of psychiatrists in Israel in the different training stages (residents, experts) towards individual psychotherapeutic treatments, including psycho-dynamic psychotherapy, psychoanalysis, cognitive-behavioral treatment (CBT) and hypnosis.

**Methods:** Cross sectional survey, that includes a questionnaire regarding the attitudes towards the different individual conversational treatments available. The questionnaire was distributed for self report via mail, email and direct approach, to residents in psychiatry and to experts. The questionnaire includes (anonymously) (a) demographic data, (b) a closed ended questions regarding attitudes toward the different modalities of psychotherapy and (c) clinical case vignettes.

**Importance:** Mapping the attitudes of psychiatrists in Israel regarding individual psycho-therapeutic treatment, might affect psychiatry residency programs in Israel, and might affect the services available in mental health, with implications on the upcoming mental health reform.

### S18 BRAIN IMAGING IN MENTAL HEALTH

**Chairpersons:** Prof. Talma Hendler, Prof. Omer Bonne

#### S18.1 NEURAL UNFOLDING OF EMOTIONAL REGULATION: FROM ADAPTIVE TO DYSFUNCTIONAL RESPONSE

**Talma Hendler**  
The Functional Brain Center, Tel Aviv Medical Center, Departments of Psychology and Faculty of Medicine, Tel Aviv University

Emotional regulation is a pivotal mechanism for adaptively coping with psychological challenges in the environment (e.g. a potentially traumatic stress). Accumulating neuroimaging evidence during the last decade has pointed to involvement of interacting brain circuits in such regulation. Hence, dynamic functional integration and segregation of such circuits may play a major role in maintaining our mental health. In this lecture we will present a multi-layered brain research approach for studying the neural correlates of the unfolding of the individual emotional response to stressful encounters in the lab or in real-life circumstances. For the former, we measured brain responses to acute social stress and for the later we measured the sensitivity to potentially traumatic content prior to and following exposure during military service. Together our findings show dynamic interactions between major nodes in functional brain circuits in correspondence to changes in the attributed emotional value. The implication of such findings to future psychiatric diagnosis and treatment will be highlighted.

### S18.2 REVEALING THE IMPRINT OF PSYCHOLOGICAL TRAUMA ON THE HUMAN BRAIN

**Omer Bonne**  
Dept. of Psychiatry, Hadassah University Hospital

Among mental disorders, PTSD has a unique advantage in examining the relation between environment and biology, since it develops after recognizable events. This enables linking maladaptive behavioral patterns to putative structural and functional changes in the brain (should they occur) as well as to abnormal endocrine and immunological responses. However, PTSD can result from a broad range of etiologies, including single trauma and prolonged stress, military and civilian trauma, childhood and adult onset trauma, and more. With the advent of advanced imaging techniques, numerous features of brain structure and function have become accessible to research. However, very few studies have performed head to head comparisons of etiologically disparate PTSD populations. In this presentation we will demonstrate the use of a broad range of imaging techniques, including structural and functional MRI, DTI, MEG and PET in seeking a specific neurobiological imprint for etiologically diverse PTSD populations.

### S18.3 BREAKDOWN IN FUNCTIONAL CONNECTIVITY IN SCHIZOPHRENIA: FMRI EVIDENCE

**Maya Bleich-Cohen**  
Functional Brain Center Wohl Institute for Advanced Imaging, Tel Aviv Medical Center

The notion that schizophrenia is not caused by focal brain abnormalities, but results from pathological connectivity between brain regions, has been an influential idea in schizophrenia research. The “Disconnection Hypothesis” proposes that dysfunctional integration of signals from different brain regions, possibly due to deficits in anatomical connectivity, underlies the impairments found in schizophrenia. This concept gained backing recently from accumulating structural and functional neuroimaging studies with schizophrenia patients and their healthy first-degree relatives. In addition to deficient responsiveness to various stimuli, there has been evidence from functional connectivity studies suggesting that the spatially distributed and highly coherent nature of the resting state and stimulated activity is disrupted in schizophrenia patients. We will demonstrate this finding from our lab’s work with schizophrenia patients and their siblings and by using a variety of cognitive and emotional testing procedures. Altogether, based on various tests of working memory, language comprehension and emotional regulation as well as resting state we demonstrated a breakdown in functional connectivity in schizophrenia patients relative to controls. Furthermore, we demonstrate that this abnormal connectivity...
in schizophrenia patients mainly involves the prefrontal lobes; a critical region for emotional-cognitive control processes. These findings thus suggest that patients with schizophrenia fail to coordinate between necessary neural components that mediate proper behavior and cognitive-affective skills.

S18.4 WHAT THE CLINICIAN REALLY LEARNS FROM NEUROIMAGING STUDIES IN MAJOR DEPRESSION

Y. Levkovitz
The Emotion-Cognition Research Center, Shalvata Mental Health Center, School of Medicine, Tel Aviv University

The aim of the presentation is to review the contribution of studies with single photon emission tomography (SPECT), positron emission tomography (PET) and magnetic resonance imaging (MRI) to the clinician’s understanding of the pathophysiology of major depressive disorder (MDD). Several studies suggested the neural networks modulating aspects of emotional behaviour to be implicated in the pathophysiology of mood disorders. These networks involve the dorso medial prefrontal cortex and closely related areas in the medial and caudolateral orbital cortex (together termed the medial prefrontal network), as well as subcortical regions such as the amygdala, hippocampus, and ventromedial parts of the basal ganglia (together termed the limbic core network). Alterations in these networks were found in grey matter volume and neurophysiological activity in cases with recurrent depressive episodes. Future work should investigate larger, clinically homogenous groups of patients and unaffected relatives, combining both categorical and dimensional approaches to illness classification in cross-sectional and longitudinal designs in order to elucidate trait versus state mechanisms and illness progression effects over time.

S19 PSYCHIATRY AND THE MEDIA – RECIPROCAL RELATIONS (ETHICAL ISSUES)

Chairpersons: Prof. Rael Strous, Dr. Michael Schneidman


Rael D. Strous
Beer Yaakov Mental Health Center; Sackler Faculty of Medicine, Tel Aviv University

The public is fascinated with medicine in general and often psychiatry in particular. This is not limited to issues of pure health, but how health influences society, political behavior and process, individuals in power, criminality and most importantly individual wellbeing. Often it is the doctor who is called upon by the media to provide information, advice, prediction, direction and answers. While a significant contribution may be made, there are important ethical issues that need to be maintained when engaging in any contact with the media. Medical ethics applies not only to the so called “big issues” of medicine but also factors of professionalism, boundary violations and confidentiality. Thus there are limits to professional interaction between the psychiatrist and the media. There are also important ethical principles that should govern participation in popular media shows including most importantly confidentiality and conflicts of interest. Psychiatrists cooperating and engaging with the media in many cases disregard vital ethical principles for a variety of reasons. While the interaction with the media may be complex, there should be certain confirmed ground rules. Although the vast majority of ethical breeches are made with good intention, this does not negate the responsibility to improve in this domain and to strive for a higher standard. The power of public media is considerable and, as in other areas of medicine, the psychiatrist must invest wisdom into his or her relationship with the media. We need to uphold our lofty standards of psychiatric care and management tempered by humility without being distracted by factors of national influence, fame, recognition, financial consideration and power.

S20 GENETICS IN PSYCHIATRY – DEVELOPMENTS AND CHALLENGES

Chairpersons: Prof. Doron Gothelf, Dr. Yoav Kohn, Prof. Bernard Lerer

S20.1 CONVERGENT GENETIC AND FUNCTIONAL EVIDENCE FOR ASSOCIATION OF THE AHI1 GENE WITH SUSCEPTIBILITY TO SCHIZOPHRENIA

Bernard Lerer**, Daniela Amann-Zalcenstein*, Ana Alkelai†, Amit Lotan†, Tzuri Lifschytz†, Alexandra Slonimsky†, Yoav Kohn†, Edna Ben-Asher†, Fabio Macciardi†, Doron Lancet†

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The first step towards unraveling the role of the Abelson Helper Integration Site 1 (AHI1) gene in schizophrenia was a genomewide linkage analysis in an inbred sample of Arab-Israeli families (Lerer et al, 2003). This revealed a schizophrenia susceptibility locus on chromosome 6q23–26. To identify candidate genes in the region we performed fine mapping, first with microsatellite markers (Levi et al, 2005) and then with single nucleotide polymorphisms (SNPs) (Amann-Zalcenstein et al, 2006). This showed strong evidence for association of AHI1 and the adjacent, primate specific gene, C6orf217, with susceptibility to schizophrenia. Association of AHI1 with schizophrenia has since been replicated by several other
groups. Contemporaneous work showed that loss of function mutations in AHI1 cause severe brain maldevelopment and other neurodevelopmental abnormalities that characterize the autosomal recessive condition, Joubert syndrome. We hypothesized that less deleterious genetic variants in AHI1 that affect gene expression rather than the structure of the AHI1 protein, may be implicated in the pathogenesis of schizophrenia. Supporting this hypothesis, we found that patients from the Arab-Israeli sample with early onset schizophrenia manifest increased expression of AHI-mRNA in EBV transformed lymphoblasts as compared to controls from the same population (Slonimsky et al, 2010). Intriguingly, under-expression of Ahi1 also exerts functional neurobiological effects in mice. Working with mice heterozygous for a knockout mutation of the Ahi gene leading to lower brain Ahi1-mRNA levels, we recently found that these mice manifest significantly lower levels of state related anxious behavior compared to wild type mice. Overall, these convergent sets of evidence, although not entirely congruent, increasingly support a role for genetic variants that influence the function of AHI1 in the pathogenesis of schizophrenia and open up exciting prospects for further study.

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S20.2 BEHAVIORAL PHENOTYPES IN PSYCHIATRIC GENETIC SYNDROMES

Doron Gothelf
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The heritability of psychiatric disorders including schizophrenia, attention-deficit/hyperactivity disorder and autism is very high. Yet the specific genes and biological pathways leading to psychiatric morbidity are yet largely unknown. Behavioral Neurogenetics is an emerging approach in clinical neuroscience focusing on genetic syndromes with a known etiology and with prominent psychiatric morbidity, distinct behaviors and cognitive deficits. In my lecture, I will define the concept of ‘behavioral phenotype’ and will provide several examples including psychosis in VCFS, hyperacusis and social appetite in Williams syndrome, and gaze aversion in fragile X syndrome. I will also describe some of the pathways leading from the genetic mutations to the neuropsychiatric phenotype in these syndromes.

S20.3 RARE VARIANTS–COMMON DISEASE: A NOVEL APPROACH TO TACKLE THE COMPLEX GENETICS OF PSYCHIATRIC DISORDERS

Yoav Kohn

Most psychiatric disorders have a multi-factorial etiology. This means that many genetic variants with a small effect on the phenotype interact with each other and with the environment to cause psychopathology. Until recently it was presumed that most of these variants are common in the general population, and are not unique to affected individuals. The current use of Genome Wide Association Studies (GWAS) is geared at identifying such common variants. Currently, researchers have become interested in identifying rare variants associated with disease, which can be unique to a certain population, a multiplex pedigree or even one individual. These rare variants, even if confined to a few individuals, can shed light on the pathogenesis of psychiatric disorders in general. Examples will be given from our work in isolated populations and unique pedigrees in Israel.

S20.4 RECENT PROGRESS AND CHALLENGES IN PSYCHIATRIC PHARMACOGENETICS

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The overall aim of psychiatric pharmacogenetics (PP) is to systematically discover the relationship between genetic variants and several phenotypes of interest (mainly treatment response and adverse effects) and to facilitate understanding of inter-individual variablity in drug response. Clinically, the main goal of pharmacogenetic research is to assist in a-priori selection of a suitable drug to a specific individual, based on his genetic profile as part of a “personalized” medicine approach. Major advances have been achieved in PP in recent years including toxic reaction prediction (e.g. agranulocytosis), antipsychotic medication response and adverse effects (extrapyramidal symptoms and metabolic side effects), predictors of smoking cessation outcomes, antidepressant drug response and mood stabilizer efficacy. Most studies were performed by implementing a candidate gene approach in relatively small and underpowered samples with lack of replication trials. Careful phenotyping of patients and symptoms has been an obstacle to participant recruitment. However, with the advance of the field, larger samples have become the gold standard and several hypothesis-free PP genome wide association studies (GWASs) have been published with promising findings. Nevertheless, the utility of the findings in clinical practice is still limited. In view of the complexity and heterogeneity of the underlying psychiatric diseases, more sophisticated tools are required to improve predictive value of PP tests. These should take into account both clinical and environmental factors, as well as combined contributions of multiple genetic variants. In this talk, we will review recent progress and challenges in PP with specific focus.
on pharmacogenetics of antipsychotic induced extrapyramidal symptoms and smoking behavior.

S21 PSYCHIATRIC REHABILITATION IN THE HOSPITAL OR IN THE COMMUNITY – COMPLEMENTARY OR CONFLICTING APPROACHES

Chairpersons: Prof. Yigal Ginath, Dr. Uri Leventhal

S21.1 REHABILITATION AND RECOVERY IN PSYCHIATRIC SERVICES: COMPETING OR COMPLEMENTARY APPROACHES?

Shmuel Kron,*
Shalvata Mental Health Center

The legislation of the Israel Law for Rehabilitation in the Community of the Mentally Ill in 2000 separated all rehabilitation services in Israel from clinical mental health services, particularly from psychiatric hospitals. This intentional dissociation, based on professional and ideological notions, resulted in a chasm between the formerly integrated elements of mental health care. The recovery model, a contemporary predominant approach to mental health rehabilitation, declares its goals in far-reaching and ambitious terms. Patients are encouraged to define themselves “beyond the mental disease”, and to regain “active control of a meaningful and satisfying life”. The components of the model are termed in words like hope, optimism, self-direction, strength, responsibility and empowerment. In contrast to this positively-valued view of recovery, the psychiatric hospital, being based on a medical model, is frequently portrayed by recovery partakers in a rather unfavorable view, as an authoritative and paternalistic system that emphasizes psychopathology, disability and dependence.

The typical objectives of healthcare – to cure, ease suffering or care for disease symptoms, are at times regarded as irrelevant, and even harmful for recovery. Recovery is focused on community reintegration, and hospitals are not designed to be a “rehabilitation environment”. Yet, psychiatric services have some critical roles in rehabilitation of persons with mental health disability, including: Evaluation, preparing and maintenance of preparedness for rehabilitation, and assurance of continuity between all elements of care, particularly in times of clinical crises. The recovery model challenges the mental health services, and demands changes in their professional views and organizational culture. It suggests changes in clinical focus, from treating disorders to intervening in their consequences. A better dialogue between health care and rehabilitation services will help to reduce the tension between competing systems and establish a continuum of care based on these complementary viewpoints.

S21.2 RECOVERY ORIENTED SERVICE: FROM VISION TO PRACTICE

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Beer Sheva Mental Health Center is involved in a project of implementing recovery ideas, thus transforming the center to a recovery oriented service. Elements of empowerment, choice, and shared decision making are essential for the recovery process. Recovery Oriented Service puts the person in the center and the values of hope and strength as key values. We will focus on two practices: 1. Illness Management and Recovery (IMR). Together with partners from ISPRA (Israel Psycho Rehabilitation Association), the Ministry of Health and Haifa University we established a training program in order to implement this practice within the hospital and in the community 2. Psychiatric Advanced Directive (PAD) which is a legal document developed in order to answer the question of loss of autonomy and choice during mental crisis. PAD allows people to express their will and preferences and to plan their treatment in a future crisis. The goals of Recovery Oriented Service is to help people with severe mental disorders to gain knowledge and develop skills in order to minimize the effect of the disease on their lives, to set objectives and proceed towards achieving significant personal goals. By this process they can learn how to manage their illnesses and promote their journeys to recovery.

S21.3 SUPPORTED ACADEMIC EDUCATION SERVICES FOR STUDENTS COPING WITH MENTAL HEALTH DISORDERS

Penina Weiss¹, Yigal Ginath²
¹National Coordinator of Supported Academic Education
²Chairperson, “Reut”, Organization for Community Mental Health

Following the legislation of the “Rehabilitation of the Mentally Disabled in the Community Law”(2000), the Ministry of Health promoted a host of community- based rehabilitation services. One of the recent and novel of these is the Supported Academic Education (SAE) program. “Reut” initiated SAE services 8 years ago as a pilot program. The program was run with the support of a grant from the National Insurance Institute which included a research project intended to evaluate the SAE service. The positive results of this study caused the Ministry of Health to gradually include all Israeli universities, and a few academic colleges in the project. At present, some 70 students receive SAE services. These students have to be admitted to the university on their own merit and be enrolled in at least half a program towards an academic degree in a given year. Each participant in the program is supported by a mentor, usually a senior student, who meets with him/her discretely up to 4 hours a week, throughout the year. According to our accumulating
experience, SAE is useful for participating students in the following areas: *Assistance in application, registration, choice of academic venue, and choice of courses.* Orientation to campus settings, locations, services, etc. *Developing and improving cognitive skills and learning strategies* Developing and improving social skills * Better use of resources on and off campus. SAE services are provided using non-stigmatizing methods and settings, they are flexible, individualized, protect privacy and maintain respect for cultural diversity. A number of studies conducted in Israel point to the usefulness of the Israeli model of SAE services and its advantages in helping participants complete their higher education goals. It is our belief that many people coping with mental illness have academic skills, which, when nurtured, can lead to acquiring an academic education, thus, improving employment prospects, contributing to the reduction of social and self-stigma, paving the way to recovery, integration and normalization.

### S21.4 A PATIENT’S STORY: FROM A MAXIMUM SECURITY UNIT TO A FLAT IN NETANYA

Adiel Doron  
Lev Hasharon Mental Health Center, Netanya and Sackler Faculty of Medicine, Tel-Aviv University.

Empowerment is a principle of mental health rehabilitation. We try to restore the patient’s belief in his abilities to care for himself and to take responsibility for his pharmacotherapy. What happens when the patient is dangerous? Can the reigns still be put in his hands? When we determine that a patient needs a guardian, are we attentive when he feels that he no longer needs one? In most cases, the answers are negative. When there is a danger, the caregivers prefer to take responsibility for treatment. After we recommended that the Court appoint a guardian we prefer not to return responsibility to the patient. We present Shai’s story. Shai is 23 years old, he fought to be discharged from hospitalization and relieved of the guardian appointed to him. Shai was diagnosed with CP at age six months. At 14 he was admitted to an adolescent ward in a psychotic state. He was diagnosed with schizophrenia, paranoid type. In 2006 a legal guardian was appointed for Shai. Shai claimed that the guardian was stealing his money. The system related to his claims as if they were part of his psychosis. Later his claims proved to be true. A nonprofit organization was appointed to replace the guardian. Shai continued to complain about the organization as well. In 2009 he went to visit a hostel and returned angry claiming that the hostel was not for him. In a meeting with the social worker and the guardian Shai locked the door and threatened to hurt them. He was transferred to the maximum security unit. He was presented to the Psychiatric Committee that recommended admitting him to an open ward. There, he continued to ask to be relieved of the guardian. The fear was that without a guardian he would not be capable of supporting himself. Shai succeeded in convincing the court to discharge his guardian. At the same time, Shai rented a small apartment and began to work in sheltered employment. Shai was discharged from the hospital on June 1, 2010. He manages on a modest income, goes to work every day and regularly attends his follow up visits.

### S22 ADVANCING NEUROPROTECTIVE-BASED TREATMENTS FOR SCHIZOPHRENIA

Chairpersons: Prof. Michael Ritsner, Prof. Vladimir Lerner

#### S22.1 IS A NEUROPROTECTIVE THERAPY SUITABLE FOR SCHIZOPHRENIA PATIENTS? CHALLENGES AND OPPORTUNITIES

Michael Ritsner  
The Rappaport Faculty of Medicine, Technion, Haifa, Israel, Sha’ar Menashe Mental Health Center, Hadera, Israel

Schizophrenia is a chronic and disabling mental disorder characterized by positive, negative and mood symptoms, disturbed coping abilities with elevated distress and a significant decline in cognition, quality of life and psychosocial functioning. About one-third of all patients with schizophrenia do not respond adequately to drug treatment. Today neuroscience and clinical research have sufficiently advanced to introduce a novel generation of compounds with neuroprotective properties. The use of neuroprotective agents in schizophrenia is not yet significantly established. An in-depth review of new compounds such as neurosteroids (DHEA, pregnenolone), and L-theanine with neuroprotective properties is presented. The mechanisms underlying the neuroprotective effects of these compounds vary and differ from classically defined dopamine and serotonin receptors. This presentation highlights selective evidence supporting a neuroprotective approach in the search for novel compounds, and suggests future directions for this exciting area. Neuroprotection strategy may be a useful paradigm for treatment of prodromal and first-episode schizophrenia patients and might have a significant impact on the subsequent course and outcome of the illness. The clinical effects of neuroprotective agents clearly merit further investigation in schizophrenia spectrum disorders.

