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KONUŞMA ÖZETLERİ KİTABI

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Konuşma özetleri bilimsel programdaki sıraya göre yerleştirilmiştir

KONUŞMA ÖZETLERİ

Course: Case Illustrations in Metacognitive Therapy Applications

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Metacognitive therapy (MCT) is a process-based therapy that addresses psychopathology from a metacognitive perspective (Batmaz 2023). In this approach, cognitive attentional syndrome (CAS) and biased metacognitive beliefs play a role the emergence and maintenance of psychopathology. Components of the CAS include perseverative thinking style, biased attentional control, and counterproductive coping strategies. Metacognitive beliefs which suggest that the person cannot control these components and that they are somehow useful also affect psychopathology. Metacognitive therapy applications mainly try to find rational and more functional alternatives to these beliefs and to understand the underlying causes of mental disorders. For this purpose, in MCT therapists keep the interview at the metacognitive level, use an individualized conceptualization of distress, and offer various techniques to psychoeducate, reduce perseverative thinking, develop alternatives for attentional biases, and develop functional coping strategies. The therapist and patient also discuss the validity, function, advantages and disadvantages of the metacognitive beliefs in order to come up with a different perspective to the problems faced by the patient (Wells 2009). In MCT, the main focus is on thinking processes rather than the content of cognitions, which differentiates MCT from traditional cognitive behavioral therapies (Batmaz & Altınöz 2023). During this introductory workshop, metacognitive theory will be briefly mentioned and its distinctions from traditional cognitive behavioral approaches will be explained, and then video recordings of case illustrations will be presented. The unique methods and techniques of MCT will be discussed with the participants through these recordings. Participants' questions about their own cases will be reviewed from the perspective of metacognitive theory. A question and answer session will be provided to encourage active participation. Role plays or small group activities to increase interaction will also be included in the workshop. The main aim of the workshop is to provide fundamental knowledge about metacognitive theory and therapy. At the end of the workshop, participants will have acquired introductory level of knowledge about metacognitive theory and its applications in various clinical scenarios.

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Course: How Does a Clinician Psychiatrist Benefit from Neuroscience

Deniz Ceylan

The phrase "Psychiatry is the oldest of the medical arts, the newest of the medical sciences" is attributed to Stanley Cobb, a pioneer in biological psychiatry. This field, like many aspects of medicine, has a rich history of both observing and attempting to treat psychiatric conditions, making it one of the oldest medical arts. Yet, it remains a relatively recent scientific discipline.

Historically, it's been understood for over 2,500 years that the mind and behavior are linked to brain function. The ongoing challenge of deciphering how a 1300-gram organ—the brain—manages such complex tasks continues to captivate researchers. Since the 17th century, when Cajal first sketched nerve cells due to the absence of photography, our understanding of brain cell properties has expanded significantly.

Over the past century, advances like measuring brain electrical activity and imaging brain structures have revolutionized neurological medical practice. Meanwhile, psychiatry has been slower to integrate such technologies into diagnostic and treatment protocols. Fields such as neuroscience utilize these techniques to probe the biological underpinnings of psychiatric disorders.

The 21st century marks a rapid development phase in computational sciences, which are integral to neuroscience for modeling brain functions based on imaging and electrical data.

"Brain-computer interfaces" represent a frontier technology integrating digital environments with brain function. This technology translates brain activity into digital signals, enabling individuals, especially those with motor impairments, to operate computers or other devices hands-free. Additionally, those with vocal cord paralysis can use avatars for communication, hinting at future enhancements in life quality for those with various disabilities.

Despite significant advancements, the complex mechanisms underlying psychiatric disorders remain elusive. Psychiatry has made remarkable progress in treating conditions without fully understanding their biological bases. From a history of confining individuals in asylums, today, even severe psychiatric patients can lead productive lives. Yet, in areas like depression treatment, success rates hover around seventy percent, highlighting the ongoing need for deeper knowledge.

As technology evolves, it promises to revolutionize many medical fields, including psychiatry. Embracing neuroscience as a foundational tool is essential for clinicians to navigate and contribute to the evolution of their field, ensuring they remain at the forefront of medical practice and patient care.

Course: Compass of Modern Psychiatry: Neuroscience Modeling Psychiatric Disorders in Animals

Emre Cem Esen, MD, PhD
T.C. Sağlık Bakanlığı Hassa Devlet Hastanesi

Psychiatric disorders present complex challenges in both diagnosis and treatment due to their multifaceted etiology and diverse symptomatology. To gain deeper insights into the complex neurobiological mechanisms underlying mental health disorders and develop more effective interventions, researchers have turned to animal models. This presentation explores the rationale, methodologies, and implications of modeling psychiatric disorders in animals. These models offer a controlled environment for studying the genetic, neurochemical, and behavioral aspects of psychiatric conditions that would be otherwise impossible in human subjects. During the presentation, we will review how animal models have helped uncover the role of neurotransmitters, neural circuits, genetic vulnerabilities, and potential treatment targets for conditions such as anxiety disorders, depression, schizophrenia, and addiction.

The Forced Swim Test (FST) and Tail Suspension Test (TST) are commonly used to assess depressive-like states in rodents by measuring their immobility, suggesting despair. For anxiety, the Elevated Plus Maze (EPM) and Open Field Test (OFT) are frequently employed, where animals' tendencies to avoid open and elevated areas indicate anxiety-like behavior. Chronic Mild Stress (CMS) is a model used for both conditions, exposing animals to prolonged mild stressors, leading to behaviors akin to human depression and anxiety, such as anhedonia and increased wariness.

Animal models typically focus on reproducing symptoms or endophenotypes associated with schizophrenia, such as cognitive deficits, abnormal social interactions, and disrupted sensorimotor gating. The amphetamine-induced hyperactivity model simulates the positive symptoms of schizophrenia, like paranoia and hallucinations, by administering amphetamines that increase dopamine activity, mimicking psychosis. The prepulse inhibition (PPI) model assesses the disruption of sensorimotor gating present in schizophrenic patients. Genetic models involve manipulating genes associated with schizophrenia and observing the effects on the behavior and brain structure.

Animal models often simulate the process of addiction in humans, including compulsive drug-seeking behavior and high relapse rates after periods of abstinence. The self-administration model is widely used, where animals are trained to self-administer drugs, providing insights into the reinforcing properties of addictive substances. The conditioned place preference (CPP) model assesses the association between environmental cues and drug effects, highlighting the role of context in addiction. Additionally, the drug-induced reinstatement model is employed to study relapse, where previously drug-free animals are re-exposed to drugs or drug-related cues to see if they revert to drug-seeking behaviors.

In conclusion, while challenges remain, animal models are significant for psychiatric research. This presentation will highlight the animal models for anxiety disorders, depression, schizophrenia, and addiction, especially in rodents; and discuss the strengths and inherent limitations of current models.

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Course: Intervention Approaches From The Perspectives Of Cognitive Behavioral Therapy And Schema Therapy In The Presence Of Personality Disorders Most Commonly Associated With A Diagnosis Of Depression

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Depression is one of the most common mental health problems and a significant cause of disability. It is known that various factors contribute to the development of depression from an etiological perspective. It often has co-occurring diagnoses, tends to recur, and can have a chronic course. Given these characteristics, therapeutic interventions in the treatment of depressive symptoms are crucial. Cognitive Behavioral Therapy has been shown to be effective in treating depression in many studies, and it is listed as a treatment option in clinical guidelines. Beck proposed that negative cognitive concepts could explain most of the symptoms characteristic of depressive syndromes. The "cognitive triad" of negative perceptions of the self, the future, and the world, along with negative automatic thoughts, cognitive biases, and core dysfunctional beliefs, play significant roles in the clinical picture of depression. These dysfunctional patterns of thinking influence the course, severity, and recurrence of the illness, highlighting the importance of interventions targeting these thought patterns and beliefs to reduce relapse and aid in remission.

Personality can be defined as "the relatively enduring patterns of interpersonal behavior that characterize a person's life." When personality traits are rigid, maladaptive, cause significant functional impairment, and create personal distress, they are described as personality disorders. Certain personality traits or pathologies may predispose individuals to develop mental health issues. Schema therapy, a holistic treatment approach derived from cognitive behavioral approaches, was initially designed to address chronic, lifelong problems. It has shown effectiveness in treating personality pathologies in various studies. When personality pathologies commonly co-occur with depression, interventions targeting schema structures are reported to reduce the risk of relapse and improve functionality and quality of life.

In this course, we will address cognitive behavioral therapy interventions for cases diagnosed with depression, as well as the intervention techniques commonly used in schema therapy when there are co-occurring personality disorders with a depression diagnosis. We will also cover how to apply these techniques.