#### S22.2 PREGNENOLONE AUGMENTATION IN RECENT-ONSET SCHIZOPHRENIA AND SCHIZOAFFECTIVE DISORDERS: AN 8-WEEK, RANDOMIZED, DOUBLE-BLIND, PLACEBO-CONTROLLED, 2-CENTER TRIAL
**S22.3 BEXAROTENE AUGMENTATION SUPPORTS THE RETINOID DYSREGULATION HYPOTHESIS OF SCHIZOPHRENIA: FINDINGS FROM A 6-WEEK, RANDOMIZED, DOUBLE-BLIND, PLACEBO-CONTROLLED, MULTICENTER TRIAL**

**Vladimir Lerner**, Chanoch Miodownik

1Division of Psychiatry, Ministry of Health Mental Health Center, Faculty of Health Sciences Ben-Gurion University of the Negev, Be’er-Sheva, Israel

**Background:** Alterations in a retinoid-signalling pathway may lead to schizophrenia by compromising the regulation of synaptic plasticity. Based on this retinoid dysregulation hypothesis we assessed the add-on effects of bexarotene (a synthetic retinoid) to regular antipsychotic therapy in schizophrenia patients.

**Methods:** A 6-week, multicenter, randomized, double-blind, placebo controlled design was applied. Schizophrenia and schizoaffective inpatients with a suboptimal response to antipsychotic agents were randomly assigned to receive either bexarotene (75 mg/d) or placebo as add-on to their regular antipsychotic medications. The primary outcomes were the mean changes from baseline to endpoint in the Positive and Negative Symptoms Scale scores.

**Results:** Ninety subjects underwent randomization. The two groups (each included 45 inpatients) were similar with respect to baseline characteristics and adherence to the study drug. Outcome data were available for 79 participants. Results indicated significant improvement in positive symptoms (P<.001), and in general functioning (P=.010) in individuals receiving bexarotene compared placebo group. No obvious adverse effects were experienced by participating subjects.

**Conclusions:** Efficacy of bexarotene augmentation in the management of positive symptoms and general functioning deficit suggests that a retinoid-signalling pathway may present a novel target for the pharmacotherapy of schizophrenia. Further studies are needed. (Funded by the Stanley Medical Research Institute; ClinicalTrials.gov number, NCT00535574.)

**S22.4 NEUROPROTECTIVE EFFICACY OF VITAMINS**

Chanoch Miodownik*, Vladimir Lerner

Division of Psychiatry, Ministry of Health Mental Health Center, Faculty of Health Sciences Ben-Gurion University of the Negev, Be’er-Sheva, Israel.

It has been known for a long time that vitamins are essential nutrients for humans and animals. These substances are important for regular cell function, growth and development. Relatively small amounts of vitamins are needed to perform vital functions. As a rule vitamins promote the actions of enzymes in order to improve their efficiency and in this role they are called coenzymes. According to the present invention, antioxidants like vitamins and other antioxidative agents may be considered as further active components because antioxidants inhibit free radical destructive activities. Antioxidants, especially lipid-soluble antioxidants, can be absorbed into the cell membrane to neutralize oxygen radicals and thereby protect the membrane. This presentation is focused on evidence from clinical and basic science studies supporting a role of several vitamins as potential neuroprotective compounds. Their neuroprotective effects as add-on therapies merit further investigations in patients with schizophrenia and mood disorders.

**S23 INTERNET, SOCIAL NETWORKS AND PSYCHIATRY**

Chairpersons: Dr. Uri Nitzan, Dr. Jordan Lewinski
S23.1 COMPUTER-MEDIATED-COMMUNICATION (CMC) – A SIGN OF THE TIMES?

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1Shalvata mental health center, Hod-Hasharon, Israel
2Sackler School of Medicine, Tel-Aviv University, Israel

Extensive psychiatric and psychoanalytic literature already exists on the complex relations between television and computer games and disorders such as depression, ADHD, and violence among adolescents. The internet, on the other hand, with its considerable influence on culture in general and on psychopathology in particular, has been less studied in this respect. This lecture will focus on the unique features of computer-mediated-communication (CMC), and the mental environment it creates. CMC refers to chat rooms, Facebook, and other similar modes of communication in which the user replaces interpersonal relationships with the virtual reality of cyberspace. My main argument is that a number of unique features of CMC can substantially influence the experience of self. These features include: fluidity of time and space on the web; lack of body language and intonation; the difficulty to decipher the meaning of messages; the speed of CMC and the possibility to communicate simultaneously with more than one person; cyberspace anonymity; the possibility to expose oneself to a complete stranger (the paradox of the intimate stranger); the amoral potential of CMC; the option to adapt and change identities; and the problem of protecting personal data. I will address a few relevant clinical examples, and focus on a series of patients who sought psychiatric treatment due to psychotic symptoms for the first time in their lives, which appeared de novo while they were immersed in CMC. On the basis of this accumulated experience, we hypothesize that the features of CMC might play a role in the formation of psychotic and dissociative experiences among vulnerable individuals.

S23.2 SOCIAL USE OF THE INTERNET AND SOCIAL ANXIETY AMONG ADOLESCENTS: CHARACTERISTICS AND IMPLICATIONS

Iris Shachar*, Eva Gilboa-Schechtman
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Computer Mediated Communication (CMC) carries characteristics that are especially appealing for socially inhibited individuals, such as anonymity, a-synchronicity and the absence of visual and auditory signals. These characteristics are presumed to engender a greater sense of control over self-presentation during social interactions, thus reducing fear of negative evaluation and social rejection. The latter are thought to play a dominant role in the development and maintenance of Social Anxiety (SA). The key question regarding the implications of CMC for the socially fearful is met with two opposing hypotheses: The “compensation” hypothesis posits that SA adolescents will be drawn to CMC as a way to compensate for their inhibitions in offline relationships. In contrast, according to the “rich get richer” hypothesis, CMC interaction is beneficial for those adolescents who approach it with adequate social skills, while individuals high in SA will be at disadvantage. The current study examined internet use characteristics as well as psychological attributes of 1360 Israeli adolescents [mean age=14.4] during 2010. Our objective was to delineate the online communication habits of highly SA adolescents. Online behavior was broadly evaluated and included quantitative (e.g., time spent in Facebook) as well as qualitative parameters (e.g., avatar’s characteristics in online games). The results show that high SA adolescents find online communication as less threatening. Yet they are still not as socially active as their non SA counterparts. The results lend partial support for both hypotheses; even though SA adolescents may perceive online interaction as safer and their online persona to better reflect their “true selves”, their online behavior does not alter from their “offline” social inclinations. The presentation will highlight the importance of examining both qualitative and quantitative aspects of CMC. It will also emphasize the need to link CMC with the cognitive, evolutionary and interpersonal theories of SA.

S23.3 SOCIAL NETWORKS: LIGHT AT THE END OF THE TUNNEL

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Web browsing in general and social networking in particular create fertile grounds for social ideas and trends, with significant impact on the nature of interpersonal communication. In contemporary society people communicate via e-mail, social networks, virtual communities and chat rooms. The diversity of these communication platforms allows different degrees of intimacy with extremely high availability and frequency. People suffering from schizophrenia have complex “relationships” with the internet. On the one hand, they browse the web regularly for common uses. On the other hand, similarities can be found between the psychotic form of thinking and the internet “language”; chaotic, associative and full of bizarre and fantastic ideas. The unique and contradicting nature of the internet through its transparency, lack of centralization, anonymity sided by exposure withholds the potential for enhancement of psychotic states. One of the major symptoms of schizophrenia is a decline in social abilities. This symptom increases the negative stigma and social isolation which in turn affect the disease. A question rises about the main component of this decline. Do these patients still have a preserved desire to meet and interact with others but lack the ability to execute their interpersonal will? And if the latter is plausible could
the innovative features of the internet be used as a tool to enhance these patients’ social skills? This lecture will refer to the exclusive influence of the internet on people suffering from schizophrenia, focusing on a study that took place at the outpatient clinics of “Shalvata” Mental Health Center. In our study we compared internet availability and the usage of web browsing for creating interpersonal interactions among people with severe mental illness (n = 261) and a control group (n=100). Our study offers the use of the internet as a tool for enhancing social abilities in patients with schizophrenia.

S23.4 TECHNOLOGY IN THE SERVICE OF THE PRACTICING PSYCHIATRIST

Jordan Lewinski
Idan Clinic for Online Mental Health Therapy, Psychiatric Division, Haim Sheba Medical Center, Israel.

Modern technology can become part of patient-doctor relationships, in order to improve healthcare, patient doctor communication and patients’ prognoses. There are various available tools that can help a psychiatrist to maintain care continuity, increase adherence and compliance and improve therapeutic alliance. This presentation will introduce available tools that any psychiatrist can use immediately to achieve these goals.

S24 THE 2011 ISRAELI CONSensus CONFERENCE FOR THE DIAGNOSIS AND TREATMENT OF ALZHEIMER’S DISEASE AND RELATED DEMENTIAS

Chairperson: Prof. Yoram Barak
Yehudit Aharon-Peretz, Amos Korczyn, Zvi Dwoletski, Yoram Barak
Israel Medical Association.

For the first time in 10 years, new criteria and guidelines for the diagnosis and treatment of Alzheimer’s disease have been published by four expert workgroups spearheaded by the Israel Medical Association. The expert groups were established by the associations for family medicine, neurology, geriatrics and psychiatry. The workgroups established four topics for recommendations: prevention, diagnosis, drug treatment and non-pharmacological interventions. These include ready-to-use clinical diagnostic criteria for Alzheimer’s disease dementia and mild cognitive impairment (MCI) due to Alzheimer’s disease. The use of biomarkers in Alzheimer’s dementia and MCI was proposed as a research agenda not intended for application in clinical settings at this time. The recommendations expand the definition of Alzheimer’s disease to include two new phases of the disease: (1) presymptomatic and (2) mildly symptomatic but pre-dementia, along with (3) dementia caused by Alzheimer’s disease. This reflects current thinking that Alzheimer’s disease begins creating distinct and measurable changes in the brains of affected people decades before cognitive symptoms are noticeable.

The new guidelines reflect today’s understanding of how key changes in the brain lead to Alzheimer’s disease pathology and how they relate to the clinical signs of mild cognitive impairment and dementia. We are also beginning to be able to detect these changes at a preclinical stage, long before symptoms appear in many people. With further research on biomarkers, as set forth in the new consensus, we may ultimately be able to predict who is at risk for development of mild cognitive impairment and dementia, and who would benefit most as interventions are developed. The new criteria enable better assessment of needs from research to care services, to patient and caregiver education materials, to nursing home beds, to the number of gerontologists and nurses that we need. And, they give us a basis for creating the next generation of Alzheimer’s treatments that will be effective in each stage of the disease.

S25 SUICIDE: RISK FACTORS AND PRINCIPLES OF PROFESSIONAL AND SYSTEMIC TREATMENT OF THE SUICIDAL PATIENT

Chairpersons: Prof. Alan Apter, Prof. Gil Zalsman, Prof. Zahava Solomon

S25.1 HEALTH RISK BEHAVIORS AMONG BEREAVED OFFSPRING

Hamdan Sami
The Academic College of Tel- Aviv Jaffa, Israel

The objective of the presentation is to describe the course of health risk behaviors (HRBs) over the 3-year period after a parent’s sudden death (such as suicide, accident) in 240 bereaved youth compared to 183 non-bereaved controls. In this study, the bereaved group showed persistently higher HRBs compared to the non-bereaved group, even after taking into account correlates and sequelae of bereavement that were also associated with HRBs, such as youth functional impairment and aggression, and antisocial disorder and anxiety in the deceased parent. Parental bereavement is associated with higher HRBs over time, even after controlling for other covariates also associated with HRBs. Interventions that augment individual and family protective resources may help to attenuate the negative impact of bereavement on HRBs.

S25.2 PHARMACOGENETICS OF ACUTE TREATMENT OF DEPRESSION AND ANXIETY IN CHILDREN AND ADOLESCENTS: IMPROVING THE RISK-BENEFIT RATIO FOR THE USE OF SSRIS IN THE PEDIATRIC POPULATION

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Suicide is a major public health problem. In Israel 450 people commit suicide every year, about one third are under 18 years old. The National Inter-ministerial Committee for Suicide Prevention set official guidelines for practitioners, managers, officers, media and policy makers on the subject of suicide prevention in Israel. The process of creating the guidelines was long and educational. We used guidelines from the Israel Association, the American and British Associations, the police, ministries of education, health and welfare. The guidelines will be presented and the audience will have an opportunity to discuss them.

S25.3 THE OFFICIAL GUIDELINES FOR SUICIDE ASSESSMENT IN ISRAEL

Gil Zalsman*
Geha Mental Health Center, Tel Aviv University

Pharmacogenetics deals with studying the relationship between a person’s genetic makeup and the medicine he is taking. So far, only two published studies investigated the pharmacogenetics of antidepressants in the pediatric population. Since anti-depressants, mainly SSRIs, take around 4 to 6 weeks to manifest their effect, it is crucial to be able to discern in advance the group of patients that is unlikely to benefit from such a treatment. We started collecting our cohort in the year 2002, including children and adolescents who suffered from at least moderate depression and anxiety. These subjects were interviewed semi-structurally and structurally by questionnaires (such as CDRS-R, BDI, CDI, SCARED and SIQ). The patients received the SSRI citalopram and were followed for eight weeks. We also used a questionnaire to measure potential side-effects and we calculated BMI at the beginning and at endpoint. In the year 2007, we published our first results by analyzing the association of the serotonin transporter (5-HTTLPR) and response to citalopram in a cohort of 80 children. This gene was chosen for its importance in the etiology of depression. Our results demonstrated a significant correlation between polymorphisms in this gene and response rates. The database is still growing; now encompassing more than 130 children and adolescents, being tested for a variety of polymorphisms discussed in the latest scientific research: serotonin receptors 2A, 1Band 2C, the corticotrophin releasing hormone receptor 1 and 2, MAO, COMT and FK506 binding protein 5. Of these, the latter is of major importance, having been associated with suicidality (Brent, Am J Psychiatry, 2010). We now intend to present the full results of our study, based on the enlarged cohort of 130 patients and the association to the aforementioned key CNS genes. In our new results we partially replicated the recent Brent et al. study.

S25.4 CASE FINDING AND ADOLESCENT SUICIDE PREVENTION

Alan Apter, Dana Feldman
Schneider’s Children’s Medical Center of Israel

Introduction: Adolescent suicide is a major public health problem. The detection of at risk individuals is a major goal of any prevention program. Many different strategies have been proposed but empirical evidence as to which methods are best is lacking. Two major schools of thought predominate: those who believe that any adolescent given a sufficient amount of stress can commit suicide and those who believe that suicide is predominately a risk in adolescents with defined predispositions. The former school is usually dominated by educators and health promoters and the latter by clinically oriented investigators. An example of a clinical scheme is that of the “Columbia Teen Screen”. The present project was carried out as part of a pan European adolescent suicide prevention project coordinated by the Karolinska Institute in Stockholm. This report will be restricted to preliminary findings. Objectives: To compare three methods of detecting at risk adolescents in a high school population. These were 1. Educating gatekeepers [teachers] in identifying potential suicide victims. 2. Awareness training for pupils so that they can identify and refer peers who are in danger. 3. Mass screening of classes by questionnaires for various suicide risk factors. Methods: 12 high-schools were randomly chosen from schools throughout Israel. Both Jewish and Arab schools were included in the study. 1200 pupils completed self-report questionnaires regarding suicide ideation or attempt [Paykel Suicide Scale], psychopathology (Strengths and Difficulties Questionnaire; Beck Depression Inventory; Zung Anxiety Scale), life styles [Global School-based Student Health Survey], socio-demographic background, non-suicidal self-injury, life events and social support. For ethical reasons questionnaires were screened for severe suicidal ideation or behavior and those subjects were interviewed by school counselors. Students considered to be at risk were then referred for psychiatric intervention. Students were then randomized to either a gatekeeper program aimed at the school staff, to an awareness program aimed at the school’s students or to screening by questionnaire. Preliminary results: The study was designed to be longitudinal and prospective. Here we present only the first cross-sectional analysis. 12.1% of students thought about suicide during the past 2 weeks while 6.8% of students had a suicide plan. 9.7% of students had attempted suicide. 34% of those needed medical care after the attempt and 25.2% of the attempters had made repeated attempts. 65% of those admitting to have made a suicide attempt were unknown to the school authorities. Mass screening by questionnaire was over sensitive and identifies 50% of pupils as being at risk. Gate-Keeper training and student awareness training lacked sensitivity and hardly identified any at risk pupils.
The best results were obtained by a two-question screen which had reasonable sensitivity and specificity and is inexpensive and easy to perform. These questions were about having made a definite suicide attempt or about having serious thoughts of self-harm. Follow up over the next year will allow confirmation of these results. The significance of this study is that it confirms reports from the Columbia Teen Screen Project that a two question screening is feasible and sensitive in schools. Since this is easy to do and is relatively inexpensive, these findings could mean a significant advance in suicide prevention methods for young people and thus save many lives.

**S26 EVIDENCE BASED PSYCHIATRY IN RUSSIA AND ISRAEL**

Chairpersons: Prof. A.S. Tiganov, Prof. M. Ritsner

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**S26.1 CURRENT STATE OF THE PROBLEM OF SCHIZOPHRENIA (PSYCHOPATHOLOGY, CLASSIFICATION AND TREATMENT)**

A. S. Tiganov
Mental Health Research Center Russian Academy Medical Science, Moscow

The report deals with current problems of diagnostics and classification of schizophrenia. The concepts of defect and negative disorders in schizophrenia are discussed. The clinical factors influencing the structure of positive and negative symptoms in schizophrenia are discussed, as well as aspects of differentiated use of modern antipsychotic drugs in the treatment of schizophrenia.

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**S26.2 TOWARD A MULTI-DIMENSIONAL CONTINUUM MODEL OF FUNCTIONAL PSYCHOSES FOR RESEARCH PURPOSES**

Michael S. Ritsner
Rappaport Faculty of Medicine, Technion - Israel Institute of Technology Haifa, and Sha’ar Menashe Mental Health Center, Israel

Schizophrenia (SZ), schizoaffective disorder (SA), major depressive disorder (MDD) and bipolar disorder (BPD) are clinically heterogeneous conditions called ‘functional psychoses’ [FP]. The paradigm, underlying the current model of FP, was based on Kraepelinian dichotomy and was a practical starting point for the categorical classification of FP. Nevertheless, the concept is increasingly challenged by emerging data from modern research in the field of clinical, genetic epidemiology, molecular genetics, neuroscience and neurobiological studies. It has been suggested in the literature that, despite intensive efforts and progress towards more reliability in classification, no definite and causally relevant biological abnormalities have been identified to date. Because the underlying disease mechanisms are poorly understood it is difficult to define a biologically plausible classification of functional psychoses. Recent research findings support a multidimensional model for FP. This lecture presents proof-of-concept for the Multidimensional Continuum Model (MDC model) of functional psychoses for research purposes. It is based on multi-dimensional parameterization of the clinical-endophenotype-genetic domains with a three-axis continuum (distribution) of psychopathological and behavior patterns among FP-affected persons, their relatives and the general population, on a hypothesis-free approach, and on an endophenotype strategy. The MDC model provides a framework for research purposes, in particular, for the study of the interactions between clinical, neurocognitive, behavioral, brain imaging and other neurobiological representations of functional psychoses. Postulated common to functional psychoses etiological and pathogenetic mechanisms include at least four interactive hits: a genetic load hit ("genetic vulnerability"), a neurodevelopmental hit ("neuronal vulnerability"), a stress sensitization hit ("life stress vulnerability"), and a neurodegeneration hit. Implications for future researches in this field are discussed.

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**S26.3 THERAPEUTIC REMISSION IN SCHIZOPHRENIA: RATIONALE FOR NEW OPERATIONAL CRITERIA**

Sergey N. Mosolov,*, Andrey V. Potapov,
Moscow Research Institute of Psychiatry Minzdravsocrazvitia of Russian Federation

Schizophrenia is characterized by significant heterogeneity of psychopathology and outcomes, and it is impossible to ignore the different clinical types and courses of the disorder even in periods of remission. Present diagnostic developments in this field such as clinical types of remission in accordance with the effectiveness of therapy and international criteria of the Andreasen group (2005) have serious limitations. Our recent study showed that only 31.5% of 203 schizophrenia outpatients of 2 healthcare districts in Moscow met the criteria for symptomatic remission, but at the end of the 6-month follow-up period 77.8% were stable and among them only 26.1% patients fulfilled the remission criteria. These were mainly patients with remittent and episodic course, whereas for stable patients with chronic course these criteria remained unachievable. Logistic regression model revealed that ICD-10 diagnosis (OR = 5.95) and level of functioning (GAF score) (OR = 1.29) significantly predicted the outcome of symptomatic remission whereas history of psychotic disorder in first degree relatives (OR = 1.29) significantly predicted the outcome of symptomatic remission whereas history of psychotic disorder in first degree relatives (OR = 0.44) and presence of disability (OR = 0.64) decreased likelihood of symptomatic remission. The new operational criteria of remission took into account a specific threshold for 8 core symptoms according to ICD-10 diagnosis. Moreover, developed criteria were supplemented with psychopathological symptoms that are also important in the remission period (affective symptoms, disturbance of volition and insight of illness) as well as level of
functioning as assessed with the Personal and Social Performance scale. Symptomatic and functional components of the developed remission criteria were validated in an independent population of patients in an outpatient service. Thus, it was shown that these criteria covered a wider range of stable schizophrenic patients as compared to international criteria of remission and serve as a more realistic target for modern antipsychotic therapy according to various clinical types and courses of illness.

S26.4 TREATMENT OF RESISTANT DEPRESSION: STATE OF THE ART

Boris Nemets
Beer Sheva Mental Health Center, Faculty of Health Sciences, Ben-Gurion University of the Negev

Treatment-resistant depression is not a diagnosis, but rather is a description of a particular moment in an individual’s treatment history. About one-fourth to one-third of people who receive 2 adequate courses of pharmacotherapy will meet criteria for the most inclusive definition of treatment resistant depression. There are a number of reasons that people either don’t respond - or stop responding - to antidepressants, including nonadherence, misdiagnosis of the depressive disorder (eg, not recognizing psychiatric features or bipolarity), and complicating comorbidities that warrant other specific treatments (eg, substance abuse or hypothyroidism). Systematic approaches to management of treatment-resistant depressive episodes usually emphasize hierarchies or therapeutic algorithms that begin with first-line medication options, and move on to other classes of medications or augmentation strategies.

S27 DANGEROUSNESS IN PSYCHIATRY – COPING WITH DANGEROUS PATIENTS THAT ARE NOT MENTALLY ILL

Chairpersons: Dr. Moshe Kalian, Prof. Yuval Melamed

S27.1 COPING WITH THE DANGEROUS PATIENT WHO IS NOT MENTALLY ILL

Yuval Melamed
Lev Hasharon Mental Health Center, Sackler Faculty of Medicine, Tel-Aviv University

In recent years we have been exposed to dangerous patients more frequently, some of whom have committed serious crimes of inflicting harm on others including on spouses and children. Some of the crimes stemmed from life crises that led to hospitalization and therapy. The crises generally manifested in depression and suicide, and the diagnoses were often adjustment disorder. In severe cases during or after treatment the patient committed a serious crime, in extreme cases even murdered children. What can we learn from such serious and extreme events and what are the implications for future treatment of dangerous patients?

S27.2 HCR-20 AS AN ASSESSMENT TOOL TO EVALUATE PROBABILITY OF VIOLENCE AMONG THE PSYCHIATRIC POPULATION IN ISRAEL

Michael Shayit
Department of Forensic Psychiatry, Lev Hasharon Mental Health Center

Risk assessment becomes more cogent in decisions concerning involuntary intervention, denial of rights and naturally attracts attention. Facing increasing demands from professionals to assess potential for violence of individuals, in Israel, most decisions concerning risk assessment are based on subjective clinical evaluation and not on an actuarial assessment. The Historical Clinical Risk Management -20, (HCR-20) is one of the most common tools used worldwide to standardize the clinical evaluation of violence (Webster et al., 1997). The HCR-20 includes 20 risk factors for future violent behavior that are based on three domains: Historical, Clinical, and Risk Management. One of its most prominent benefits is that it includes static items alongside dynamic components that may change across time. The assessment tool is currently being validated in Israel, and its implementation and standardization will enable an improvement in the evaluation process both in terms of the duration of time necessary to make a decision and in terms of the reliability and validity of the evaluation.

S27.3 SEX OFFENDERS – DIAGNOSIS, RISK EVALUATION AND TREATMENT IN LIGHT OF THE NEW LEGISLATION

Shmuel Hirschmann
Sha’ar Menashe Mental Health and Rappaport Faculty of Medicine, Technion, Israel Institute of Technology, Israel

Sex offences, and pedophilia in particular have become the focus of interest of therapists, owing to the magnitude of concern for preventing harm among children and adolescents. Throughout the years, diagnostic methods for the disorder have been developed, especially for the prediction of potential dangerousness of sex offenders. Across time, experience has accumulated for preferred treatments. Combined treatment includes supervision, psychotherapy, pharmacotherapy and rehabilitation. The Law for the Public Protection from Sex Offenders, 2006 – created the first legal framework. The law included the obligation to report. In the year 2010, there were 689 convictions of sex crimes in the various courts in Israel. Two hundred and forty three new Supervision Orders were issued and the total number of Supervision Orders was 609. There were six convictions of sex crimes during supervision in 2010. Throughout the years dissatisfaction with the law was expressed, and finally private bills for the Law of Public Protection were combined with the government bill. During the 18th Knesset, the Constitution
Committee discussed the issue. Processes for risk assessment and treatment of sex offenders in conjunction with legislation will be reviewed in the lecture. The main issue to be discussed is how the new legislation will influence clinical practice.

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**S27.4 Psychopathy and Psychopathology – Some Reflections on the Psychiatric Treatment of Inmates and Violent Offenders**

Joshua Weiss, Moshe Birger
Israel Prison Service, and Ashkelon Academic College

This presentation has two parts in accordance with the prison population - inmates with severe personality disorders and those with personality problems. In the first section Dr. Birger, the head of Maban, the Forensic Department of Beer Yaakov-Ness Ziona Center for Mental Health, situated in the Israeli prison service, will discuss the challenges in managing and treating inmates suffering from severe personality disorders. He will present a model of mental health services within prison wards, utilizing the structure of the prison and its multi-professional staff in managing and treating the inmate. In addition, Dr. Birger will present some of the difficulties intrinsic in the combination of psychiatry with judicial needs and decisions regarding this complex offender. In the second section, Dr. Joshua Weiss, head of Assessment and Placement in the Israeli prison services will discuss how using psychiatric diagnosis can be detrimental both to the inmate and to psychiatry as a profession. There is a tendency to over diagnose psychopathology on the one hand, and a contamination of pathology with “evil”. The diagnosis of psychopathology is meant to treat and rehabilitate patients but within prison and the judicial processes psychiatric diagnosis may serve to demobilize the violent offender. Assessing problems in living and coping, and directing the offender towards living a better life (or “good life”) can help in managing the offender and reducing violent recidivism. This approach encourages viewing the offender as being responsible for his actions, those that brought him into prison and those that can help him in the future.

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**S28 Child Psychiatry: Environment, Genetics and Everything In Between**

Chairpersons: Prof. Gil Zalsman, Dr. Shoshana Arbelle

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**S28.1 Autistic Spectrum Disorders in the Bedouin Population of the Negev**

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²Infant Psychiatry Unit, Soroka University Medical Center, Beer Sheva.

The rate of diagnosed autistic spectrum disorders (ASD) is growing in the Western world. It is known that these diagnoses can be influenced by culture and socioeconomic classes. Little is known about the prevalence of ASD in ethnic minorities. In a few studies the prevalence of ASD in ethnic minorities is lower compared to the general population and the age of diagnosis is higher. The hypothesis for the lower rate is reduced detection for a variety of reasons. One reason relates to the fact that the criteria for diagnosis are sometimes not culture appropriate. For example, eye contact in Asian children versus American children. Looking at the M-CHAT questionnaire, normative Asian children score as suspicious for autism. Most of the questions that the Asian children “failed” related to the fact that they were not looking at the parent and were not imitating them. According to anthropological studies normative Asians families do not encourage communication between children and parents. The same is true for playing imaginary play with or with toys or dolls. Another issue related to differential diagnosis: mental retardation, for example, is commonly diagnosed in the Bedouin population. It is known that about 70% of the children with autism are mentally retarded and one needs to be skilled in order to differentiate between them. In addition there is a great difficulty in diagnosing Bedouin children with autism with no behavior problems - they usually do not bother, and are “lost” in kindergarten or at school. The vast majority of children now diagnosed as autistic in the Bedouin sector suffer from mental retardation in addition to autism. We will present our findings relating to the diagnosis of children with autistic spectrum disorders while addressing specific issues that characterize the Bedouin population, such as intermarriage, geographic proximity to industrial areas, inter-cultural aspects and comorbidity.

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**S28.2 Real and Transitional Wombs: Parents, Teachers and Systems Regulating Child Well-Being in the Face of Massive Trauma**

Leo Wolmer¹, Daniel Hamiel¹, Nathaniel Laor²,³
¹Tel Aviv-Brull Community Mental Health Center
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³Tel-Aviv University
⁴Yale Child Study Center

Children, recognized as one of the most vulnerable populations, are exposed to mass traumatic situations worldwide with serious short- and long-term effects in terms of adaptation and development. Child mental health professionals are called upon to espouse state-of-the-art knowledge and interventions in the area of mass disaster, and expand their professional responsibilities in a changing world. The presentation will summarize two decades of professional experience in developing urban models of child-centered community resilience, including a pilot program on Urban Resilience currently implemented in 18 cities nationwide. The objectives
of this presentation are to (1) present recent findings concerning vulnerability and protective developmental aspects of child trauma; (2) introduce new findings supporting the feasibility of mass stress inoculation in schools; and (3) demonstrate the creation of a community of medical and psycho-social institutions as a protective urban envelope around children.

S28.3 PHENOTYPIC PSYCHIATRIC CHARACTERIZATION OF CHILDREN WITH WILLIAMS SYNDROME AND RESPONSE OF THOSE WITH ADHD TO METHYLPHENIDATE TREATMENT

Tamar Green1, Sarit Avida, Doron Gothelf2,3
1Beer Yaakov-Ness Ziona Mental Health Center
2Sackler Faculty of Medicine, Tel Aviv University
3The Edmond and Lily Safra Children’s Hospital, Sheba Medical Center

Williams syndrome (WS) is associated with cognitive deficits, special behavioral phenotype and high rates of psychiatric disorders. The aims of the present retrospective cohort study were: (1) To compare the rates of psychiatric disorders and repetitive behaviors in children with WS to children with idiopathic developmental disability (DDs); (2) To longitudinally assess the change in psychiatric disorders during adolescence in WS; (3) To assess retrospectively the effectiveness and safety of methylphenidate (MPH) treatment in WS children with ADHD. The study consisted of a cohort of 38 children and adolescents [age 13.1 ± 5.2 years] with WS and a sample of age- matched DDs [age 15.0 ± 3.1 years]. A current follow-up evaluation was conducted after 5.6 ± 1.6 years for 25 subjects [65.8%] of the WS cohort. The rate of most psychiatric disorders was found similar in children with WS and DD controls. Specific phobia, especially from noises, obsessive compulsive symptoms [e.g., aggressive obsessions and repetitive questions] and stereotypic behaviors [e.g., glancing], were more common in WS than DDs. In a longitudinal follow-up of the WS children, we found a decrease in the rate of anxiety disorders. In addition, a clinically significant improvement was reported in 72.2% of WS children with ADHD following MPH treatment. Sadness/unhappiness was the most common side effect associated with MPH treatment in WS, occurring in 2/3 of treated individuals. The present study further elucidates the neuropsychiatric phenotype of WS. Our results also suggest that MPH treatment for ADHD in WS warrants future prospective controlled trials.

S28.4 TIMING IS CRITICAL: GENE ENVIRONMENT AND TIMING INTERACTION IN CHILD AND ADOLESCENT DEPRESSION

Gil Zalsman
Geha Mental Health Center, Petach Tiqwa, Sackler Faculty of Medicine, Tel Aviv University, Israel

Depression and suicidal behavior run in families and are prevalent in adolescence. Case-control and family-based studies in this age group failed to find a genetic association that survived replications. The gene environment approach gave new hope for possible associations especially with the short allele of the serotonin transporter promoter polymorphism (5-HTTLPR). However, a recent meta-analysis raised doubts about the consistency of these findings. Some new structural and functional imaging data may shed light on the age-related and gender-related development of the brain. This presentation suggests a new approach to gene by environment and timing interaction to understand the interplay that leads to depression and suicidality in adolescents and young adults. An animal model that assesses this hypothesis will be presented. After exposing control and “depressed” baby rats daily for a limited period of time to stress, behavioral results indicated that this brief manipulation was strong enough to enhance depression-like symptoms as indicated by reduced floating in the forced swim test as well as increased consumption of saccharin in a preference test for depressed rats. In vivo MRI diffusion tensor imaging analysis at young adulthood revealed differences in fractional anisotropy in several brain areas, in both strains between rats exposed to brief daily stress and controls.


Chairpersons: Prof. Jacek Bomba, Prof. Zahava Solomon, Prof. Haim Y. Knobler

S29.1 IN THE SHADOW OF THE HOLOCAUST

Zahava Solomon
Adler Research Center for Child Welfare and Protection, Bob Shapell School of Social Work, Tel-Aviv University

Research on Holocaust survivors and on their children was different from current research of their grandchildren – the “third generation of the Holocaust”. Past research focused mainly on the survivors’ pathology and on the transgenerational transmission of the horrors of the Holocaust to the second generation. Third generation research focuses on broader aspects, including familial, educational and cultural effects of the memory of the Holocaust. A special group of survivors - who were children during WWII, are today our major living link with the Holocaust, and new research recognizes their unique traumatic experiences. Their childhood, in the shadow of the Holocaust, was not studied thoroughly in the past for various reasons. The knowledge of the implications of the Holocaust on the three generations, gathered in Israel and abroad, may be used to prevent and to treat post traumatic disorders of future massive disasters.
S29.2 HOLOCAUST IN THE SECOND GENERATION – TRAUMA OR MEMORY TRANSMISSION?

Katarzyna Prot1, Krzysztof Szwajca2, Łukasz Biedka1, Kazimierz Bierzyński1, Ewa Domagalska1, Ryszard Izdebski1, Marta Kościelnik1, Krzysztof Szwajca2, Łukasz Biedka3, Kazimierz Bierski2

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Transmission of the Holocaust trauma has been widely discussed in the psychoanalytic literature in terms of the transposition phenomenon, or projective identification, where children contain their parents’ uncontrollable feelings of bereavement and aggression. The child begins to think, feel and act in accordance with this projection, and “returns” these feelings in an attempt to compensate for the parental losses through avoiding rebellion and giving up separation. The children feel they cannot leave their family home without a total loss of the object – since separation denotes death, both symbolically and literally. Specificity of the Polish “second generation” consists of their living in families that are a fraction of the extremely small and dispersed Jewish community, in generational families with a double taboo of not only the Holocaust, but also of their Jewish origin. The silence surrounding the Holocaust leads to terrifying fantasies about parental experiences, making the separation process even more difficult. In this context we describe a group process continuing for over 13 years, the only such therapeutic group for “the second generation” in Poland. We describe the process of crucial importance to the Survivors’ children - of separation from their parents and therapists in the parental role through establishing an organization of “The Second Generation” aimed at preserving memory and building up Jewish identity. We assume that enabling “the second generation” children to complete the process of separation gives them a chance to build the history of the Holocaust into the family history, to perceive the Holocaust as a myth, and to focus on living their lives and not only dwelling upon death. The myth of the Holocaust becomes a part of their identity, influencing both their way of perceiving life and their philosophy of life.

S29.3 IS THE POLISH SECOND GENERATION OF HOLOCAUST SURVIVORS THE SAME AS EVERYWHERE ELSE?

Krzysztof Szwajca

Department of Child and Adolescent Psychiatry, Collegium Medicum, The Jagiellonian University, Kraków

Research on transgenerational transmission of the Holocaust trauma has been mainly carried out in the United States and Israel, the countries to which the majority of the Holocaust survivors migrated. The conclusions are ambiguous. Both the fact of transmission itself and the specific psychopathology of SGs (second generation of Holocaust survivors) are sometimes questioned. The very small group of SGs living in Poland is unique. The majority of them are offspring of Holocaust children, i.e. persons who suffered long-lasting and massive trauma of the Holocaust as children. Their key existential experience was related to deaths of their closest families, loneliness, anxiety and hiding their Jewish identity. They were brought up in ethnically mixed families, in which the transfer of Jewish culture was interrupted, with the construction of group identities largely hampered. On the other hand, this population is dramatically different from the subjects of the other research programs as they did not suffer migration or change of language of narration, which vitally impact transgenerational transmission. Based on research of 51 persons - children of Holocaust survivors - a specific character of the second generation of Holocaust survivors that live in Poland will be described.

S29.4 DEDICATED PHYSICIANS IN THE FACE OF ADVERSITY: THE ASSOCIATION OF JEWISH PHYSICIANS AND THE JEWISH HEALTH ORGANIZATION IN POLAND (1921-1942)

Avi Ohry1,2, Karin Ohry-Kossoy 1 Reuth Medical Center, Tel Aviv 2 Sackler Faculty of Medicine, Tel Aviv University, Israel

Two important achievements of Jewish physicians in Poland in the years between the two World Wars were the founding of their own separate medical society [Association of Jewish Physicians of the Polish Republic, in Polish: Z.L.R.P.], and the establishment of a central public health organization. This was first founded as the Warsaw branch of O.S.E (Russian initials for Association for the Protection of Jews’ Health), its official name being TOZ, Polish initials for Society for the Protection of the Health of the Jewish Population in Poland. Along with the encouragement of research, additional items appeared on Z.L.R.P.’s agenda: a mutual assistance fund and an employment advice service were set up. During the Z.L.R.P.’s 16 years of existence, around 280 regular meetings devoted to medical topics were held in Warsaw. Preventive medicine was TOZ’s first mission, for example teaching the Jewish population basic rules of hygiene and good health. TOZ opened clinics for pregnant women and babies, as well as nurseries. Schoolchildren were looked after in clinics or by health visitors, received hot lunches at school and were offered summer camps. The importance of physical exercise and healthy nutrition was stressed. There was special counseling for families with disabled or retarded children. TOZ had its own sanatoriums and clinics with up-to-date equipment to fight infectious and contagious diseases.

S30 SOCIAL ANXIETY: CURRENT STATUS AND FUTURE DIRECTIONS

Chairpersons: Dr. Iulian Ianco, Prof. Haggai Hermesh
Social Anxiety Disorder (SAD) is a highly prevalent disorder in Western countries, reaching lifetime prevalence rates of up to 13%. Over time, increased disability and a reduced quality of life, as well as increasing rates of comorbidity with secondary mental disorders (i.e. depression, substance abuse), can be expected in such individuals. The symposium will provide an overview of the etiology of SAD, especially regarding psychological etiologies (i.e. link with perfectionism). Various psychotherapeutic treatments and biological factors (deficiency of ePUFA in SAD patients and the lack of relationship between SAD severity and ePUFA concentration) will be presented. Also, we will describe the phenomena of bruxism in SAD and its improvement after successful treatment of the anxiety disorder. Recommendations for further research and treatment directions will be given.

**S30.1 THE STATE OF THE ART IN EVIDENCE BASED TREATMENT OF SOCIAL ANXIETY**

Sergio Marchevsky  
Ebetim Clinic & Beer Yaakov Mental Health Center

Cognitive-behavioral treatment is considered by many as the best psychotherapeutic intervention in Social Anxiety Disorder. In this presentation, I will review evidence regarding central questions as regards the treatment of Social Anxiety Disorder. Is pharmacotherapy desired or is it an obstacle to effective treatment? What is the most proven psychotherapeutic approach for this disorder? Is individual treatment better than group therapy? What about awareness and motivation for change? Is the same treatment required when there are complications like alcoholism, drug abuse or depression? This brief review of central questions will serve as a background for other presentations in this symposium.