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Course: Case Management in Substance Use Disorders with Case Examples
Two Cases Of Methamphetamine Addiction

Mine Ergelen
Erenköy Ruh ve Sinir Hastalıkları Eğitim ve Araştırma Hastanesi

Abstract
Methamphetamine use continues to be a major public health issue globally. Among illicit drugs, amphetamine-type stimulants (ATS), particularly methamphetamine, are among the most commonly used substances worldwide (Courtney & Ray 2014). Methamphetamine is now available in various forms, including ice, powder, and pills, each with unique pharmacokinetic characteristics that appeal to specific individuals. This substance is mainly known for its ability to release dopamine, serotonin, noradrenaline, and adrenaline from nerve terminals in both the central and peripheral nervous system (Paulus & Stewart 2020). Methamphetamine use can lead to immediate effects such as heightened energy and alertness, reduced need for sleep, feelings of euphoria, increased talkativeness, decreased appetite and weight loss, excessive sweating, and teeth grinding. Additionally, it is recognized to worsen positive psychotic symptoms like suspiciousness, unusual thought content, hallucinations, and bizarre behavior. Most methamphetamine-associated psychoses are short-lived, lasting hours to days, there are instances where psychotic episodes can extend beyond 6 months and may recur during periods of drug abstinence (Paulus & Stewart 2020). In this presentation, we will discuss the treatment process and clinical course of 2 cases admitted with methamphetamine use.

A 39-year-old woman was admitted to our hospital because she wanted to stop using methamphetamine. She has a history of multiple suicide attempts, self-mutilative behaviors, and childhood sexual traumas. After receiving detoxification treatment, she was referred to a long-term outpatient rehabilitation program for follow-up care. The second case involved a 33-year-old male patient who was admitted to our hospital due to aggression and suicidal thoughts. He has been using methamphetamine for 2 years, and he has been experiencing psychotic symptoms for 1.5 years. The addiction treatment process, along with the treatment of comorbidities, and the long-term follow-up processes of these two cases were deliberated upon.

It is important to offer all individuals who use amphetamine or methamphetamine the opportunity to receive suitable psychosocial and pharmacological treatment that is tailored to their needs and level of motivation. There are only a few pharmacologic options available to treat methamphetamine use. On the other hand, larger-scale studies demonstrated positive indications of multiple agents, showing that agonist treatments may hold promise (Siefried ve ark. 2020). Nonetheless, it is crucial to develop a customized plan for addiction treatment that offers a range of support services for the individual over the long term, possibly spanning several years or even a lifetime. This includes staying connected, participating in various levels of treatment programs, and accessing crisis interventions when necessary.

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Course: Development of Basic Anamnesis Skills in the Evaluation of Sexual Dysfunctions from Theory to Practice: Vaginismus as a Case Example

Görkem Karakaş Uğurlu, Prof. MD
AYBÜ Psychiatry Department

Greetings and Welcome,
Today, we will talk about the assessment of sexual dysfunctions and the understanding of one of these disorders, vaginismus.
Our talk will focus on analyzing a critical process that underlies the understanding of sexual health and dysfunctions, namely, the process of taking anamnesis. However, we will also touch on topics related to this topic. Anamnesis gives us detailed information about sexual health, an area that directly affects the quality of life of our patients. This not only helps us to understand the patient's sexual history, relationships, and experiences but also forms the basis for personalized treatment plans.

This process is an essential skill, especially for psychiatrists and mental health professionals, to build solid and meaningful relationships with patients. Here, the principles of active listening, empathy, and confidentiality come to the fore. In this relationship with our patients, we take on the role of comforting and supporting them while listening to their stories.

Then, we will continue with role-playing applications we designed based on real scenarios. Role-playing allows us to simulate situations we may encounter in practice. It is an invaluable tool for developing our skills in managing emotional reactions and the need for privacy. This method makes an in-depth contribution to the learning and developing practical skills such as anamnesis.

In this interactive environment, we will refresh our theoretical knowledge on the one hand and learn by applying this knowledge to real-life scenarios on the other. The latter is significant to understand and overcome the barriers that exist in the field of sexual health for both the patient and the specialist. In addition, we will see how to determine the correct diagnosis and treatment approaches for sexual dysfunctions by working on a vaginismus case.

In the part where we will focus on vaginismus, we will talk about the anamnesis, the symptoms and possible causes of this condition, and the issues we need to pay attention to establish a relationship while collecting information to create a personalized treatment plan. We will understand how a patient diagnosed with vaginismus feels comprehensively and the effects of this condition on her life and relationships.

Finally, in light of all this information, we will discuss how we can provide a better healthcare service with a multidisciplinary approach and improved communication skills. Effective communication improves the quality of our relationships with our patients and contributes to the success of the treatment process.

At the end, we will have a question-answer and discussion section where you can share your experiences and questions.
I am happy to accompany you on this journey. Now, let's take an in-depth look at this critical topic together.