**S30.2 SOCIAL ANXIETY DISORDER AND PERFECTIONISM**

Iulian Iancu*, Ehud Bodner, Samia Joubnan, Edward Ram  
Yavne Mental Health Clinic, Ness Ziona Beer Yaakov Mental Health Hospital.

**Background:** Subjects with Social Anxiety Disorder (SAD) are characterized with low self-esteem, pessimism, procrastination and also perfectionism. The link between social anxiety and perfectionism is important, both regarding etiology and treatment of SAD.

**Methods:** This study examined the link between social anxiety and perfectionism in a group of 160 Jewish and Arab students in Israel.

**Results:** The rate of SAD in these students according to a score of 60 or more on the Liebowitz Social Anxiety Scale (LSAS) was 16%, a rather high rate in the Western world. The correlation between the total LSAS score and the score of perfectionism was significant (r=0.31). Differences between our two cultural sub-samples will be presented.

**Conclusions:** The linkage between SAD and perfectionism will be discussed and implications for treatment will be suggested.

**S30.3 UNALTERED COMPOSITION OF N-3 POLYUNSATURATED FATTY ACID IN ERYTHROCYTE MEMBRANES OF NON-DEPRESSED GENERALIZED SOCIAL PHOBIA PATIENTS FOLLOWING SUCCESSFUL PSYCHOTHERAPY**

Natalie Ellencweig*, Hetziba Green1,4, Sofi Marom1, Pnina Green2,3  
Abraham Weizman1,2, Haggai Hermesh1

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4Department of Internal Medicine E, Rabin Medical Center, Beilinson Campus, Petah Tiqva

**Background:** The “phospholipid hypothesis” attributes a pathophysiologic role to deficiency of n-3 polyunsaturated fatty acids (PUFA) in depression. We demonstrated lower erythrocyte n-3 PUFAs (ePUFA) levels in patients with generalized social phobia (GSP) and inverse correlation between the severity of GSP and ePUFA levels. These findings suggest that GSP anxiety leads to low ePUFA concentrations, or the deficient PUFA plays role in the pathophysiology of GSP. We monitored the ePUFA composition in GSP patients before and after psychotherapy.

**Methods:** We assessed the long-term influence of cognitive behavior group therapy (CBGT) on anxiety and ePUFA levels in 17 non-depressed GSP outpatients. GSP Severity was evaluated with the Liebowitz Social Anxiety Scale (LSAS). LSAS and ePUFA concentrations were monitored thrice: prior to, at completion of CBGT and 10-24 months later. Results: CBGT reduced LSAS scores by 40% (p<0.001), but ePUFA composition remained remarkably unchanged (+ 2%).

**Conclusion:** We previously demonstrated ePUFA deficiency in GSP patients. The present results suggest that the CBGT-related improvement in GSP levels is independent of alterations in ePUFA concentration. PUFA deficiency may be a trait dependent biomarker in GSP. Complementary studies should investigate the therapeutic effectiveness of n-3 PUFA supplementation in SP patients and the impact of such intervention on GSP and PUFA concentrations.

**S30.4 ENHANCED ORAL ACTIVITIES, TEMPOROMANDIBULAR DISORDERS AND BRUXISM AMONG SOCIAL PHOBIA OUTPATIENTS**

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Background: Anxiety and selective serotonin reuptake inhibitor (SSRI) therapy are both considered aggravating factors for awake- and sleep-bruxism and clenching. Bruxism may be destructive for the dentures, and the temporomandibular joint (TMJ), as well as causing myofascial pain. However, knowledge of the relationship between anxiety and bruxism is mostly based on data from non-clinical populations. We examined the influences of prolonged clinical anxiety, in social phobia (SP), depression and SSRI treatment on bruxism and clenching.

Method: Participants were SP patients who were either drug naïve or treated with SSRIs and healthy individuals (Ns= 23,17,33; respectively). A structured diagnostic interview was used for psychiatric diagnosis, and Liebowitz Social Anxiety Scale, Beck Depression Inventory, for assessing the severity of SP and depression. TMJ status and oral parafunctional activity (PF) were evaluated using a questionnaire and dental examination.

Results: Awake-bruxism, “Jaw Play”, the presence of at least one PF, as well as disc displacement (OR=1.25-23.7, p<0.05 for all) and an inclination towards sleep-bruxism (p=0.077), were more prevalent in SP than in control subjects. Drug-naïve and SSRI-treated SP patients did not differ on any of the demographic, clinical and TMJ measures. Severity of SP score, but not depression, robustly predicted the presence of PF (p<0.002).

Conclusions: SP diagnosis and its severity (but not depression) are associated with higher risk of oral awake PF activity and bruxism. Chronic SSRI treatment of SP did not deleteriously affect bruxism. Patients of both psychiatric and dental clinics may benefit from denture and anxiety screening. Effective treatment of SP may mitigate bruxism.

S30.5 VIRTUAL REALITY COGNITIVE BEHAVIOR THERAPY FOR PUBLIC SPEAKING ANXIETY: ONE YEAR FOLLOW UP

Marilyn P. Safir, Helene S. Wallach, Margalit Bar-Zvi
Department of Psychology, University of Haifa, Haifa

Background: Public speaking anxiety (PSA) is a common social phobia. Although Cognitive Behavior Therapy (CBT) is the treatment of choice, difficulties arise with both in-vivo and in-vitro exposure (lack of therapist control, patient’s inability to imagine, self-flooding, and a lack of confidentiality resulting from public exposure).

Methods: Virtual Reality CBT (VRCBT) enables a high degree of therapist control, thus overcoming these difficulties. In a previous publication, we reported on our findings that VRCBT (N=28) and CBT (N=30) groups were significantly more effective than a wait-list control (WLC N= 30) in anxiety reduction on four of five anxiety measures, as well as on subject’s self-rating of anxiety during a behavioral task. No significant differences were found between VRCBT and CBT. However, twice as many clients dropped out of CBT (15) than from VRCBT (6). Our results demonstrated that VRCBT is an effective and brief treatment regimen, equal to CBT.

This brief report examined durability of these changes.

Results: We found that both VRCBT (25) and CBT (24) groups maintained their improvement from post-treatment to follow-up, on all five measures. In addition, we found that the CBT group continued to improve from post-treatment to follow-up on LSAS fear. Thus, treatment gains were maintained at a one year follow-up.

Conclusions: Recommendations for further progress in the treatment of Public speaking anxiety will be given.

S31 EVIDENCED BASED PSYCHIATRY IN RUSSIA AND IN ISRAEL

Chairpersons: Prof. Vladimir Lerner, Dr. Natalia Petrova

S31.1 SPECIALTIES OF PROLACTIN SECRETION AND PERIPHERAL REPRODUCTIVE SEX HORMONES IN PATIENTS WITH FIRST-EPIISODE SCHIZOPHRENIA

L.N. Gorobets, M.I. Matrosova, A.V. Litvinov
Moscow Research Institute of Psychiatry

Objective: to study the level of prolactin secretion in patients with first-episode schizophrenia (FES), depending on the severity of mental disorders and gender. Materials: Study subjects were 50 patients with FES (23 women and 27 men), mean age - 27, 3±7, 5 years. The control group included 17 healthy probands (7 women and 10 men), mean age was 26, 8±4, 5 years.

Methods: Clinical-psychopathological, hormonal and statistical.

Results: The severity of illness of patients with FES averaged 88,8±10,1 PANSS score. The main group was divided into two subgroups of patients depending on the severity of psychopathology. The first subgroup consisted of patients with severe psychopathology - PANSS more than 80 (on average - 93, 16±7, 5 points). The second subgroup consisted of patients with 68-79 score (mean - 76, 5±5, 07 points). Comparative analysis of hormonal levels was performed with gender and severity of mental health. Mean prolactin levels in the whole group among women with FES were slightly higher than its content (an average of 20.6%) compared with the control group. The average of prolactin values in the men’s group was higher by 25% and differed significantly from controls (p=0, 04). Mean prolactin levels in the women’s group slightly exceeded the levels in men.
Comparative analysis of average prolactin levels according to the severity of mental illness among women showed that the women in the second subgroup had slightly higher levels [533, 6 ± 119, 9 MML / l]. Among men the average prolactin levels were higher in patients with more severe mental disorders (first subgroup) and differed significantly when compared with controls [446, 6 ± 206, 1 MML / l; 322,5 ± 9,8 MML / l, p = 0.04]. It should be noted that in the whole group and subgroup average of hormone levels in the studied patients and probands were within acceptable limits.

**Conclusions:** The results of the study demonstrate that the severity and acuteness of the schizophrenic process as well as prolactin levels depend on the hyperactivity of the dopaminergic system of the CNS.

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**S31.2 CLOZAPINE POLYPHARMACY IN TREATMENT-RESISTANT SCHIZOPHRENIA PATIENTS**

Vladimir Lerner*, Chanoch Miodownik

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Treatment resistance and unsatisfactory functional outcomes of schizophrenia patients continue to be a significant clinical and public health problem. About one fifth to one third of these patients derive little or no benefit from treatment with conventional or novel atypical antipsychotics of adequate dosage and duration. Despite being recommended in most evidence based guidelines as a strategy of last resort for unresponsive psychotic illness, antipsychotic polypharmacy is commonly prescribed over prolonged periods for people with established schizophrenia. In this context, antipsychotic combination treatment, also called antipsychotic polypharmacy, has been utilized frequently in clinical practice. For example, the prevalence of antipsychotic polypharmacy in the United States varies from 7% to 50%, with most studies finding prevalence rates of between 10% and 30%.

Clozapine has remained the only treatment that consistently resulted in significantly superior outcomes compared with other antipsychotics in patients unresponsive or partially responsive to antipsychotic monotherapy. However, approximately 40–70% of treatment-resistant schizophrenic patients are also clozapine resistant as they have persistent positive, negative or residual symptoms and cognitive deficits despite clozapine monotherapy of adequate dosage and duration. During recent years several clozapine adjunctive agents have come into clinical practice to enhance the antipsychotic efficacy of clozapine. Conventional or novel atypical antipsychotics, various antidepressants, lithium, novel anticonvulsants, dopamine agonists, glutamate receptor agonists, omega-3 fatty acids, and ECT have all been tried as clozapine adjuncts to address resistant positive, negative or cognitive symptoms. The relevant randomized clinical trials and open-label studies of clozapine augmentation have generally reported the strategy to be relatively well tolerated.

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**S31.3 PSYCHOSOMATIC MEDICINE IN CLINICAL ASPECTS AND EPIDEMIOLOGY**

A.B. Smulevich

Mental Health Research Center Russian Academy Medical Science, Moscow

The report contains problem analysis of contemporary psychosomatic medicine in clinical and epidemiological aspects. According to results of the SYNTHESIS program, the prevalence of psychiatric disorders in the general medicine population is up to 86.5%. The original classification (new psychopathological model) of psychosomatic disorders is presented. Psychosomatic disorders are divided into two subtypes: 1 - psychiatric disorders secondary to medical conditions; 2 – primary psychiatric disorders.

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**S31.4 NEUROTROPHIC APPROACH IN PREVENTIVE THERAPY OF ALZHEIMER’S DISEASE**

S. I. Gavrilova

Department of Geriatric Psychiatry, Section of Alzheimer’s disease and related disorders, Mental Health Research Centre of RAMS, Moscow

Background: In recent decades the problem of Alzheimer’s disease (AD) preventive therapy has acquired extreme actuality. Cerebrolysin is a complex of aminoacids and peptide brain factors, containing oligopeptides with neurotrophic action. Objective: to compare the ability of Cerebrolysin (1st group) and Cavinton (2nd group, control) to prevent transition of mild cognitive impairment (MCI) syndrome into AD during 3 years. Methods: The total sample included 110 patients with amnestic MCI. A set of clinical scales (MMSE, GDS, CDR etc.) and neuropsychological cognitive tests were used. The groups were similar in cognitive disorders severity and ApoE e4 frequency. Results: To the end of the study AD was diagnosed only in 2 cases (3.6%) the 1st group and 6 patients (10,9%) in the 2nd group. Thus the rate of transition of MCI into dementia in the control group was 3 times higher than in group of Cerebrolysin. The improvement in 3 tests (Boston Naming Test, reproduction of 10 words and Digit span backward test) was significantly more in the 1st group vs the 2nd group. There was no deterioration in Cerebrolysin group in most of the tests vs initial assessments. Final scores in the 1st group were better than initial ones. Final cognitive assessments in the group of Cavinton were worse in 2 tests (Digit span backward, reproduction 10 words). In the Cavinton group only in the test «similarity» final assessments improved significantly. In the Cerebrolysin group the score improvement was more prominent in ApoEe4(+) patients. Conclusion: Superiority of Cerebrolysin over Cavinton in slowing down the progression of cognitive deficit and delaying MCI transition to AD was demonstrated. Cerebrolysin was particularly effective in MCI patients with the ApoE4 (+) genotype, i.e. in those with higher risk of Alzheimer’s disease.
S32 BRAIN BASED PSYCHIATRIC DIAGNOSIS – ARE WE THERE?

Chairpersons: Dr. Avi Peled, Dr. Shmuel Hirschmann

S32.1 CLINICAL BRAIN PROFILING

Avi Peled
Sha’ar Menashe Mental Health Center affiliated to Rappaport Faculty of Medicine, Technion, Israel Institute of Technology

Can psychiatrists diagnose their patients neuroscientifically? And if so how? In this session I will attempt to answer these questions, and discuss their implications for treatment. Today when a psychiatrist diagnoses patients with depression anxiety or schizophrenia, these diagnoses are not related to neuroscience. Typically the diagnosis will involve description, i.e., giving a name to the complaints (symptoms) of the patient, if the patient complains of depressed mood, helplessness, reduced motivation, reduced appetite and insomnia, the title of his diagnosis will be “depression”. This diagnosis provides no added value to the patient or the clinician. This is unlike the situation with other physicians that, for example might diagnose appendicitis when the patient complains of stomach ache. Upon diagnosing appendicitis the physician gains added values he knows where (in the body) to go and what to do (for cure). The psychiatrist that has diagnosed depression or schizophrenia does not know where to go (in the brain) and what to do for treatment. Diagnosing mental disorders neuroscientifically is based on the assumption that mental disorders arise from altered normal optimal brain organization. Clinical Brain Profiling is a conceptual neuroscientific diagnosis that may one day substitute current DSM-related conceptualizations.

S32.2 FINDING BEHAVIORAL AND NETWORK INDICATORS OF BRAIN VULNERABILITY

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Resilience research has usually focused on identifying protective factors associated with specific stress conditions (e.g., war, trauma) or psychopathologies (e.g. post-traumatic stress disorder). Implicit in this research is the concept that resilience is a global construct, invariant to the unfavorable circumstances or the psychopathologies that may develop (i.e., the mechanisms underlying the resilience of an individual in all cases are expected to be similar). Here we contribute to the understanding of resilience and its counterpart, vulnerability, by employing an approach that makes use of this invariant quality. We outline two main characteristics that we would expect from indicators of a vulnerable state: that they should appear across disorders regardless of specific circumstances, and that they should appear much before the disorder is evident. Next, we identify two sets of factors that exhibit this pattern of association with psychopathological states. The first was a set of “low-level” sensory, motor and regulatory irregularities that have been reported across the clinical literature; we suggest that these can serve as behavioral indicators of a vulnerable state. The second was the set of aberrations in network metrics that have been reported in the field of systems neuroscience; we suggest that these can serve as network indicators of a vulnerable state. Finally, we explore how behavioral indicators may be related to network indicators and discuss the clinical and research-related implications of our work.

S32.3 ELECTROPHYSIOLOGICAL CORRELATES OF CONTEXTUAL PROCESSING IN SCHIZOPHRENIA AND IN MAJOR DEPRESSIVE DISORDER

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Background: Contextual processing is considered to be a subcomponent of working memory, which is essential for the performance of cognitive functions, ensuring that we are able to flexibly adapt our behavior according to the requirements of particular goals or tasks. Deficits in processing contextual information are one of the main features of cognitive dysfunction in schizophrenia, while working memory deficits are common in major depression. We used event-related potentials to investigate local contextual processing in patients with schizophrenia and in patients with major depression. Local context was defined as the occurrence of a short predictive series of stimuli occurring before delivery of a target event.

Results: Schizophrenic patients failed to generate the P3b latency shift between predicted and random targets that was observed in age-matched controls. Patients with major depression demonstrated a P3b latency shift between predicted and random targets, similar to the one demonstrated in age-matched controls.

Conclusions: The current study utilizes neural correlates of local contextual processing to demonstrate contextual processing deficits in patients with schizophrenia, while showing that this cognitive function is largely conserved in patients with major depression.
P1  SIGNIFICANT IMPROVEMENT IN DEPRESSIVE SYMPTOMS AND NO CHANGE IN ANXIETY SYMPTOMS, 3 MONTHS AFTER ICD IMPLANTATION, A PROSPECTIVE STUDY

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Background: The effects of implantable cardioverter defibrillators (ICDs) implantation and ICD shocks on emotional well-being have been studied in the past with conflicting results. Most previous studies on the psychological effects of ICDs have been cross-sectional and rarely use validated and standardized instruments to document patients’ psychosocial status.

Aim: Systematic evaluation of the effects of ICD implantation on the psychological, physical, and mental well-being of cardiac patients using a set of standardized quality of life (QOL) scales.

Methods: Thirty six consecutive patients without previous psychopathology, who underwent an elective ICD implantation in our cardiac center since June 2010 and provided an informed consent, were enrolled to our study. Various demographic, clinical and echocardiographic data were prospectively collected. Each patient was psychologically evaluated upon enrolment and 3 months after ICD implantation using the Hamilton Rating Scale for Depression (HAM-D) and the Hamilton Anxiety Scale (HAM-A). Furthermore, patients were asked to describe their subjective feelings towards the ICD, ranked 1-5 (1 very satisfied, 5 very unsatisfied).

Results: Out of 36 patients, 26 (72%) were men, average age 64 ± 14 years, average LV ejection fraction (EF) 24% ± 1% with NYHA functional class of 2.17 ± 0.89. The average scores on the baseline HAMD and HAMA were 8.13 ± 8.54, and 3.75 ± 4.14, respectively. Three months after ICD implantation we showed significant improvement in the depression parameters with HAMD of 5.35 ± 6.51 (paired t test=2.7, p=0.011). The anxiety evaluation showed no significant change at 3 months follow up 3.75 ± 4.59 (t=1.5, p=0.14). The subjective feelings towards the ICD were, overall positive, ranked 2.21 ± 0.98 on average (1-5).

Conclusions: ICD implantation in a small cohort of patients with severe cardiomyopathy was associated with significant reduction in depressive parameters with no change in anxiety rate.

P2  SHORT-TERM EFFECTS OF LITHIUM ON SERUM THYROID-STIMULATING HORMONE (TSH) AND CREATININE LEVELS AND WBC COUNTS IN HOSPITALIZED PEDIATRIC POPULATION: A RETROSPECTIVE NATURALISTIC STUDY

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Introduction: Lithium’s side effects are well known in adults and include, among others, thyroid and kidney function abnormalities and hematological changes.

Objective: to assess the impact of lithium treatment alone or combined with other medications on thyroid-stimulating hormone (TSH) levels, creatinine levels and white blood cell (WBC) count in hospitalized bipolar (BP) and non-bipolar (non-BP) children, adolescents and young adults using data extracted from electronic medical records.

Method: The study investigated serum TSH and creatinine levels as well as WBC counts in lithium treated hospitalized youth, aged 12-24 years. The retrospective naturalistic study included 122 BP (N=67) or non-BP (N= 55) disorder in patients treated with lithium for 173 days between the years 1994-2010. TSH, creatinine and WBC values were examined at baseline and at the end of the hospitalization. Subjects were divided into two groups for analysis: group 1 was treated with lithium as monotherapy and group 2 was treated with lithium combined with other psychotropic agents.

Results: The mean end-point TSH levels were significantly higher (3.16 ± 2.68 vs 1.52± 0.92 mU/L, P<0.05) after lithium treatment. Sixteen of 54 children (29%) had TSH values above the upper normal value of 4 mU/L at the end-point. A positive correlation was found between pre- and post-treatment TSH levels (Pearson’s correlation: r= 0.568, P<0.05). A statistical significant difference was also found in mean WBC’s count (7195.3 + 2151.88 vs 7944.1+2096.53 count/mm³ cells, P<0.05). No significant elevation in creatinine was detected. No differences were detected between the monotherapy and the polytherapy groups.