Course: From Theory to Practice: Fundamental History Taking Skills in the Evaluation of Sexual Dysfunctions Case Examples of "Vaginismus"

Irmak Polat, Assistant Professor of Psychiatry
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Case-1: Ms. Berna, 32 years old, is a textile engineer, graduated from ITU, did her master's degree in the UK, and returned to Turkey to head the family business. She lives with her partner and plans to get married in 3 months, but she applied for counseling on the advice of a very close friend because she does not favor sexual intercourse and thinks that it will cause problems in her marriage. Ms. Berna, a heterosexual woman, had three male partners before her current partner. She says that she had sexual desire for both her past partners and her current partner, that had lubrication at the beginning of the sexual activity, but that she did not want intercourse because she experienced intense contractions in her vagina and entire pelvis when they tried penis entry, and that she enjoyed sexuality in this state, but that her partners were dissatisfied. While she states that she has pain in these areas due to the contractions in her vagina and pelvis, she has no fear of penile penetration. Still, she does not like the idea of "a different person's organ entering her body" and thinks that "too much meaning is attributed" to intercourse.

Case-2: Ms. Zeynep, 26 years old, housewife. She was married for one year. She lives with her husband, mother-in-law, and father-in-law. She has not had sexual intercourse with her husband since her marriage. She states that she is sexually attracted to her husband and sometimes initiates sexual intercourse herself. Still, she is terrified of penile penetration and prevents her husband from attempting penetration. Although she did not seek help for this difficulty, she sought treatment because of her husband's desire for children. She stated that before psychiatry, she was treated in the gynecology clinic for a while "to relieve the hymen" and that her gynecological treatment was completed because she had completed the graded dilators insertions, but that her doctor referred her to psychiatry because penile penetration was still not possible.

In this part of the course, the speakers will conduct a role-playing exercise with two different vaginismus cases. One of the course facilitators will interview the first case, and the second case will be interviewed by the course participants on a voluntary basis. The other course speaker will play the role of the simulated patient.

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Course: Listening to the Rhythm of Sleep: Assessment of Circadian Rhythm and Approach to Circadian Rhythm Sleep Disorders
Biology of Circadian Rhythms

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'Chronobiology' is the branch of science that deals with biological time. Human beings have noticed the effects of the changing environment with daylight and seasonality since their existence. Seasonality affects reproduction rate, sexual activity, perception-comprehension, pain thresholds, growth rate, hormonal changes, mood, appetite, sleep, energy, metabolism, and social behavioral changes. Some cycles last milliseconds, while others last for years. The most well-known and understood biological rhythm from these cycles is the circadian rhythm (CR).

The circadian system has become increasingly prominent and studied in recent years. The awarding of Nobel Prizes in medicine for research in this area has raised awareness of its importance.
CRs are biological processes that progress in 24-25 hour cycles. Regulation of the rhythm is achieved by some mechanisms that synchronize our internal biological clocks with the variable external environment. The main biological clock is located in the suprachiasmatic nucleus and allows for the coordinated timing of physiological processes in the body along with peripheral clocks.

Understanding circadian biology has explained the relationship between shift work, jet lag, and many other conditions with CR irregularities.

CR also plays an active role in the functioning of metabolism. Leading a lifestyle in accordance with CR is protective against obesity, diabetes, and cardiovascular diseases. Emotional regulation and memory functions are closely associated with CR. Conversely, when CR is disrupted, individuals become prone to inflammation, memory impairments, executive functions, learning capacity, and psychiatric, and physical disorders. There are studies in clinical practice suggesting that the timing of drug administration according to this rhythm has a positive effect on treatment outcomes.

The relationship between circadian rhythm disorders encountered by clinicians in many cases in psychiatric practice and psychiatric disorders has been verified with various recent studies. Mood disorders, anxiety disorders, cognitive impairment, substance use disorders, schizophrenia, attention deficit, and hyperactivity disorder, among many disorders, have been associated with them. Chronotherapy is one of the treatments that has been put into practice with the recognition of this relationship. Practices such as bright light therapy, agents effective on melatonin and melatonin receptors, regulation of food intake times, interventions to improve daily rhythms, and regulation of sleep and exercise times can correct circadian pacemakers. There are studies in clinical practice suggesting that the timing of drug administration according to this rhythm has a positive effect on treatment outcomes.

Learning about the biology of the circadian system will have positive effects on the current practice of every physician.
During the course, basic concepts and the biology of circadian rhythms will be discussed.

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Course: Chronotype and Circadian Rhythm in Psychiatric Disorders

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Chronotype refers to an individual's natural inclination toward the timing of their sleep and activity periods within the 24-hour day. This concept, rooted in the study of circadian rhythms, acknowledges that people have inherent variations in their preferences and performances for daily activities, essentially categorizing them into "morning types," "evening types," and those in between. The classification is often assessed through questionnaires, such as the Morningness-Eveningness Questionnaire (MEQ), enabling a better understanding of how these biological timings influence behavior, mood, and health.