Conclusions: Lithium is associated with significant increased rates of thyrotropin and WBC levels in youth. Higher-baseline TSH levels are associated with higher rates of elevated TSH levels in lithium-treated subjects. Close monitoring of thyroid functions in children and adolescents taking lithium is recommended.
P3 TEN-YEAR QUALITY OF LIFE OUTCOMES AMONG PATIENTS WITH SCHIZOPHRENIA AND SCHIZOAFFECTIVE DISORDER: PREDICTIVE VALUE OF PSYCHOSOCIAL FACTORS

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Purpose: To identify psychosocial predictors of change in health related quality of life (HRQL) among patients with schizophrenia (SZ) and schizoaffective (SA) disorders over a 10-year period.

Methods: In a naturalistic longitudinal design, 108 patients with SZ/SA disorders completed a comprehensive rating scale battery including self-reported quality of life, emotional distress symptoms, coping styles, sense of self-efficacy and social support, as well as, observer-rated psychopathology, medication side effects and general functioning at two time points; baseline and 10 years later.

Results: Regression models revealed that a reduction in self-reported symptoms of depression, sensitivity or anxiety along with an increase in self-efficacy, social support and emotion-oriented coping scores predicted improvement in domain-specific perceived quality of life. Adjustment of the psychosocial models for the effects of disorder-related factors (psychopathology, functioning and medication side effects) confirmed the above findings and amplified their statistical power.

Conclusions: In the long-term course of severe mental disorders (SZ/SA), changes in the psychosocial factors are stronger predictors of subjective quality of life outcome than disorder-related changes. The findings enable better understanding of the combined effects of psychopathology and psychosocial factors on quality of life outcome over 10-year period.

P4 PROSPECTIVE PREDICTORS OF ADOLESCENT SUICIDAL BEHAVIOUR AS VIEWED THROUGH THE INTERPERSONAL THEORY OF SUICIDE

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Suicide is the second highest cause of death among young people in Israel. Studies of suicidal behaviour have provided valuable information about the risk factors associated with these behaviors, yet there is not much information about predictors of transitions from suicidal thoughts to actual suicide behavior.

Objectives: The current study aims to elucidate the mechanisms in which suicidal ideation emerges over time and how suicidal ideation can lead to suicidal actions. We will attempt to determine the effects of risk factors such as psychopathology, non-suicidal self-injury (NSSI) and risk behaviors on suicidal behavior. This will be examined through the prism of a putative model of youth suicidal behavior based on the theoretical framework of Joiner’s Interpersonal Theory of Suicide.

Methods: The prospective study design included baseline and two follow-up assessments within one year. The follow-up sample included a total of 708 adolescents from schools throughout Israel. The students completed self-report questionnaires regarding suicide ideation and attempts, psychopathology, life style, socio-demographic background, non-suicidal self-injury, life events and social support.

Preliminary results: Within the follow-up year, 9.0% of the students reported suicidal behavior. Preliminary results indicate that internalized and externalized psychopathology symptoms, lack of parental and peer support and feelings of being a liability on others predict later emergence of suicide ideation. We also found that persistent suicide ideation, engagement in risk behaviors (such as alcohol and tobacco use) and NSSI predict later engagement in suicidal behavior.

Conclusion: Hopefully this model will improve our understanding of the short-term course of suicidal ideation and behavior among adolescents. The model identifies the different phases along the path to suicidal behavior, and risk factors associated with each phase. This could lead to potential improvements for intervention and prevention.

P5 GENDER DIFFERENCES IN HEALTH SERVICES UTILIZATION BY PRIMARY CARE DEPRESSED PATIENTS

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Objectives: To identify gender differences among patients diagnosed as depressed, using the MINI (Mini-International Neuropsychiatric Interview) as a screening tool in primary care clinics in Israel, and to compare the health services utilization and costs of male and female patients who are identified as depressed. Design: Phone interviews (between 1997 and 2000) of registered patients and data regarding health services utilization was extracted from computerized databases. Setting: Three primary care clinics belonging to Clalit Health Services (HMO).

Participants: A random sample of 2755 patients, aged 21-65. Main Outcome Measures: MINI score results, utilization data.

Results: We performed 2,507 phone interviews using the screening questionnaire, and identified 5.9% with major depression, 1.6% with minor depression and 14.3% with depressive symptoms. Women had higher rates of major
PrimarY care of The orenburg region regarding interaction when determining the somatic profile of

1. First and foremost, the regional mental health service must coordinate and strengthen various forms of psychiatric organizations. 2. An active network of outpatient health service must coordinate and strengthen various forms of psychiatric organizations. 3. Subjects who reported using cannabis derivatives were found among veterans who evacuated bodies during combat. Subject to have high levels of resilience. 4. The relation between the extent of psychoactive substance use and traumatic events was found significant only regarding abuse of prescription drugs or their use without a physician’s recommendation. The study contributes to the understanding of psychoactive substance use among combat post-traumatic Israeli soldiers. It seems that in many cases, psychoactive substance use is meant to relieve the suffering and distress caused by PTSD. Furthermore, like similar reports among Israeli c-PTSD patients, the study reinforces the suggestion that cannabis derivatives may be a beneficial treatment for c-PTSD.

P6 PROBLEMS AND METHODS TO IMPROVE THE MENTAL HEALTH SERVICE INTERACTION WITH PHYSICIANS IN PRIMARY CARE OF THE ORENBURG REGION

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An urgent task of psychiatric services at present is to strengthen the interaction of psychiatrists and primary care physicians. There is a fairly high prevalence and low detectability of borderline personality disorder, and this leads to a lack of effectiveness of care, poor organization and contributes to dissatisfaction with the quality of public health care. Another important problem is the lack of study of psycho-physiological mechanisms of the pathogenesis of many diseases and sociogenesis, which results in lower quality psycho- rehabilitation programs. The experience in the Orenburg Region (Russia) shows that in order to improve collaboration between psychiatrists and physicians in primary care a number of organizational and educational problems must be addressed. 1. First and foremost, the regional mental health service must coordinate and strengthen various forms of psychiatric organizations. 2. An active network of outpatient psychotherapy offices with appropriate facilities must be developed. 3. Additional training of doctors and therapists regarding interaction when determining the somatic profile of patients. 4. Additional training of primary care physicians in the detection and management of patients with mental disorders. 5. Clarification of duties and reorganization of the roles of physicians and professional therapists working in municipal clinics. 6. Development of the management and administration of health care settings, and the quality of the interaction of psychiatrists, psychotherapists in the precincts. The main issue is the willingness of central and local public health agencies to recognize the human, institutional and economic importance of the development in this area of work that can fundamentally change the face of comprehensive health care.

P7 PSYCHOACTIVE SUBSTANCE USE AMONG COMBAT POST-TRAUMATIC VETERANS

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Psychoactive substance use among combat Post Traumatic Stress Disorder (c-PTSD) patients is a well-known phenomenon. Studies conducted in the USA among soldiers who had fought in Vietnam, Iraq and Afghanistan, have shown a much higher rate of psychoactive substance use among these veterans than among the general population. Furthermore, some of them perceive these substances as a means to cope with the post-traumatic syndrome. The aims of the present study were to examine the frequency of psychoactive substance use among Israeli veterans suffering from c-PTSD, and to detect factors that contribute to such use. The study was conducted among 201 veterans diagnosed with severe chronic c-PTSD. The research tools included structured questionnaires to detect and determine PTSD, levels of anxiety, depression and a measure of resilience, and the extent of psychoactive substance use. The main findings were: 1. Compared to Israel’s adult population, the veterans reported a high rate of psychoactive substance use. 2. High-level use of psychoactive substances was related to high intensity of post-traumatic symptoms, high anxiety and depression levels and low levels of resilience. Higher levels of substance abuse were also found among veterans who evacuated bodies during combat. 3. Subjects who reported using cannabis derivatives were found to have high levels of resilience. 4. The relation between the extent of psychoactive substance use and traumatic events was found significant only regarding abuse of prescription drugs or their use without a physician’s recommendation. The study contributes to the understanding of psychoactive substance use among combat post-traumatic Israeli soldiers. It seems that in many cases, psychoactive substance use is meant to relieve the suffering and distress caused by PTSD. Furthermore, like similar reports among Israeli c-PTSD patients, the study reinforces the suggestion that cannabis derivatives may be a beneficial treatment for c-PTSD.
P8  **COGNITIVE DYSFUNCTION IN FIBROMYALGIA PATIENTS: SPECIFIC NEUROPSYCHOLOGICAL DYSFUNCTIONS, PSYCHIATRIC CO-MORBIDITY AND INTEGRATIVE ASSESSMENTS**

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Fibromyalgia (FM) is a rheumatologic disorder with complex symptom presentation that includes; widespread musculoskeletal pain, depression, sleep disturbances, anxiety, fatigue, other somatic complaints and cognitive impairment. Cognitive impairment in FM has both subjective elements: “forgetfulness”, “concentration difficulties” or “a failing memory” along with objective findings in neuro-cognitive testing. To date, the cognitive mechanisms found to be most affected in FM are: working memory, episodic memory and semantic memory. Depression, anxiety, fatigue and pain are all related to cognitive function in FM, but they do not seem to fully explain the observed cognitive dysfunction.

We conducted an extensive neuro-cognitive assessment including full intellectual examination (WAIS III), a broad psychiatric assessment (SCID) and a full neuro-psychological battery including: complex attention; auditory and visual memory; visuo-spatial abilities; psychomotor speed; and executive functions. Self-assessment rating scales were administered in order to assess any concurrent symptoms of depression, anxiety, fatigue, pain, sleep disturbances and motivation levels. To date, we have preliminary findings of 10 fibromyalgia patients. Our findings suggest that working memory; manifested mainly as attention span disturbances, is particularly impaired in FM patients compared to their other intellectual indexes. A further major impairment found in these patients is a moderately to severely slowing of psychomotor speed. Interestingly, a finding that has not been reported so far but is consistent with most patients’ subjective reports, is impaired executive functioning; presented as a non-effective goal-oriented behavior, compared to healthy population norms. The main psychiatric co-morbidities found were major depression and post-traumatic stress disorder.

These preliminary findings shed light on possible mechanisms underlying cognitive impairment in FM patients. Further research may lead to the development of tailored cognitive rehabilitation for FM patients, something that has previously not been addressed.

Adherence to pharmacotherapy is one of the most important issues in the treatment of schizophrenia patients. Compliance with pharmacotherapy has significant consequences for the disease process and prognosis. However, despite this, about 50% of schizophrenia patients do not comply with treatment. It is therefore important to implement efficient intervention methods to improve compliance. The aim of the study is to examine the efficacy of integrative intervention in improvement of compliance with pharmacotherapy among schizophrenia inpatients in an active open ward in Lev Hasharon Mental Health Center. The study was performed in a prospective comparative experimental study that included a convenience sample of 60 schizophrenia patients, with random allocation. Data were collected using patient self-report questionnaires; Visual Analogue Scale for Assessing Treatment Compliance, and the Drug Attitude Inventory (DAI-10). The questionnaires were completed at two time points. Baseline was close to hospital admission. The second time point was at the end of the intervention, or alternatively, at hospital discharge. The main study results revealed a significant difference between the level of compliance before and after the intervention. In the study group, the level of treatment compliance was higher following the intervention. In the study group, the level of treatment compliance following the intervention was higher in comparison to the control group. Similarly, there was a significant difference between the attitude towards pharmacotherapy before and after the intervention. In the study group, the attitude toward pharmacotherapy following the intervention was more positive in comparison to the control group. The study results show that integrative intervention for the improvement of treatment compliance among schizophrenia inpatients improves the treatment compliance and the attitudes of the patients toward pharmacotherapy. Attitudes towards pharmacotherapy was found to be a high predictor for treatment compliance. Thus intervention improves the compliance of the patients with pharmacotherapy.

P10  **DOES THE RIGHT TO VOTE EMPOWER PSYCHIATRIC PATIENTS OR DOES IT COMPROMISE THE INTEGRITY OF THE ELECTIONS?**

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In the era of mental health reform and the emphasis on empowerment of psychiatric patients, disenfranchisement seemingly undermines integration into society. Lack of decision making capacity is often used to deny psychiatric inpatients the right to vote. Methods: The authors evaluated capacity to vote using the Competency assessment tool for voting (CAT-V) to assess understanding, appreciation, reasoning, and choice. In addition, the Brief Psychiatric Rating Scale and the Mini Mental

P9  **INTEGRATIVE INTERVENTION TO IMPROVE MEDICATION ADHERENCE AMONG INPATIENTS WITH SCHIZOPHRENIA**

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In the era of mental health reform and the emphasis on empowerment of psychiatric patients, disenfranchisement seemingly undermines integration into society. Lack of decision making capacity is often used to deny psychiatric inpatients the right to vote. Methods: The authors evaluated capacity to vote using the Competency assessment tool for voting (CAT-V) to assess understanding, appreciation, reasoning, and choice. In addition, the Brief Psychiatric Rating Scale and the Mini Mental
State Exam were administered to evaluate clinical status.

**Results:** Fifty-six inpatients and twelve healthy controls participated. Controls revealed significantly higher understanding of the meaning of elections than patients ($t=7.75$, $p<0.01$. The more severe the illness (higher BPRS score), the less the patient understood the meaning of elections ($r = -0.32$, $p<.05$). The higher the score on the MMSE the greater the capacity to understand the elections ($r = .54$, $p<.001$). Regression analysis revealed that the patient’s illness severity and cognitive state predicted capacity to vote. Chi square analysis revealed that patients with a legal guardian had lower scores on the CAT-V reflecting less understanding of the electoral process ($x^2 (11) = 19.6$, $p<.05$). As Israel is one of five countries that does not disenfranchise persons with mental health or intellectual disabilities, and considering the legislation that allows for mobile ballots in psychiatric hospitals, we sought to draw the line that would help identify patients who retained capacity to understand the electoral process.

**Conclusions:** We propose performance of individual assessments of competency only for patients with legal guardians, to determine capacity to participate in elections. This would not stigmatize all mentally ill individuals and would allow their representation in elections. If found capable, patients with guardians will be able to vote, and if not, the integrity of the elections will be preserved by eliminating the risk of undue influence or manipulation of individuals who lack the capacity to understand the meaning of elections.

**P11 COMPARISON OF COGNITIVE FUNCTION IN BIPOLAR DEPRESSION VERSUS MAJOR DEPRESSIVE DISORDER**

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**Introduction:** Major depressive episodes are characteristic of both Unipolar Depression (UPD) and Bipolar Disorder (BD). Cognitive impairment is a well-documented finding in such episodes. Wide-ranging cognitive deficits have been reported in UPD patients, including psychomotor, attention, memory and executive functions. BD patients were found impaired in attention capacity, memory and learning deficits. Distinguishing BD from UPD patients on the basis of cognitive impairment requires additional research.

**Objectives:** Our objective was to clarify differences in cognitive functioning between UPD and BD patients during acute depressive episodes. Aims: Better understanding of the cognitive impairments in each disorder, may significantly improve early diagnosis in acute depressed patients, in cases where it is unclear whether the patient presents with UPD or BD.

**Methods:** Participants were 128 acute depressive outpatients, 87 had UPD and 41 had BD. Patients were assessed using Hamilton depression rating scale; Clinical Global Impression severity scale; Hamilton Anxiety Depression Survey; Beck Depression Inventory and Cambridge Neuropsychological Test Automated Battery (CANTAB). We used statistical modeling via logistic regression, to differentiate between UPD vs. BD, by means of their cognitive functions.

**Results:** Significant differences between the two groups were found in several domains: visual memory, working memory and sustained attention. The predictive model that was constructed has a discriminatory power as measured by the area under the ROC curve of 0.76.

**Conclusions:** UPD and BD patients present different cognitive impairments during acute depression. Our model may help to predict the underlying mental disorder, and thus facilitate earlier initiation of proper treatment.

**P12 TRENDS IN PRESCRIBING OF PSYCHOTROPIC MEDICATIONS FOR INPATIENT ADOLESCENTS IN ISRAEL: A 10 YEAR RETROSPECTIVE ANALYSIS**

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We examined the trends in prescribing psychotropic drugs to children and adolescents in an inpatient adolescent psychiatric ward in Israel. Data for 414 subjects, ranging from 12- to 22-years-old, covering the years 1997, 2002 and 2007, were examined retrospectively. Analyzed variables included the number and type of drug prescriptions per patient at discharge, the subject’s age at discharge and the number of diagnoses per patient at discharge. Analysis of variance (ANOVA) with repeated measures was used to evaluate changes between the three calendar years, along the 10-year study period, while Pearson x2 test was performed for categorical variables. Over the study period the mean age at discharge decreased significantly, by about a year and a half, the mean number of diagnoses increased significantly, from 1.6 to 2.4 diagnoses per patient and the total number of drugs prescribed at discharge increased significantly from 1.48 to 1.93 per patient. Overall, the number of patients who were prescribed mood stabilizers increased by 14%, those who were prescribed antidepressants increased by almost 24%, almost 16% in antipsychotics prescriptions and 51.5% in prescriptions of atypical antipsychotics. Typical antipsychotic prescriptions decreased by 35.5% and accordingly, the number of patients who were prescribed agents for the treatment of extra-pyramidal side effects decreased by almost 24%. Due to a low number of inpatients with attention deficit and hyperactivity disorder (ADHD), no significant statistical conclusions could be drawn regarding trends in psycho-stimulant prescriptions. Our findings are in accord with published studies from the last two
decades. The growing use of psychotropic agents in children and adolescents merits continuous concern with regard to their effects on the developing brain and impact on quality of life and in order to authorize these drugs for use in specific young age subgroups.

P13 AEROBIC PHYSICAL ACTIVITY FOR LONG TERM SCHIZOPHRENIA INPATIENTS

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Background: Aerobic physical activity has been shown to lower cardiovascular associated illness, metabolic syndrome associated symptoms, and to improve cognitive functions. Physical fitness has been associated with mental wellbeing. We introduced aerobic physical activity into the routine of schizophrenia patients in long-term hospitalization.

Method: A one kilometer walking route was designated on the premises of Lev Hasharon Mental Health Center. Exercise training facilities were installed along the route. Nurses encouraged patients to participate in group exercises and walk and twice weekly. Following approval by the Lev Hasharon IRB, participants in the program who provided written informed consent, completed the 18 item Quality of Life Enjoyment and Satisfaction Questionnaire (QLESQ) - the Positive and Negative Syndrome Scale (PANSS), the Clinical Global Impression Scale (CGI) and the Frontal Assessment Battery (FAB). Physical measurements including body mass index, blood pressure and pulse were also measured at 2 time points. Results: No changes were revealed in the PANSS, CGI, QLESQ, FAB scores or in BMI or other metabolic values at the end of the 6 month study period.

Summary: The participants reported enjoying the activity and willingly participated in the project regularly, thus achieving the goal of a healthier lifestyle in the routine of long term hospitalization.

Conclusions: 1. Maternal responses to hospitalization of a baby in NICU predict the development of PTSD and depression. 2. Mothers with no previous history of childbirth or abortion are more prone to develop PTSD. 3. The forced changes in maternal functioning such as inability to hold and feed the baby due to his condition and the NICU setting and depression are the most sensitive predictors of later PTSD. The more you dream, the greater the chances to have nightmares.

P15 ACCURACY OF ESTIMATION OF TIME-INTERVALS IN PSYCHO-GERIATRIC OUTPATIENTS

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Background: Accuracy of estimation of time-intervals has received marginal attention in contemporary clinical psychiatric assessment and diagnosis which contrasts the ample consideration that the subject enjoys in experimental psychology. In an attempt to delineate a potential diagnostic role for this measure in a psycho-geriatric outpatient setting we examined presumed differences in the accuracy of estimation of time-intervals in participants with dementia (P WD) versus participants without dementia (PWoutD), subsequently further subdivided into specific diagnoses and, when feasible, performance groups (relatively better v. worse). We also studied the demographic, clinical and cognitive correlates of the major and specific groups and predictors of the accuracy of
estimation of time-intervals in the entire sample.

**Method:** 43 individuals (27 PWD: 16 dementia of the Alzheimer’s type (DAT), 11 vascular dementia (VD); 16 PWoutD: 10 major depressive disorder (MDD), 6 normal) were interviewed with the Cambridge examination for mental disorders of the elderly – revised (CAMDEX-R) protocol, that permits the registration of several time measures under “passage-of-time”. Absolute accuracy of estimation of the duration of interview was established for each participant. Demographic, clinical and cognitive data and measures were also obtained. Results: Neither absolute accuracy of estimation of duration of interview, expressed as mean value, nor its transformed log (logarithm) were significantly different between PWD and PWoutD, or between DAT and VD participants. Considered separately, MDD participants performed significantly poorer than normal and did not differ from PWD and the PWD relatively better performing subgroup. The log of absolute accuracy of estimation correlated with some clinical and cognitive variables but not with others in the total sample. No similar correlations were found in the diagnosis and performance subgroups, except for memory/learning in the worst performing PWD. Of the many variables studied only a measure of depression (Depression Diagnostic Scale) and of impaired judgment could significantly predict absolute accuracy of estimation of duration of interview.