The significance of chronotype extends into the domain of psychiatric disorders, where it has been observed that certain chronotypes may be more susceptible to specific conditions. For instance, evening types have been frequently associated with higher rates of depression, anxiety, and mood disorders compared to morning types. This vulnerability may stem from the misalignment between societal expectations and their innate circadian predispositions, leading to social jetlag, sleep disturbances, and an array of stress-related impacts.

In terms of treatment, understanding an individual's chronotype can offer a tailored approach to managing psychiatric conditions. Light therapy, for example, has been effective in treating Seasonal Affective Disorder (SAD) and certain sleep disorders, with timing adjusted according to the patient's chronotype to normalize their sleep-wake cycle. Furthermore, Chronotherapeutics, which involves timing the administration of treatments to coincide with certain circadian phases, has shown promise in enhancing the effectiveness and reducing the side effects of psychiatric medications. Behavioral interventions, such as Cognitive Behavioral Therapy (CBT) for Insomnia, also consider chronotype in their strategies to improve sleep hygiene and regulate sleep patterns.

The exploration of chronotype in psychiatry is an evolving field, suggesting that personalized treatment based on circadian biology could lead to better outcomes for patients with psychiatric disorders. As research progresses, the integration of chronotype assessments into clinical practice may offer a more nuanced understanding of psychiatric illnesses and their management.

In this course, we aim to provide effective information about chronotype definition, classification, neurobiology, its effects on psychiatric diseases and their treatment.

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Course: Listening to the Rhythm of Sleep: Assessment of Circadian Rhythm and Approach to Circadian Rhythm Sleep Disorders
Treatment Approaches In Circadian Rhythm Sleep Disorders

Doç. Dr. Elif Aktan Mutlu
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Circadian rhythm is a cycle that defines our body's daily rhythm. Apart from the circadian rhythm, we also have cycles that occur more than once a day or annually. Circadian rhythm; It includes the sleep-wake cycle, hunger-satiety regulation, temperature regulations and many metabolic regulations. The main regulator of circadian rhythm is the suprachiasmatic nucleus located in the anterior hypothalamus of the brain. There are many factors that affect circadian rhythm.

These; Other factors include sleep, nutrition, light, age, gender, melatonin, shift work, jet lag, temperature, medications used (psychotropic, antihypertensive, antibiotic, etc.).

Circadian rhythm sleep disorders describe clinical conditions in which the sleep-wake rhythm is disrupted depending on environmental and social conditions. A detailed sleep history is essential to clarify the diagnosis of these disorders. In order to call it a disorder, complaints are expected to continue for at least 3 months.

Circadian rhythm sleep disorders include the following types:
1. Delayed sleep phase disorder (DPD)
2. Early sleep phase disorder (ESPD)
3. Irregular sleep-wake rhythm disorder
4. Free-flowing sleep phase disorder
5. Shift work type sleep phase disorder
6. Jet lag type sleep phase disorder
7. Sleep phase disorder not otherwise specified

There are many different methods of treatment. For example, in the treatment of DPD, morning light therapy, chronotherapy and timed melatonin use are recommended. In addition, sleep hygiene training and, if there is a secondary cause, treatment for the cause should also be given. In the rarer treatment of ESPD, phototherapy, chronotherapy, exposure to light and darkness, and hypnotic drugs may be tried.

Apart from these, behavioral approaches, environmental regulations such as nutrition regulation and some other therapy methods can also be applied.

Treatment of circadian rhythm disorders is of great importance in terms of the social and academic losses it causes and other medical consequences it causes. Treatment should be evaluated and applied in this sense.

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Course: Acceptance and Commitment Therapy: Application in Clinical Practice

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Acceptance and Commitment Therapy (ACT), a contemporary cognitive-behavioral psychotherapeutic approach, distinguishes itself from traditional Cognitive Behavioral Therapy through its philosophical and theoretical underpinnings. Characterized as a third-wave cognitive-behavioral therapy, ACT has been validated through randomized controlled trials and meta-analyses to be effective in treating a myriad of psychological disorders including chronic pain, depression, anxiety, psychotic disorders, and obsessive-compulsive disorder (OCD). It is increasingly recommended in international treatment guidelines.

ACT targets clinically significant behavior to predict and influence such behaviors through its six core processes. These processes encompass experiential avoidance, cognitive fusion, loss of contact with the present moment, attachment to the conceptualized self, lack of contact with values or rule dominance, and avoidance, inaction, or impulsivity. The interaction of these six processes articulates the ACT model of psychopathology, termed psychological inflexibility. This model has been linked with numerous clinical conditions such as depression, anxiety disorders, suicidality, post-traumatic stress disorder, OCD, and psychosis. The goal of ACT is to reduce psychological inflexibility while enhancing psychological flexibility.