**Conclusions:** The absolute accuracy of estimation of time-intervals did not differ between the major groups and the main diagnoses subgroups of a psycho-geriatric outpatient population. The accuracy of time interval estimation covering “clinical” durations was associated with a variety of clinical and cognitive measures, and was predicted by the composite constructs of depression and impaired judgment. The diagnostic value of this measure in the psycho-geriatric clinic is questionable, and probably limited to “worried” well individuals. We suggest it might be useful for screening individuals encountered in primary care clinical settings and in community surveys, who are not cognitively or psychiatrically impaired.

**P17 A RETROSPECTIVE EPIDEMIOLOGIC STUDY REGARDING MENTAL ILLNESS CHARACTERISTICS AMONG JEWISH HOLOCAUST SURVIVORS**

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**Objective:** To determine whether there are differences between mentally ill Holocaust survivors and mental patients who were not exposed to the Holocaust, specifically, whether the course of illness is worse for patients who were exposed to the Holocaust.

**Methods:** An unidentified list of hospitalized psychiatric patients was extracted from the Israeli psychiatric case register according to the following criteria: Jewish patients, who were born prior to1944 and were admitted to a psychiatric ward between 1945 and 2010. 48,533 records were divided into three groups: Holocaust survivor immigrants, Israeli born, and immigrants who were not exposed to the Holocaust.

**Primary outcome measure:** The probability of belonging to the upper quartile of proportion of study time in hospitalization.

**Results:** The probability of belonging to the upper quartile of proportion of study time in hospitalization was significantly higher among Holocaust survivors compared to controls. Hospitalized female Holocaust survivors’ percentage is significantly higher than the control group, and the number of first hospitalizations after age 70 is significantly higher. There are more hospitalizations after attempted suicide among survivors.

**Background:** Today, in Israel, every citizen can approach any psychiatric emergency room and receive mental health care at no cost. In the absence of managed care there are patients that repeatedly come to psychiatric emergency rooms. Multiple return visits are a burden to the mental health system, and may indicate a quality-of-care or access problem in the outpatient arena. In anticipation of health reform, identifying characteristics of patients who repeatedly come to psychiatric emergency rooms can help reduce the number of psychiatric emergency room visits.

**Methods:** Data was obtained for patients who were identified as high utilizers (five or more visits to the emergency room) in “Lev-Hasharon Mental Health Center” in the year 2008. The control group included data for the same number of patients that had only one visit to the emergency room the same year.

**Results:** Compared to the control group, patients with multiple return visits had a greater tendency to live in Netanya and in the Arab villages, were less educated, were not employed and were on welfare. They were more likely to be diagnosed with psychotic disorders and personality disorders, to use psychoactive substances and to have prior admissions. Many of these patients were treated in a psychiatric clinic, received treatment with long acting antipsychotics and were treated by resident psychiatrists. This group of patients showed a tendency to come to the emergency room without a companion and there was less involvement of a specialist during their visits.

**Conclusions:** Patients with multiple return visits to the psychiatric emergency room had distinctive demographic, diagnostic and clinical profiles, which are potentially useful for developing clinical strategies to reduce multiple visits in the future.

**P16 MULTIPLE RETURN VISITS TO THE PSYCHIATRIC EMERGENCY ROOM**

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2Sackler Faculty of Medicine, Tel-Aviv University, Tel-Aviv, Israel

**Background:** Today, in Israel, every citizen can approach any psychiatric emergency room and receive mental health care at no cost. In the absence of managed care there are patients that repeatedly come to psychiatric emergency rooms. Multiple return visits are a burden to the mental health system, and may indicate a quality-of-care or access problem in the outpatient arena. In anticipation of health reform, identifying characteristics of patients who repeatedly come to psychiatric emergency rooms can help reduce the number of psychiatric emergency room visits.

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**Conclusions:** Patients with multiple return visits to the psychiatric emergency room had distinctive demographic, diagnostic and clinical profiles, which are potentially useful for developing clinical strategies to reduce multiple visits in the future.
Finally, we found higher mortality in survivors compared with the group of immigrants who were not exposed to the Holocaust.

**Conclusions:** Exposure to the Holocaust has a deleterious effect on the severity of the survivors’ psychiatric illness.

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**P18 ASSOCIATION BETWEEN TOBACCO SMOKING AND BIPOLAR AFFECTIVE DISORDER: CLINICAL, EPIDEMIOLOGICAL, CROSS-SECTIONAL, RETROSPECTIVE STUDY IN OUTPATIENTS**

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**Purpose:** Although high rates of smoking have been reported among psychiatric patients, only a few studies examined the prevalence of smoking in bipolar disorder, and findings are inconsistent. We investigated smoking among bipolar patients.

**Methods:** We examined the prevalence of smoking among 102 patients that met Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition criteria for bipolar I disorder in Israel and evaluated the relationship between smoking and demographic and clinical data.

**Results:** Fifty-five of the bipolar patients (53.9%) smoked, with a rate that is 2.36 times higher than among the general population in Israel (22.8%). Significant relationships were revealed between smoking and lifetime history of alcohol dependence/abuse (P = .02), between smoking and history of drug use (P < .01), and between smoking and age of illness onset (P = .04). Limitations: The cross-sectional nature of the study and the relatively small sample size preclude generalization of the findings. Nicotine levels were not measured; thus, the information regarding smoking was subjective.

**Conclusions:** Bipolar patients smoke more than the general population. Bipolar patients that are moderate or heavy smokers are more likely than nonsmokers to consume alcohol and abuse psychoactive substances. Contrary to findings of previous studies, no association was found between clinical variables of bipolar patients and smoking.

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**P19 COMMUNITY TELE-PSYCHIATRY IN MACCABI HEALTH SERVICES**

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Tele-Psychiatry, defined by The American Psychiatric Association as the use of electronic communication and information technologies to provide or support clinical psychiatric care at a distance, has been used world-wide for many years. It is considered a comfortable and practical solution to bring distant doctor and patient together. Although the first experiences date back to the 1950s, Tele-Psychiatry actually started its development in the 1990s. This method allows for a counseling experience, which is close in quality and practicality to face-to-face interaction. With the development of technology and the reduction in costs, psychiatrists in Israel should explore this method and in the process, bring accessibility and reduce the inequality between patient groups, who can now consult a distant doctor or a specialty clinic. Applications of Tele-Psychiatry include Assessment and diagnosis, treatment, consultation, case conferencing and management, education, supervision, support, forensic and legal uses, research and psychological testing. Despite the concerns about the session setting, in which patient and doctor are not in the same place, this method gained popularity worldwide and both cultural climate and professional ethics have evolved with regard to Tele-Psychiatry. In Israel, Tele-medicine has not been widely used, although the Israel Medical Association has issued a position-paper on tele-psychiatry, emphasizing psychiatrist qualities, training, confidence, privacy, documentation, and the wish that online meetings would resemble real typical consultations. Israel’s unequal scattering of specialists and population in remote areas such as the Galil, Eilat and the Negev creates accessibility difficulties for patients in need of psychiatric services. As a solution for the problem Maccabi Health Services (MHS) started use Tele-Psychiatry with different technologies for patient-doctor consultations and GP counseling. Thus joining the already-existing Tele-Medicine services such as home-care treatment of bed ridden patients, diabetes counseling, complicated wounds clinic and more. We wish to present the process of building a Tele-Psychiatry service in the community in Maccabi-Health Services, to summarize the main principles, technological aspects, possible difficulties and known successes.

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**P20 PSYCHIATRY JOINS THE REST: IMPLEMENTATION OF UNITED ELECTRONIC MEDICAL RECORD (EMR) FOR COMMUNITY MENTAL HEALTH PROVIDERS: ADVANTAGES AND DISADVANTAGES**

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Medical services worldwide are in an ongoing process of implementation of electronic documentation. Psychiatric services seem to join that movement slowly and reluctantly. In Maccabi Health Services (MHS) the electronic medical records (EMR) are the only platform for medical documentation. These records contain medical and para-medical information, diagnoses, evaluations, laboratory results, medications, treatments, and imaging tests. It allows communication between treating doctors of a specific patient, within its records. It has a clinical rules engine and reminders that help avoiding mistakes. The EMR is accompanied by an internet portal with database access, caseload analysis, quality measures, administrative information news and more. Historically, Psychiatrists in Maccabi, who see patients mainly in private independent practices, used personal medical records that were later united to within- district collaborative records. Lately the records are united to an organizational record, in which a Psychiatrist may see past documentation, concerning the patient in his office, regardless of the patient’s previous location of treatment. The usage of such integrated and united EMR by mental health providers and services raise ethical and risk management questions. The level of information shared between psychiatry and general medicine is under discussion. While all medical disciplines, but psychiatry and gynecology, may see each other’s documentation, primary physicians may only see medication acquisitions prescribed according to psychiatric recommendation. In order to protect sensitive information concerning mental health content, most of the data that includes diagnoses, visits, psychology and psychiatry evaluations or descriptions are blocked for all medical service suppliers except for the psychiatrists and psychotherapists. The next stage to be discussed is the proper level of data sharing between primary medicine and psychiatry for the benefit of the patient. Do we move towards continuity in treatment management of all medical disciplines? Is psychiatric information different from other medical information? And how can we avoid possible misuse of data outside the medical field (Insurance companies, military forces)? We wish to present our perspective and experience on the subject.

P21 ANNA O.: 130 YEARS OF MISDIAGNOSIS?

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Objectives: Polysymptomatic patients like the famous Anna O., who was described by Joseph Breuer and Sigmund Freud in 1895 in their book “Studies on Hysteria”, are sometimes seen by clinicians and are misdiagnosed. The objective of this study was to reevaluate this case report from a neurobiological perspective. Methods: 1. Each sign of her disease and its time course, as described by J. Breuer, were explored from an organic point of view. The differential diagnosis included some clinical entities. 2. Another aspect that was explored was the historical and cultural climate surrounding the publication of this case report.

Results: Bertha’s illness started in November 1880 with severe cough and weakness. In the first days of December she developed a unilateral (VI) cranial nerve palsy, progressively altered state of consciousness, “absences”, and rapidly progressive spastic right and left hemiparesis, progressive aphasia with agraphia that culminated in mutism. During March 1881 she started to convalesce gradually and her neurological deficits resolved ad integrum during the following months. We explain all other signs of her illness as entirely consistent with the neurobiology and epidemiology of acute disseminated encephalomyelitis (ADEM), a disease that was described for the first time in 1790 by the British physician J. Lucas. ADEM is a benign regressive post infectious demyelinating process of the CNS. Its characteristic signs are: altered level of consciousness, focal or generalized seizures, cranial nerve palsies, spastic hemi- or paraparesis, meningismus, aphasia, bilateral optic neuritis and behavioral changes. Complete recovery is a rule. It should not be forgotten that Breuer’s diagnosis was consistent with the climate of his epoch.

Conclusions: Psychiatrists and psychologists should always stay alert to the possibility of an organic nature of their patient’s symptoms no matter how famously hysterical the patient is.

P22 "THE IMPOSSIBLE SITUATION": COMMUNICATION AND MENTAL PAIN IN MEDICALLY SERIOUS SUICIDAL BEHAVIOR

Yossi Levi*, 1 Netta Horesh 2, Tzvi Fischel 1, Ilan Treves 1, Evgenia Or 1, Avi Bleich 1, Mark Weiser 1, Haim Shem David 1, Shai Konas 3, Hagai Hermesh 4, Yari Givon2 & Alan Apter MD 5

1Department of Behavioral Sciences, Ruppin Academic Center, Israel; 2Department of Clinical Psychology, Bar Ilan University, Israel; 3Sheba Psychiatric Hospital, Petah Tiqva, Israel and Sackler Faculty of Medicine, Tel Aviv University, Israel; 4Shalvata Mental Health Center, Hod Hasharon, Israel and Sackler Faculty of Medicine, Tel Aviv University, Israel; 5Lev Hasharon Psychiatric Hospital, Pardesia, Israel; 6Psychiatric Ambulatory Services, Sheba Medical Center, Israel; 7The Feinberg Child Study Center, Schneider Children’s Medical Center of Israel, and Sackler Faculty of Medicine, Tel Aviv University, Israel.

Introduction: The study of near-fatual suicide attempters may provide insight into the minds of suicidal subjects. Our aims were to test the hypothesis that mental pain is a general risk factor for suicidal behavior and communication difficulties are a particular risk factor for medically serious suicidal behavior.

Methods: Thirty-five subjects who made medically serious suicide attempts were compared with 67 non-medically serious suicide attempters and 71 healthy controls. All were interviewed with the SCID-I and completed questionnaires covering mental pain, communication difficulties, and seriousness of the suicide attempt.

Results: The most striking result of this study was that the major factor differentiating subjects who made medically
serious suicide attempts from subjects who made medically not serious suicide attempts was difficulty in communication, as reflected by problems in self-disclosure, and also by the related constructs of schizoid traits, alexithymia, and loneliness. These findings were supported by the observation that the variables comprising the construct of mental pain distinguished between the suicidal and non-suicidal groups, but not between the suicidal subjects with medically serious and medically not serious attempts, such that they were not predictive of the lethality of the suicide attempt.

Conclusions: Problems with sharing feelings with others are an important risk factor for near-lethal suicide, over and above the contribution of psychiatric illness and mental pain, including depression and hopelessness. On the basis of our findings, we propose a model of serious suicidal behavior: Stressful life events induce mental pain in predisposed individuals and lead to suicidal thoughts and actions. If the individual is able to ask for help, either by verbal communication or by action (medically not serious suicide attempt), the process can be interrupted. If the individual is unable to ask for help, the situation becomes “impossible” and the suicide act becomes more severe.

P23 SUICIDE INTENT OF MEDICALLY SERIOUS SUICIDE ATTEMPTS AND ITS RELATIONSHIP WITH CLINICAL AND INTERPERSONAL CHARACTERISTICS

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1Department of Behavioral Sciences, Ruppin Academic Center, Israel; 2Department of Clinical Psychology, Bar Ilan University, Israel; 3Geha Psychiatric Hospital, Petah Tiqva, Israel and Sackler Faculty of Medicine, Tel Aviv University, Israel; 4Shalvata Mental Health Center, Hod Hasharon, Israel and Sackler Faculty of Medicine, Tel Aviv University, Israel; 5Lev Hasharon Psychiatric Hospital, Netanya, Israel; 6Lev Hasharon Hospital, Petah Tiqva, Israel and Sackler Faculty of Medicine, Tel Aviv University, Israel.

Introduction: The study of near fatal suicide attempters may provide insight into the minds of persons who die by suicide. Such attempts are characterized by high suicide intent, together with high medical lethality. The ability to fully understand the specific psychological profiles associated with severity of suicide intent can provide insights for suicide prevention.

Objectives & Aims: The objective of the present study was to investigate the relationship of suicide intent to lethality among medically serious suicide attempters. Our aim was to examine specific psychological variables related to the subjective and objective components within suicide intent.

Methods: 102 suicide attempters belonged to one of two groups: 35 subjects who made medically serious suicide attempts were compared with 67 non-medically serious suicide attempters. All were interviewed (SCID-I) and completed questionnaires covering mental pain, communication difficulties, and seriousness of the suicide intent.

Results: The objective component of the suicide intent scale (SIS) was highly correlated the lethality, as well as to communication difficulties, such as self-disclosure while the subjective component of the SIS was related to mental pain variables such as depression and hopelessness. A significant interaction between mental pain and communication difficulties was found to predict severity of the objective suicide intent.

Conclusions: The suicidal person whom suffers from depression and hopelessness and cannot signal his pain to others because of communication difficulties can be a risk for a serious suicide attempt – which is more planned, with more precautions against discovery and without communication before or during the attempts.

P24 EVALUATION OF THE CAPACITY OF INPATIENTS WITH CHRONIC SCHIZOPHRENIA TO PROVIDE INFORMED CONSENT FOR PARTICIPATION IN CLINICAL TRIALS USING THE HEBREW VERSION OF THE MACARTHUR COMPETENCE ASSESSMENT TOOL FOR CLINICAL RESEARCH (MACCAT-CR)

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Patient protection includes the requirement for the provision of informed consent for participation in medical research. The MacArthur Competence Assessment Tool for Clinical Research (MacCAT-CR) is frequently used for screening research subjects’ capacities to consent to participation in research. We evaluated the utility of the Hebrew translation of the MacCAT-CR, by comparing the capacity of patients with chronic schizophrenia to provide informed consent to participate in clinical trials using the MacCAT-CR Hebrew version with standardized neurocognitive assessment tools (Addenbrooke’s Cognitive Examination [ACE] and Frontal Assessment Battery, [FAB]), and the attending doctor’s assessment. Twenty-one patients participated. Mean MacCAT-CR score was 12 + 10.57 (range 0-32); mean FAB score was 9.9 + 4.77, (range 1-18); mean ACE was 59.14 + 16.6 (range 27-86) mean doctor’s assessment was 5.24 + 1.18 (range 3-7). The Hebrew-version of the MacCAT-CR helped identify patients with capacity to provide informed consent for participation in research. Patients with FAB scores > 12 tended to score higher on the Hebrew-version of the MacCAT-CR, thus confirming utility of the Hebrew-version of the MacCAT-CR. During the screening process for clinical trials it may save time to administer the concise FAB questionnaire, and then administer the MacCAT-CR only to those s who scored >12 on the FAB.
Background: Depression is an important co-occurring syndrome in schizophrenia associated with increased morbidity and mortality rates. Pharmacological treatment of this condition has certain difficulties and brain stimulation techniques may be considered as methods of choice. The aim of the study was to estimate the effectiveness of rTMS for the treatment of depression and probably negative symptoms in schizophrenia patients.

Methods: 66 patients with schizophrenia (ICD-10) stabilized on antipsychotic medications with the prevalence of negative symptoms were included. All the patients had clinically significant depression (CDSS score ≥ 6). Patients were randomized in 2 groups: 32 patients of the 1st group received 15-Hz rTMS on the left dorsolateral prefrontal cortex, 34 patients of the 2nd group were treated with antidepressant (SSRI) which was added to antipsychotic therapy. Patients were assessed weekly with PANSS, CDSS, and CGI-S. The criterion of efficacy was 50% CDSS score reduction after the 3rd week of treatment. Results: The number of responders was 20 (62,5%) in rTMS group and 5,8% (p<0,05) in the active control group. PANSS negative subscale score reduction was 15,5% (p<0,05) in the group of rTMS and 34,6% (p<0,05) in the active control group. rTMS was more effective in the treatment of severe depression (CDSS>11) than SSRi therapy: 58,8% vs. 50% of responders. PANSS negative subscale score reduction was 15,5% (p<0,05) in rTMS group and 5,8% (p<0,05) in the active control group. There weren't any cases of psychotic symptoms exacerbation.

Conclusion: Our results have shown that antidepressive effect of rTMS in schizophrenia is comparable to conventional methods of pharmacological treatment. Good tolerability, rapid onset of action and more potent reduction of negative symptoms were the prominent features of rTMS action.

There is an increasing need for rehabilitation of chronic psychiatric inpatients whose conditions preclude discharge to the community. During the last Knesset elections some patients could not vote, for lack of identity cards. The hospital staff with the support of the Friends of Lev-Hasharon Hospital and Ministry-of-Interior clerks volunteered to assist in issuing identity cards and framed photographed portraits for inpatients with chronic mental disorders.

Goals: To examine why the patients did not have identity cards, the importance of ID’s for patients with persistent mental disorders, and to evaluate their feelings after receiving the documents.

Methods: Patients with no ID’s or personal pictures were identified. Patients were photographed by a professional photographer on the hospital premises. Nurses helped patients complete application forms for identity cards. Patients completed questionnaires about the importance of identity cards before they were issued, and two months after they were received.

Results: 108 chronic inpatients wanted a framed photographed portrait (63 men, 45 women, mean age 57, range 23-71 years). Of them, 60 patients (41 men, 19 women, mean age 51, range 23-71) wanted an identity card. 48% said they did not have ID’s because they were ill, 23% claimed that the cards were lost or stolen, 21% did not know why they did not have ID’s, and 9% said they did not need them. 35% reported that the framed portrait was a source of pride and honor, 29% reported that it gave them identity, 26% said it made them happy, and 10% said it was irrelevant. 69% of the recipients reported that the ID’s had a beneficial effect, 27% said they had no effect and 4% reported a negative effect.

Discussion: Issuance of identity cards and framed photographed portraits was a beneficial experience for these patients.
Background: Compulsory treatment that includes coercion of mentally ill patients is sometimes mandatory in order to prevent situations that endanger the patient and/or his/her surroundings. Coercion can cause stress and mentally adverse effects to the patient. Most patients who underwent coercion report negative experiences. In our study we aimed to investigate the coercive experiences (seclusion and restraint) among female patients in a secure women's ward.

Method: The sample included hospitalized patients from the women's secure ward at Lev Hasharon Mental Health Center, that underwent coercion (115 patients were secluded and 21 patients that were restrained, 13 patients among them were both secluded and restrained). The measures included the Coercion Experience Scale (CES; with additional open questions), Traumatic Events Questionnaire, Clinical Global Impression Scale and Working Alliance Scale.

Results: Most of the patients that underwent coercion reported negative experiences when asked directly. The responses to open questions revealed more negative experiences during restraints than during seclusions. However, the CES questionnaire found different results. The humiliation experience during restraints was more severe than during seclusions. On the other hand, the environmental conditions were perceived as worse during seclusions. Schizophrenia spectrum background diagnosis was found to predict a less severe experience. Good working alliance predicted less severe experiences during coercions. Family status, age, previous coercion and history of sexual or physical violence were not found to predict the severity of the coercion experiences.

Discussion: the research findings show that psychotherapeutic working alliance can assist in prevention and reduction of negative experiences during coercion. In addition, it seems that delusional states, cognitive and affective impairments act as a defense mechanism for inpatients with schizophrenia when facing coercion.

Background: Falls are an everyday risk for the elderly and their etiology is multifactorial. The incidence of falls is known to be higher in psychiatric settings, particularly among geriatric patients, with estimated rates of 13.1 to 25 per 1000 patients/day. Inpatient falls lead to physical injury in up to 30% of patients as well as to increased length of hospitalization and discharge to nursing facilities. Risk factors predisposing older adult psychiatric patients to falls include chronic illness, cognitive impairment, behavioral disturbance particular agitation and wandering, psychotropic medication and polypharmacy.

Objective: To identify risk factors associated with falls in a psychogeriatric inpatient population. Setting: A psychogeriatric inpatient unit at Sha’ar Menashe Mental Health Center.

Methods: In this retrospective case-control study psychiatric inpatients age 65 or older with documented falls served as study cases. They were matched by age, gender and admission year to control patients from the same unit. Over 5 years, all adverse-event reports of falls were reviewed. Data on demographic and clinical characteristics of the patients, type, doses and total number of medications and other potential risk factors of the falls were collected retrospectively for five year periods. A comparison between fallers and non-fallers was performed using chi-square and T-test analysis. Logistic regression was performed for determination of the impact of each risk factor on fall risks.

Results: A total of 159 falls were recorded during the study period. The number of patients who fell during the five year period was 79, 27 (34%) of the patients had recurrent falls. Mean number of falls was - 2.19, range 1-17. Most of the falls did not result in serious injury. Falls were significantly associated with age, gait disturbances, cognitive impairment, number of medications, recent changes in medication and benzodiazepine use.

Conclusion: The present study demonstrates that patient related factors such as age and gender, and treatment related factors such as polypharmacy, recent change of medication, are independent risk factors for falls in a psychogeriatric unit. The results suggest that fall prevention programs should target patients with these risk factors.

Background: Addiction is a disease that triggers a process that can significantly affect the family system. The most effective treatment involves the addicts and their families. The family oriented method is relatively new in Israel, but abundant research and the precedence of clinical practice performed in the USA underscore the importance of family involvement in addiction rehabilitation. Commonly family members bring their loved ones into treatment

Background: Among female inpatients with schizophrenia when facing coercion.

states, cognitive and affective impairments act as a defense experiences during coercion. In addition, it seems that delusional working alliance can assist in prevention and reduction of negative Discussion: were not found to predict the severity of the coercion experiences. Age, previous coercion and history of sexual or physical violence predicted less severe experiences during coercions. Family status, found to predict a less severe experience. Good working alliance was more severe than during seclusions. On the other hand, the CES questionnaire found more negative experiences during restraints. The responses to open questions, Traumatic Events Questionnaire, Clinical Global Impression Scale and Working Alliance Scale.

Results: Most of the patients that underwent coercion reported negative experiences when asked directly. The responses to open questions revealed more negative experiences during restraints than during seclusions. However, the CES questionnaire found different results. The humiliation experience during restraints was more severe than during seclusions. On the other hand, the environmental conditions were perceived as worse during seclusions. Schizophrenia spectrum background diagnosis was found to predict a less severe experience. Good working alliance predicted less severe experiences during coercions. Family status, age, previous coercion and history of sexual or physical violence were not found to predict the severity of the coercion experiences.

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Background: Falls are an everyday risk for the elderly and their etiology is multifactorial. The incidence of falls is known to be higher in psychiatric settings, particularly among geriatric patients, with estimated rates of 13.1 to 25 per 1000 patients/day. Inpatient falls lead to physical injury in up to 30% of patients as well as to increased length of hospitalization and discharge to nursing facilities. Risk factors predisposing older adult psychiatric patients to falls include chronic illness, cognitive impairment, behavioral disturbance particular agitation and wandering, psychotropic medication and polypharmacy.

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based on the assumption that the addict requires intensive treatment. In reality the whole family has been infected by the disease that manifests itself as an “addiction to the addict”. Principles in treatment: Simultaneous but separate emotional therapy for the addict and the family, by addiction experts, with confidentiality waiver. The addiction has “array allows” and the prime goal of the treatment is to break the cooperative dependency. The essence of the addiction is its array of secrets, manipulation, isolation, and denial. Intervention on different scales and volumes of the addict and his family is an essential part of therapy. Intervention is a behavioral act that begins with initiated changes of the routine life of the addict inside the family system. This change is imitated by the therapist/interventionist. In most cases definite boundaries must identified and maintained by the family in order to stop the addiction. When the addicted member is not ready to be treated, the process of maturing the family towards intervention is the treatment goal. Psychiatric treatment will be needed in most cases. In most cases, anti-depressive, and anti-anxiety coverage will also be advised, at the beginning of therapy. In our experience SNRI’s are preferred. Bupropion has high preferences in cases that do not involve anxiety because of its effect on craving. Sleeping problems are common. Sometimes short-term full antipsychotic treatment is required. Our current clinical experience emphasizes the need of medication combinations. Benzodiazepines and amphetamines should be avoided even in an ADHD patient. Family members with depression or anxiety must be treated as well. Essential holistic treatment- the greatest and most popular organization in the world that has treated millions of addicted members from the 30’s is “the twelve steps” organization. In addition, body and soul practice that is personally suitable is also highly recommended.

P31 FAIRY TALE GROUP THERAPY: A COGNITIVE-BEHAVIORAL GROUP THERAPY PROGRAM BY MEANS OF DRAMA-THERAPY FOR CHILDREN WITH DISRUPTIVE BEHAVIOR DISORDERS

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The aim of the proposed study is to examine the impact of Fairy Tale Group Therapy (FTGT) – a cognitive-behavioral group therapy program by means of drama-therapy on children with Disruptive Behavior Disorders (DBD). Children who suffer from this syndrome are liable to develop impulsive and harmful behavior, social and emotional difficulties, anxiety and mood disorders. This study suggests FTGT to cope with impulsive and aggressive behavior, to develop self-restraint and empathy toward victims. Moreover, FTGT might affect verbal dysfunction among children with DBD, which might diminish harmful behavior and facilitate self-confidence. Twenty seven 6- to 12-year-old conduct problem children were assigned to a FTGT protocol of 15 weekly sessions of 1.5 hours, in 4 consecutive groups. The treatment is conceived in terms of the Functional Theory of Cognition and is operationalized via this theory’s methodological counterpart – Functional Measurement. According to the theory, the entire array of individuals’ related experience is organized in terms of functional cognitive schemata. This method enables the production of valid reflection of the child’s two sorts of related cognitive schemata: 1. a bio-psycho-social schema assumed to represent the perceived involvement to DBD; 2. a neuro-cognitive schema assumed to represent the perceived neuro-cognitive dysfunction of children who are suffering from DBD. Before and immediately after completion of the treatment, children were assigned the relative weight (importance) to the components of each schema, which provides a valid representation of the studied schemata. Moreover, there was a significant change of related cognitive schemata among the subjects as a function of treatment. The results will contribute to the development of a battery of tests and treatment programs among children with DBD for cultivation of such virtues as self-restraint, cooperative strategies in social interactions, tolerance of other people’s views and moral behavior. These tests and treatment programs will be further studied in future research using a control group to better establish their significance.

P32 “SEEING IS BELIEVING”: PSYCHIATRISTS’ SATISFACTION OF VIDEO CONFERENCE TECHNOLOGY IN PSYCHIATRIC EVALUATIONS OF PRISON INMATES: RESULTS OF ONE YEAR OF EXPERIENCE

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¹Israel Prison Service – Assessment and Placement Branch.
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Background: Assessment and placement services in the Israel Prison Service include the psychiatric evaluation of inmates during their first few days in prison. The objectives of these evaluations are to diagnose psychiatric disorders and mental distress, recommend crisis intervention and drug treatment. When a psychiatrist is not present patients are referred for a video conference psychiatric evaluation. This study examines the quality characteristics of psychiatric examinations using video conference and psychiatrists’ satisfaction of evaluations conducted using this method.

Methods: The sample population included all inmates evaluated in 2011 by two psychiatric experts. Satisfaction was assessed by a questionnaire that rated the technical quality of sound and picture, and general satisfaction. Technical quality was rated as good, moderate or poor. General satisfaction was rated as “Satisfactory”, “Sufficient but further evaluation required”, and “Not – sufficient”. We used the video conference technology
Psichiatri as a naïve PhilosoPher and “normal” in another. I am normal More specifically this article phenomena” and “non-cultural phenomena” in clinical practice and full knowledge about boundaries of culture The “cultural assumptions for CBS and BD are: The psychiatrist has a correct really exist in clinical practice? We propose that common basic it is possible to say that cultural-bound delusions are culturally bizarre or cultural-bound within different cultural situations? If so, is it possible to say that cultural-bound delusions are culturally accepted bizarre delusions only? Cultural Bizarreness according to R. Mullen). Do non cultural (or extra cultural) phenomena fall in these categories (delusions of possession Dibuk for example is it a bizarre delusion or cultural-bound syndrome?) Perhaps the same phenomena can be attributed as bizarre or cultural-bound within different cultural situations? It is possible that is it possible to say that cultural-bound delusions are culturally accepted bizarre delusions only? Cultural Bizarreness according to R. Mullen). Do non cultural (or extra cultural) phenomena really exist in clinical practice? We propose that common basic assumptions for CBS and BD are: The psychiatrist has a correct and full knowledge about reality The psychiatrist has a correct and full knowledge about boundaries of culture The “cultural phenomena” and “non-cultural phenomena” in clinical practice coexist. The same symptom may be pathological in one culture and “normal” in another. I am normal. More specifically this article argues that: We really use these principles in routine clinical practice; We use these principles implicitly. These postulates are based upon naïve realism theory and the epistemological and descriptive concepts for CBS and BD are common and based upon naïve realism theory.

P34 MEDICAL CANNABIS USE IN PATIENTS WITH POST-TRAUMATIC STRESS DISORDER: A NATURALISTIC OBSERVATIONAL STUDY

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Background: The optimal treatment for posttraumatic stress disorder (PTSD) and its comorbid conditions is still in development. Many PTSD patients frequently use marijuana. The aim of the present study was to evaluate the effectiveness and safety of Cannabis (as Medical marijuana) use in PTSD patients.

Methods: As a part of our routine consulting work, we assessed the mental condition of 160 adult PTSD patients, who applied to the Ministry of Health in order to obtain a license for Medical Cannabis. The group consisted of patients with “pure” PTSD, PTSD patients with clinical depression and patients suffering from PTSD/chronic pain comorbidity. The Clinician-Administered PTSD scale (CAPS) was used to assess traumatic symptoms and the Quality of Life Scale (QOLS) was completed. The changes in Clinical Global Impression-Improvement scale (CGI-I) were recorded. The data on somatic conditions and pain levels were provided by treating physicians. Only about 50% of the patients received Medical Cannabis licenses (study group). Most were supervised (periodical evaluations) for a period of about two years.

Results: The majority of PTSD patients also used conventional medications (such as antidepressants and sedatives, pain killers etc.), prescribed by their treating physicians. The average daily dosage of pain killers etc.), prescribed by their treating physicians. Only about 50% of the patients received Medical Cannabis licenses (study group). Most were supervised (periodical evaluations) for a period of about two years.

Conclusions: This naturalistic observational study represents a first attempt to assess and to monitor the effectiveness and safety of Medical Cannabis use in PTSD patients. The results show good tolerability and other benefits (especially in the quality of life & on CGI-I) of a flexible combined approach, especially in patients with either pain and/or depression comorbidity. Further large-scale investigations are needed to substantiate our observations and to determine the most effective and safe therapeutic approaches for this difficult-to-treat group.
P35 PSYCHOSOCIAL REHABILITATION, ANTIPSYCHOTIC MEDICATION AND THE TIME-TO-RE-HOSPITALIZATION IN SCHIZOPHRENIA

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Background: Time to re-hospitalization of persons with schizophrenia is considered a proxy measure for evaluating treatment outcome. Following legislation and adoption of the Rehabilitation of Mentally Disabled Act in Israel, there has been an increase in the use of the psychiatric rehabilitation services (PRS). However, its specific effect on time to re-hospitalization has not been evaluated.

Aim: To assess effects of PRS on time to re-hospitalization in persons with schizophrenia, controlling for type of antipsychotic medication during hospitalization and other confounding variables (e.g., cumulative time in-hospital, education).

Methods: A retrospective study, based on data from a regional mental health center, including all hospitalizations from 2004-2008, with a last discharge diagnosis of schizophrenia (n=912). Data extracted included demographic and clinical variables, and dates of index and subsequent hospitalizations. Persons with and without PRS were compared.

Results: In comparison with persons without PRS, those referred for PRS had lower rates of re-hospitalizations (29.5%, 49.7% respectively, p<0.0001), with longer survival time in the community (432 and 353 days, respectively, p<0.0001). In a multi-variable model, PRS was associated with longer time re-hospitalization (HR=0.52, 95%CI 0.37-0.74, p=0.0002). When compared to first generation antipsychotic medication (and combinations), second generation medications were associated with longer time to re-hospitalization (HR=0.8, 95%CI 0.65-0.98, p=0.032).

Conclusions: Participation of schizophrenia patients in psychosocial rehabilitation interventions was associated with both longer survival time in the community and a lower re-hospitalization risk. These findings may assist in planning the comprehensive treatment and care, as well as the resources needed to implement these services.

P36 “THE BINDING BRIDGE” – A MODEL FOR COPING WITH LACK OF MOTIVATION AS A COMPONENT OF NEGATIVE SYMPTOMS IN SCHIZOPHRENIC PATIENTS. THE MODEL INVOLVES PHYSICAL, COGNITIVE AND EMOTIONAL ACTIVITY WITH CREATIVE TOOLS

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“The Binding Bridge” (TBB) – An art treatment studio, was established in 2002 as an answer for continuity of treatment following hospitalization for schizophrenic patients. Psychiatric treatment offers essentially good solutions for the positive symptoms of schizophrenia while solutions for negative symptoms are lacking. The internal world is expressed through our imagination and through metaphors, and is essential for inner motivation. While psychotic, schizophrenic patients experience the metaphoric expression of the fantasy as a concrete external reality. In the negative symptoms the connection with fantasy is blocked and hence the patient loses the ability to establish directions and meaning in life. TBB studio gives answers to a variety of negative symptoms. This lecture will focus on motivation. TBB model comprises 4 parts each day: - Physical consciousness, - Metaphorical expression of “here and now” and establishment of intention for mental work, - Artistic work, - Observation of the creative process. The metaphoric language is central in all parts of the day and forms a “transitional space” in which internal-external communication can be exercised. This provides validity of the expression of the internal world in art, visibility and meaning to the subjective experience, and a distinction is made between the internal and external worlds. Creative art with materials provides the meeting point between fantasy, and external reality represented by the limitations of the substance and the artist. The ability to choose, to act accordingly and to establish responsibility is exercised in all parts of the model. We have found that after few months in the studio, patients showed better motivation and good capacity to accept responsibility in building their own quality of life, and were less inclined to have negative attitudes towards medications. An improvement was noted in the ability to make a distinction between reality and imagination. A distinct decrease in the number and length of hospitalizations was measured.

P37 NEUROIMMUNOLOGICAL FUNCTION IN PARENTS OF CHILDREN SUFFERING FROM CANCER

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Background: Over the last 15 years data has accumulated on the psychiatry morbidity of children suffering from cancer and their parents. Objective: To evaluate the relationship between depressive reaction to stress and immunological function in
parents of children with cancer.

**Method:** Thirty-two parents participated in the study (23 female and 9 males, mean age, 42.0±1.4 years). The parents completed a list of major stressful events in a Hemato-Oncology ward (calculated as “traumatic score”), the Beck Depression Inventory (BDI), the Posttraumatic Stress Diagnostic Scale (PDS) and the WHO Quality of Life Assessment (WHOQOL-BREF). The children were assessed for depression (Children’s Depression Rating Scale–Revised [CDRS-R]), anxiety (The Screen for Child Anxiety Related Emotional Disorders [SCARED]), post-traumatic stress disorder (PTSD-RI) and quality of life (The Pediatric Quality of Life Inventory [PedsQOL]). A single blood sample was drawn from parents for evaluation of cortisol levels and lymphocyte cell subgroups (CD4, CD8 and CD56). The parents were divided into two groups: those who suffered from depression (DP, n=7) as defined by BDI cutoff score of 14, and nondepressed parents (Non-DP, n=25).

**Results:** The DP group had statistically significantly higher traumatic scores, dysfunction scores (PDS) and CD8 percentage compared to the Non-DP group. Quality of life, CD4 percentage and CD4/CD8 ratio were significantly lower in the DP group. The BDI scores significantly positively correlated with traumatic and dysfunctional scores, and significantly negatively correlated with QOL scores and CD4/CD8 ratio. No significant difference was found in cortisol levels, or CD56 percentage between the groups.

**Conclusion:** High prevalence of depression and PTSD were found in children with cancer and their parents. The findings of altered immunity in DP provide further evidence that the physiological response to stress and depression may alter immune functions.