Psychological flexibility, which is the desired outcome of ACT, is comprised of dimensions like acceptance, cognitive defusion, flexible contact with the present moment, self-as-context, values, and committed actions. Improving one dimension has the propensity to bolster others due to their interconnected nature. ACT's transdiagnostic approach provides an advantage in cases with comorbid conditions by enabling economic interventions that can address multiple issues concurrently, from psychiatric comorbidities to accompanying clinical conditions such as epilepsy, multiple sclerosis, and chronic pain. Additionally, ACT can effectively target non-clinical issues that impact life quality, such as work and sports performance, caregiver stress, and migration stress. The effectiveness of ACT in these areas is well-supported by scientific evidence.

In the daily clinical settings of our country, the brief durations allocated per patient highlight the importance of methods that allow for interventions within a constrained timeframe. There are brief, targeted interventions available within ACT that can enhance the dimensions of psychological flexibility. The adoption of these brief interventions under clinical conditions has the potential to contribute significantly to increasing patients' psychological flexibility, which is shown to correlate with mental well-being.

This session aims to inform attendees about ACT's transdiagnostic approach and to equip them with therapeutic practices suitable for daily clinical conditions. The session will be interactive, complementing didactic presentations with experiential exercises, and will emphasize the practical application of ACT interventions in a time-efficient manner.

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Course: Supportive Psychiatric Care for Parents of LGBT Individuals of Any Age

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Abstract
Numerous studies have shown that people from "sexual minority" groups (LGBTI+), who are subjected to stigmatization and discrimination in social life due to their characteristics such as gender, gender identity and expression, and sexual orientation, are associated with more negative mental and physical health outcomes than the general population. The dominant cis-heteronormativity in society, the assumption that everyone is cisgender and heterosexual and that it is morbid and wrong not to be so, paves the way for stigmatization, discrimination, and violence related to sexual identity. In diverse social contexts, stigma can be reflected in the rules and functioning of institutions and cause structural inequalities and discrimination in interpersonal relations. Individuals can sometimes internalize this approach. Structural, interpersonal, and individual dimensions of discrimination and stigmatization related to sexual identity are known to be associated with inequality in health (Başar et al., 2020). This threat of discrimination and stigmatization, which manifests itself in almost all social contexts, shows its most prominent effect in family relationships from the moment the individual starts to question themselves. When the person expresses himself/herself openly to family members, this disclosure contradicts expectations about the person until then. The disclosure is experienced as a crisis that varies between families. Support from mental health professionals is often requested to overcome this crisis. Health professionals can play an essential role in this long process that may result in acceptance and supportive attitude, rejection or partial acceptance experienced by family members. Although many factors determine the parents' reaction, positive results can be achieved when appropriate support can be accessed and cooperation can be established. This support can be provided individually or through group work. In these interventions, which can roughly be considered crisis interventions, it is possible for family members to feel empathically listened to, to understand that they are experiencing similar anxieties, worries, and anger with their loved ones, to return to their functional parental roles, and in many cases to assume the role of rights defender together with their children and sexual minorities. In this course, the importance of family support for persons from sexual minorities is discussed, and presentations on professional interventions that can be made to provide family support will be conveyed through case examples. Support will also be provided in areas where participants have difficulties.

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Course: The Cognitive Behavioral Treatment of Somatic Symptom Disorders with Case Reports

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Somatic symptom disorder (SSD) is characterized by one or more distressing or significantly disruptive somatic symptoms accompanied by excessive thoughts, feelings, and/or behaviors related to these symptoms (1,2). These symptoms cause significant impairments in individuals' functioning. Somatic symptoms may or may not be associated with a diagnosed medical condition. SSD can occur with or without a general medical illness that 'explains' the somatic symptoms (1).

Individuals with SSD have increased attention to bodily sensations and possess negative cognitions and emotions related to these sensations. Perceiving bodily symptoms as dangerous leads to constant vigilance and intense focus on bodily complaints, ultimately resulting in an exacerbation of symptoms (3).

In the assessment process of patients with SSD, the initial steps involve identifying the problem, determining triggering/predisposing factors, addressing problem behaviors, identifying maintaining factors, avoidance behaviors, and coping mechanisms used. Additionally, a detailed evaluation should include addressing the cognitive, emotional, physiological, and behavioral components of the symptoms, exploring psychosocial status, the degree of impairment in functionality, and past treatment experiences.

In cognitive-behavioral psychotherapy of SSD, establishing good communication to build collaboration and trust with the patient, conducting appropriate assessment through active listening, providing information about diagnosis and treatment rationale, and offering psychoeducation about the symptoms constitute the initial steps of treatment. The aim is to identify the temporal relationship between stress factors and somatic symptoms. Longitudinal formulation involves identifying predisposing and perpetuating factors by determining situations that exacerbate or alleviate symptoms.

The evaluation of an individual's cognitions and thought patterns related to their symptoms, activation of cognitive restructuring processes, and interventions aimed at shifting attention away from bodily symptoms to different focal points are addressed. Treatment interventions focus on reducing catastrophizing, enhancing coping skills for sleep, and implementing behavioral activation to increase individuals' self-efficacy perceptions and reduce negative cognitions (2,3). Other treatment goals include stress management, improvement of interpersonal relationships, and enhancement of functionality.

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Innovative Approach: New Dimensions in Psychotherapy with EMDR 2.0

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Abstract: Eye Movement Desensitization and Reprocessing (EMDR) therapy has gained increasing acceptance in the field of mental health since its initial development. It has emerged as an effective approach in treating conditions such as Post-Traumatic Stress Disorder (PTSD) that follow trauma. Developed by Francine Shapiro, EMDR alleviates the distinct symptoms caused by stressful events and is a holistic psychotherapeutic approach that enhances an individual's quality of life.
EMDR, primarily used for treating Post-Traumatic Stress Disorder (PTSD), also addresses other disorders where traumatic memories are present, applying to adult, child, and adolescent clients. EMDR 2.0 is a protocol developed by Ad de Jongh and Suzy Matthijssen, building upon EMDR. It integrates a strategy of asking questions during bilateral stimulation to distract operational memory, allowing it to divide its focus among multiple stimuli while thinking about the target memory. This technique minimizes exposure to the traumatic memory and utilizes a distraction function. Typically in EMDR, half of the client's attention should be on the traumatic memory, and the other half in the session room. Clinicians may require focusing simultaneously on various "channels" related to the traumatic scene, such as "image," "thought," "emotion," and "bodily sensation," to allow attention to shift to the traumatic memory and start "processing." This focus is crucial during the desensitization phase of EMDR. However, if the focus leads to a "dissociation" state, where the client's attention completely detaches from the session room, various techniques are used to re-engage the client in the moment. The how and why of all these techniques are increasingly supported by both clinical and neurobiological research. These neurobiological studies contribute to the theoretical development and practice of psychotherapy, enhancing the effectiveness and activity within sessions. The seminar will introduce EMDR therapy and the advanced application of EMDR 2.0.

There is extensive research in the literature indicating that EMDR therapy can be effectively used for treating PTSD in both individual and group settings. Various specific protocols have been developed for individual and group applications of EMDR therapy across different disorders. The Flash Technique, developed by Philip Manfield, is one such EMDR protocol. In this protocol, there is less contact with the traumatic memory and a greater focus on positive memories. Reducing contact with traumatic memories can decrease the risk of dissociation and abreactions during therapy. Therefore, this method might be more suitable for group settings where individual intervention opportunities are limited.

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Aftermath of the Earthquake: Experiences of Mersin University Psychology Department

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On 6 February 2023, a devastating earthquake with a magnitude of 7.8 struck southeastern Turkey and northwestern Syria. This earthquake was followed by a series of aftershocks, including one with a similar magnitude to the first earthquake. The earthquakes affected approximately 14 million people in these regions. As of 8 March 2023, the Turkish Disaster and Emergency Management Presidency announced that 47,932 people had lost their lives and more than 115,000 people were injured in the earthquake. Immediately after the earthquake, hundreds of thousands of people started to flock to nearby provinces in search of safety. Some of the earthquake victims who came to Mersin, especially from Hatay, were placed in the dormitories of the Credit and Dormitories Institution (KYK). Mersin University Psychology Department staff and graduate students provided psychosocial support services in KYK dormitories and various associations. The first part of this talk aims to introduce the services provided to earthquake victims and the software developed for general screening. At the end of this section, the importance of software for general screening in disasters of this magnitude will be emphasized.

In the second stage of the talk, the studies conducted by the faculty members of Mersin University Psychology Department with the data collected shortly after the earthquake will be introduced. In the first study, the symptoms of depression and post-traumatic stress disorder (PTSD) of 978 adult participants (592 women and 401 men) were analyzed by network analysis method 2 months after the earthquake. The analysis revealed that agitation was the highest centrality in the network, followed by startle response, a symptom of PTSD. In contrast, suicidal thoughts, a symptom of depression, showed weak relationships with other symptoms. Moreover, sleep problems were the highest bridging symptom between PTSD and depression. Finally, 114 (11.5%) of the participants met the symptoms of depression and 248 (25%) of the participants met the symptoms of PTSD, while 294 (29.6%) of the participants showed comorbidity.