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**P38 COMMUNITY BASED OUTREACH PROGRAM FOR CHILDREN AND ADOLESCENTS – IS IT POSSIBLE?**

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Traumatic events in childhood constitute a major risk factor for psychopathology in adulthood. Unfortunately, access to care in child and adolescent psychiatry has always been and still is a major public health problem. Among the reasons we can cite the lack of child and adolescent practitioners, stigma, and lack of insurance coverage. In Israel, more specifically, high motivation to serve in the military service encourages patients and families resist care even when clinically indicated and offered. After the second Lebanon war the child and adolescent psychiatry clinic in Ha’Emek Hospital in Afula developed a community based outreach program that provided time limited therapy within schools, kindergartens and pediatric outpatient clinics in the north of Israel. The poster will describe the data accumulated and lessons learned from this program.
## Author Index

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Abramowitz, Moshe</td>
<td>S15.4</td>
</tr>
<tr>
<td></td>
<td>Admon, Roei</td>
<td>S2.3</td>
</tr>
<tr>
<td></td>
<td>Aharon, Judith</td>
<td>S8.3</td>
</tr>
<tr>
<td></td>
<td>Aharon-Peretz, Yehudit</td>
<td>S24</td>
</tr>
<tr>
<td></td>
<td>Aleksandrowicz, Dov R</td>
<td>S17.1</td>
</tr>
<tr>
<td></td>
<td>Alkelai, Ana</td>
<td>S20.1</td>
</tr>
<tr>
<td></td>
<td>Amann-Zalcenstein, Daniela</td>
<td>S20.1</td>
</tr>
<tr>
<td></td>
<td>Amiaz, Revital</td>
<td>P1</td>
</tr>
<tr>
<td></td>
<td>Amitai, Maya</td>
<td>P2</td>
</tr>
<tr>
<td></td>
<td>Apter, Alan</td>
<td>P2, P4, P22, P23, P36, S25, S25.2, S25.4</td>
</tr>
<tr>
<td></td>
<td>Arbel, Oded</td>
<td>S7.4</td>
</tr>
<tr>
<td></td>
<td>Arbelle, Shoshana</td>
<td>S3.2, S28, S28.1</td>
</tr>
<tr>
<td></td>
<td>Arbitman, Marina</td>
<td>P3</td>
</tr>
<tr>
<td></td>
<td>Asher, Elad</td>
<td>P1</td>
</tr>
<tr>
<td></td>
<td>Avda, Sarit</td>
<td>S28.3</td>
</tr>
<tr>
<td></td>
<td>Bahler, Michiel</td>
<td>S14.2</td>
</tr>
<tr>
<td></td>
<td>Bantman, Patrick</td>
<td>S17.2</td>
</tr>
<tr>
<td></td>
<td>Bar Eyal, Adi</td>
<td>S9.1</td>
</tr>
<tr>
<td></td>
<td>Barak, Yoram</td>
<td>S3.4, S24</td>
</tr>
<tr>
<td></td>
<td>Barash, Igor</td>
<td>S14.1, S15.2</td>
</tr>
<tr>
<td></td>
<td>Barber, Yerachmiel</td>
<td>P19, P20, S14.4</td>
</tr>
<tr>
<td></td>
<td>Bar-Lev, David</td>
<td>P1</td>
</tr>
<tr>
<td></td>
<td>Barnea, E</td>
<td>S30.4</td>
</tr>
<tr>
<td></td>
<td>Baruch, Yehuda</td>
<td>S13, S13.4</td>
</tr>
<tr>
<td></td>
<td>Barzilay-Levkowitz, Shira</td>
<td>P4</td>
</tr>
<tr>
<td></td>
<td>Bar-Zvi, Margalit</td>
<td>S30.5</td>
</tr>
<tr>
<td></td>
<td>Bawakny, Nisham</td>
<td>S22.2</td>
</tr>
<tr>
<td></td>
<td>Becker, Gideon</td>
<td>S23.3</td>
</tr>
<tr>
<td></td>
<td>Behrbalk, Pnina</td>
<td>P9, P13, P27</td>
</tr>
<tr>
<td></td>
<td>Ben Hayun, Rachel</td>
<td>S8.3</td>
</tr>
<tr>
<td></td>
<td>Ben-Asher, Edna</td>
<td>S20.1</td>
</tr>
<tr>
<td></td>
<td>Benaroya-MilshteinNoa</td>
<td>P37</td>
</tr>
<tr>
<td></td>
<td>Benatov, Ruben</td>
<td>S22.3</td>
</tr>
<tr>
<td></td>
<td>Ben-Dor, David H.</td>
<td>P12</td>
</tr>
<tr>
<td></td>
<td>BenNaim, S</td>
<td>P8</td>
</tr>
<tr>
<td></td>
<td>Ben-Shachar, Dorit</td>
<td>S2.2</td>
</tr>
<tr>
<td></td>
<td>Bengal, Y</td>
<td>P37</td>
</tr>
<tr>
<td></td>
<td>Bercovich, S</td>
<td>S9.2</td>
</tr>
<tr>
<td></td>
<td>Bergman, Hagai</td>
<td>S6.4</td>
</tr>
<tr>
<td></td>
<td>Biderman, A</td>
<td>P5</td>
</tr>
<tr>
<td></td>
<td>Biedka, Lukasz</td>
<td>S29.2</td>
</tr>
<tr>
<td></td>
<td>Bierzyński, Kazimierz</td>
<td>S29.2</td>
</tr>
<tr>
<td></td>
<td>Bin Nun, Gabi</td>
<td>P13</td>
</tr>
<tr>
<td></td>
<td>Birger, Moshe</td>
<td>S27.4</td>
</tr>
<tr>
<td></td>
<td>Bleich, Avi</td>
<td>P22, P23, P26, P27, S12.2</td>
</tr>
<tr>
<td></td>
<td>Bleich-Cohen, Maya</td>
<td>S18.3</td>
</tr>
<tr>
<td></td>
<td>Bloch, Yuval</td>
<td>P11, S8.4, S23.3</td>
</tr>
<tr>
<td></td>
<td>Bodner, Ehud,</td>
<td>S30.2</td>
</tr>
<tr>
<td></td>
<td>Bomba, Jacek</td>
<td>S29</td>
</tr>
<tr>
<td></td>
<td>Bomonov, Pavel O</td>
<td>P6</td>
</tr>
<tr>
<td></td>
<td>Bonne, Omer</td>
<td>S9.4, S18, S18.2</td>
</tr>
<tr>
<td></td>
<td>Bracha, Ziva</td>
<td>P38</td>
</tr>
<tr>
<td></td>
<td>Braw, Yoram</td>
<td>P11</td>
</tr>
<tr>
<td></td>
<td>Brunstein-Klomek, Anat</td>
<td>S9.1</td>
</tr>
<tr>
<td></td>
<td>Buchwald, I</td>
<td>P37</td>
</tr>
<tr>
<td></td>
<td>Bush, Ilan</td>
<td>S22.3</td>
</tr>
<tr>
<td></td>
<td>Bzura, Georgiana</td>
<td>P28</td>
</tr>
<tr>
<td></td>
<td>Carmel, Miri</td>
<td>S25.2</td>
</tr>
<tr>
<td></td>
<td>Carmel, Ziv</td>
<td>S13.1</td>
</tr>
<tr>
<td></td>
<td>Chataila, Suhil</td>
<td>P32</td>
</tr>
<tr>
<td></td>
<td>Chodick, Gabriel</td>
<td>S14.3</td>
</tr>
<tr>
<td></td>
<td>Cohen, Dan</td>
<td>S14.2</td>
</tr>
<tr>
<td></td>
<td>Cohen, Ety</td>
<td>P7</td>
</tr>
<tr>
<td></td>
<td>Cooper-Kazaz, R</td>
<td>P8</td>
</tr>
<tr>
<td></td>
<td>Dahan, Eyal</td>
<td>S7.1</td>
</tr>
<tr>
<td></td>
<td>Dahan, Sagit</td>
<td>P9</td>
</tr>
<tr>
<td></td>
<td>Daniely, Yaron</td>
<td>S8.3</td>
</tr>
<tr>
<td></td>
<td>David, Haim Shem</td>
<td>P22, P23</td>
</tr>
<tr>
<td></td>
<td>Davidson, Michael</td>
<td>S5</td>
</tr>
<tr>
<td></td>
<td>Davies, Jonathan</td>
<td>S16.2</td>
</tr>
<tr>
<td></td>
<td>Dolberg, Pnina</td>
<td>S10.1</td>
</tr>
<tr>
<td></td>
<td>Dolev, Zippi</td>
<td>S4, S4.1</td>
</tr>
<tr>
<td></td>
<td>Domagalska, Ewa</td>
<td>S29.2</td>
</tr>
<tr>
<td></td>
<td>Donsky, Liora</td>
<td>P26</td>
</tr>
<tr>
<td>Name</td>
<td>Registration Numbers</td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------------</td>
<td></td>
</tr>
<tr>
<td>Doron, Adiel</td>
<td>P10, S7.1, S21.4</td>
<td></td>
</tr>
<tr>
<td>Dwoletski, Zvi</td>
<td>S24</td>
<td></td>
</tr>
<tr>
<td>Ebstein, Richard P</td>
<td>S1.1</td>
<td></td>
</tr>
<tr>
<td>Edelstein, Arnon</td>
<td>S10.4</td>
<td></td>
</tr>
<tr>
<td>Eitan, Renana</td>
<td>S6.2, S6.4</td>
<td></td>
</tr>
<tr>
<td>Ellencweig, Natalie</td>
<td>S30.3</td>
<td></td>
</tr>
<tr>
<td>Erez, Galit</td>
<td>P11</td>
<td></td>
</tr>
<tr>
<td>Feldman, Dana</td>
<td>S25.4</td>
<td></td>
</tr>
<tr>
<td>Fennig, Shmuel</td>
<td>S23.1, S23.3</td>
<td></td>
</tr>
<tr>
<td>Fennig, Silvana</td>
<td>S9.1</td>
<td></td>
</tr>
<tr>
<td>Fischel, Tzvi</td>
<td>P22, P23</td>
<td></td>
</tr>
<tr>
<td>Fleischhacker, W. Wolfgang</td>
<td>P15</td>
<td></td>
</tr>
<tr>
<td>Fogelson, N</td>
<td>S32.3</td>
<td></td>
</tr>
<tr>
<td>Frisch, Amos</td>
<td>S25.2</td>
<td></td>
</tr>
<tr>
<td>Gavrilova, S.I.</td>
<td>S31.4</td>
<td></td>
</tr>
<tr>
<td>Gelkopf, Marc</td>
<td>P26, P27, S14.3</td>
<td></td>
</tr>
<tr>
<td>Geraisy, Nabil N.</td>
<td>S10.2</td>
<td></td>
</tr>
<tr>
<td>Ghaemi, Nassir</td>
<td>P12</td>
<td></td>
</tr>
<tr>
<td>Gibel, Anatoly</td>
<td>S22.3</td>
<td></td>
</tr>
<tr>
<td>Gilat, Izhak</td>
<td>S7.1</td>
<td></td>
</tr>
<tr>
<td>Gilat, Y</td>
<td>P12</td>
<td></td>
</tr>
<tr>
<td>Gilboa-Schechtman, Eva</td>
<td>S23.2</td>
<td></td>
</tr>
<tr>
<td>Ginath, Yigal</td>
<td>S21, S21.3</td>
<td></td>
</tr>
<tr>
<td>Gissin, Rachel</td>
<td>P35</td>
<td></td>
</tr>
<tr>
<td>Givon, Yari</td>
<td>P22, P23</td>
<td></td>
</tr>
<tr>
<td>Glikson, Michael</td>
<td>P1</td>
<td></td>
</tr>
<tr>
<td>Goldshtein, Inbal</td>
<td>S14.3</td>
<td></td>
</tr>
<tr>
<td>Gorbatsevich, Elena</td>
<td>P1</td>
<td></td>
</tr>
<tr>
<td>Goren, Iris</td>
<td>S14.3</td>
<td></td>
</tr>
<tr>
<td>Goren, Limor</td>
<td>P13, S13.1</td>
<td></td>
</tr>
<tr>
<td>Gorobets, L. N.</td>
<td>S31.1</td>
<td></td>
</tr>
<tr>
<td>Gothelf, Doron</td>
<td>S20, S20.2, S28.3</td>
<td></td>
</tr>
<tr>
<td>Granit, Hava</td>
<td>P1</td>
<td></td>
</tr>
<tr>
<td>Green, Hefziba</td>
<td>S30.3</td>
<td></td>
</tr>
<tr>
<td>Green, Phina</td>
<td>S30.3</td>
<td></td>
</tr>
<tr>
<td>Green, Tamar</td>
<td>S28.3</td>
<td></td>
</tr>
<tr>
<td>Greenbaum, Lior</td>
<td>S20.4</td>
<td></td>
</tr>
<tr>
<td>Greenberg, David</td>
<td>S5.2</td>
<td></td>
</tr>
<tr>
<td>Greenberg, Yifa</td>
<td>P14</td>
<td></td>
</tr>
<tr>
<td>Grinshpoon, Alexander</td>
<td>P18, S7.3, S14</td>
<td></td>
</tr>
<tr>
<td>Grisaru, Nimrod</td>
<td>S10, S10.5</td>
<td></td>
</tr>
<tr>
<td>Gross, Raz</td>
<td>S3.1</td>
<td></td>
</tr>
<tr>
<td>Grunhaus, Leon</td>
<td>S3, S3.3, S6, S6.3</td>
<td></td>
</tr>
<tr>
<td>Gur, Eitan</td>
<td>S9, S9.4, S9.5</td>
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<td>P14, S22.3</td>
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<td>HalifaKurtzman, Irit</td>
<td>S9.1</td>
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<td>S25.1</td>
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<td>S28.2</td>
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<td>Heinik, Jeremia</td>
<td>P15</td>
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<td>Heller, Anat</td>
<td>P36</td>
<td></td>
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<td>Hendler, Talma</td>
<td>S2, S2.3, S18, S18.1</td>
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<td>P17</td>
<td></td>
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<td>P22, P23, S30, S30.3, S30.4</td>
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<td>S16, S16.2, S27.3, S32</td>
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<td>Horesh, Netta</td>
<td>P22, P23</td>
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<td>Ianco, Iulian</td>
<td>S30, S30.2</td>
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<td>Idan, Asher</td>
<td>P11</td>
<td></td>
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<tr>
<td>Israel, Zvi</td>
<td>S6.4</td>
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<td>Izdebski, Ryszard</td>
<td>S29.2</td>
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<td>Javitt, Daniel C</td>
<td>S1.3</td>
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<td>Joubran, Samia</td>
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<tr>
<td>Kalian, Moshe</td>
<td>S27</td>
<td></td>
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<td>Kalman, Noa</td>
<td>P16</td>
<td></td>
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<td>Kaplan, Že’ev</td>
<td>S12, S21.2</td>
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<td>Kapur, Shitij</td>
<td>P14</td>
<td></td>
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<td>S2.2</td>
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<td>Keet, René</td>
<td>S14.2</td>
<td></td>
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<tr>
<td>Keller, Shikma</td>
<td>P17</td>
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<td>Klein, Ehud</td>
<td>S2, S2.2, S2.5, S32.3</td>
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<td>Knobler, Haim Y</td>
<td>P7</td>
<td></td>
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<tr>
<td>Knobler, Haim</td>
<td>S29</td>
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<td>Kochavi B</td>
<td>S9.3</td>
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<td>P19, P20, S14.3, S14.4</td>
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<td>Kodman, Y</td>
<td>P37</td>
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<td>Kohn, Yoav</td>
<td>S20, S20.1, S20.3</td>
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<td>P22, P23</td>
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<td>P36</td>
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<td>P18, S22.2</td>
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<td>S7, S11, S17</td>
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<td>P35</td>
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<td>Kritman, Milli,</td>
<td>S2.2</td>
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<td>P35, S21.1</td>
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<td>P10, P24</td>
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<table>
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<th>Section</th>
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<td>P19, P20, S14.4</td>
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<td>S8, S8.1, S8.2, S8.3</td>
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<td>Manor, Orly</td>
<td>P17</td>
</tr>
<tr>
<td>Marchevsky, Sergio</td>
<td>S13.1, S30.1</td>
</tr>
<tr>
<td>Marmor, S</td>
<td>S32.3</td>
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<tr>
<td>Marom, Sophie</td>
<td>S30.3, S30.4</td>
</tr>
<tr>
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<td>S2.2</td>
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<td>P25</td>
</tr>
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<td>Matrosova, M.I.</td>
<td>S31.1</td>
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<td>Meiri, Gal</td>
<td>S28.1</td>
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<td>Mendlovic, Shlomo</td>
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<td>S25.2</td>
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<td>Miodownik, Chanoch</td>
<td>S22.3, S22.4, S31.2</td>
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<td>S10.1</td>
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<td>P18</td>
</tr>
<tr>
<td>Monakhov, Mikhail</td>
<td>S1.1</td>
</tr>
<tr>
<td>Mosolov, Sergey N</td>
<td>P25, S26.3</td>
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<td>S4, S4.2</td>
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<th>Section</th>
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<td>Naor, Nora</td>
<td>P14</td>
</tr>
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<td>Ne’eman-Nagur, Orit</td>
<td>S7.3</td>
</tr>
<tr>
<td>Nemets, Boris</td>
<td>S3.5, S26.4</td>
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<td>S15, S15.1</td>
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<td>Nitzan, Uri</td>
<td>S23, S23.1, S23.3</td>
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<td>Noam, Sigalit</td>
<td>P26, P27</td>
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<th>Section</th>
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<td>Or, Evgenia</td>
<td>P22, P23</td>
</tr>
<tr>
<td>Oren, Roni</td>
<td>P36</td>
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<th>Section</th>
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<td>S15.3, S31</td>
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<tr>
<td>Name</td>
<td>Page</td>
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<td>P37</td>
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<td>S29.2</td>
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<td>P18</td>
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<td>S15.4</td>
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<td>P34</td>
</tr>
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<td>Richter, Levin</td>
<td>S2.2, S2.4</td>
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<td>P13</td>
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<td>P2</td>
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<td>P17</td>
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<td>S19</td>
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<td>P17</td>
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<td>S13.3</td>
</tr>
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<td>Shemer, E</td>
<td>P37</td>
</tr>
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<td>Shifron, Bruria</td>
<td>P36</td>
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<td>Shoenfeld, Yehuda</td>
<td>S5.3</td>
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<td>Shorer, Shai</td>
<td>P38</td>
</tr>
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<td>Shlosberg, Karin</td>
<td>P10</td>
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<td>Shoshan, Efrat</td>
<td>S23.1</td>
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<td>S13.2</td>
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<td>Shvartzman, P</td>
<td>P5</td>
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<td>Sinai, Omri</td>
<td>P28</td>
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<tr>
<td>Sirot, Lea</td>
<td>P14</td>
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<tr>
<td>Sirot, Pinkhas</td>
<td>P14, P21, S22.3</td>
</tr>
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<td>S30.4</td>
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<td>S31.3</td>
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<td>S7.5</td>
</tr>
<tr>
<td>Solomesh, Isaac</td>
<td>P19</td>
</tr>
<tr>
<td>Solomon, Zahava</td>
<td>S25, S29, S29.1</td>
</tr>
<tr>
<td>Spinzy, Yaniv</td>
<td>S23.3</td>
</tr>
<tr>
<td>Spitzer, Sara</td>
<td>S8.1</td>
</tr>
<tr>
<td>Stein Reisner, Orit</td>
<td>P16</td>
</tr>
<tr>
<td>Stein, Dan</td>
<td>S9, S9.3</td>
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<tr>
<td>Stern, B</td>
<td>P37</td>
</tr>
<tr>
<td>Stolovy, Tali</td>
<td>P10, P13</td>
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<tr>
<td>Strous, Rael</td>
<td>S19, S19.1</td>
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<tr>
<td>Styv, Benedykt</td>
<td>P19, P20, S14.4</td>
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<tr>
<td>Swartz, Marina</td>
<td>S14</td>
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<td>Szor, Henry</td>
<td>S7.2, S17.3</td>
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<td>Szwajca, Krzysztof</td>
<td>S29.2, S29.3</td>
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<td>S9.1</td>
</tr>
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<td>P30</td>
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<td>P7</td>
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<tr>
<td>Teitelbaum, Alexander</td>
<td>S6.5, S15</td>
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<td>Tevelev, Vitali</td>
<td>P31</td>
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<td>Tiganov, A.S.</td>
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<td>P22, P23</td>
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<td>P25</td>
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<tr>
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<td>S8</td>
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<td>Valevski, A</td>
<td>P37</td>
</tr>
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<td>P12</td>
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<td>S30.5</td>
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<td>Name</td>
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<tr>
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<td>P5</td>
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<td>P22, S1, S1.4</td>
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<td>P32, S27.4</td>
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<td>S9.5</td>
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<td>Weiss, Penina</td>
<td>S21.3</td>
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<td>Weizman, Tal</td>
<td>P32</td>
</tr>
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<td>Winocur, E</td>
<td>S30.4</td>
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<td>Wittchen, Hans-Ulrich</td>
<td>P16</td>
</tr>
<tr>
<td>Witzum, Eliezer</td>
<td>S10, S10.5</td>
</tr>
<tr>
<td>Wolmer, Leo</td>
<td>S28.2</td>
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<td>Wolovick, Luisa</td>
<td>P12</td>
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<td>S13.1</td>
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<td>Yatzko, Olga</td>
<td>S13.1</td>
</tr>
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<td>S13.1</td>
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<td>P2, P12, S8.2, S25, S25.3, S28, S28.4</td>
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<td>Zemishlany, Zvi</td>
<td>S5, S16, S16.1</td>
</tr>
<tr>
<td>Zislin, Josef</td>
<td>P33</td>
</tr>
<tr>
<td>Ziv, Shimrit</td>
<td>S9.3</td>
</tr>
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<td>Zivony, Amir</td>
<td>P2</td>
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<td>Zohar, Joseph</td>
<td>S2.1, S12, S12.1</td>
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<td>Zuys, Marina</td>
<td>P29</td>
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