In the second study, peritraumatic reactions such as peritraumatic dissociation, peritraumatic stress, tonic immobility and mental defeat and their relationships with PTSD and depression were analysed. As a result of the analysis, it is seen that all four peritraumatic reactions are effective in the development of both PTSD and depression. Moreover, peritraumatic dissociation was found to be a stronger predictor than other peritraumatic reactions.

Post-Earthquake Experience of the Department of Psychiatry at Mersin University

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On February 6, 2023, earthquakes with magnitudes of 7.7 and 7.6 struck Kahramanmaraş, causing significant loss of life and devastation, particularly in Kahramanmaraş and Hatay, as well as in Adıyaman, Gaziantep, Malatya, Kilis, Diyarbakır, Adana, Osmaniye, Şanlıurfa, and Elazığ. According to AFAD (Disaster and Emergency Management Authority) data, approximately 14 million people were affected across these 11 provinces, with an additional nearly 2 million migrants residing in the region (1). According to official sources, it was reported that there were over fifty thousand casualties and close to forty thousand buildings collapsed. Subsequently, the demolition of severely damaged buildings was carried out in the following period.

The lack of observed destructive effects of the earthquake in Mersin, coupled with its proximity to the 11 affected provinces, has led to a significant influx of migration from the earthquake-stricken area to Mersin. The devastation caused by earthquakes affecting such a vast geography and population, along with the resulting loss, the loss of a secure environment, disrupted social order, forced migrations, disruptions in social relationships, and sudden changes in daily routines such as housing, employment, and education, can have adverse effects on individuals' mental health (2).

After the earthquake, medical and surgical interventions for the injured individuals from the region were initiated at the Mersin University Faculty of Medicine Hospital. Additionally, arrangements were made in our department to provide mental health services for those coming from the earthquake-stricken area to our province, whether they were receiving inpatient care or staying in temporary shelters or homes. To achieve this goal, as of February 10, 2023, daily psychosocial support sessions were started for patients affected by the earthquake and receiving inpatient treatment in our hospital's internal medicine and surgical units. During these sessions, individuals' needs were addressed as a priority, continuity of past treatments was ensured, and urgent intervention needs were identified. Whenever possible, the same physician followed up with the same patient until discharge. A total of 1031 sessions were conducted, including initial assessments and daily visits until discharge, for 199 inpatient individuals.

On February 13, 2023, the Trauma and Disaster Outpatient Clinic was established for individuals from the 11 affected provinces who sought mental health services on an outpatient basis and could visit without an appointment. Since that date, a total of 571 individuals have been provided with outpatient clinic services. A total of 982 sessions were conducted, including initial examinations and follow-up appointments.

During the assessment of individuals applying to our Trauma and Disaster Outpatient Clinic, a rotating work schedule was implemented to ensure the preservation of the mental health of the attending physicians. Weekly sessions of emotion and experience sharing, as well as supervision sessions, were conducted within the department.

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After the Earthquake: Inter Agency Cooperation

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Situations such as disasters, wars, and terrorist attacks, where losses reach thousands or even millions, cause psychological distress on large groups of people who are directly or indirectly affected. Although the mental health and psychosocial problems are not considered at the forefront in the acute period, interventions during this period will be preventive and restorative on long-term mental health and psychosocial well-being (IASC 2007). In order to achieve this goal, especially in mass traumas caused by human hands that cause multiple losses, all public institutions and organizations, non-governmental organizations and international humanitarian organizations must act in coordination. Since there is no structure that provides effective coordination, sharing local cooperation experiences to eliminate these deficiencies will ensure development in the field of psychosocial support in the field and increase and strengthen scientific data. Effective psychosocial support after mass trauma should ensure that the affected individuals' damaged sense of self-worth and justice are repaired and the sense of belonging of being a part of humanity is regained. For this reason, when planning services, it is very important to consider special groups such as women, children, minorities, individuals with special needs and LGBTI+ people, and to prevent secondary traumatization (Pfefferbaum & Shaw 2013). After the February 6 Kahramanmaraş and Hatay earthquakes, there was a rapid and large migration to Mersin because it was easily accessible and was protected from the devastating effects of the earthquake. Due to the social ties between the two cities, among those who migrated were those who lived with their relatives or rented a house with their own means, as well as those who did not have a place to settle. In the early period, there were around 150 temporary settlement units in Mersin, some of which were placed by government institutions, some of which were established by the municipality and some of them were created by large and small associations on their own initiative. In the report submitted by the Mersin Chamber of Medicine, it was seen that psychosocial support services were provided in only half of these units, and that no support service was provided for those who settled in homes (Yapıcı 2023). While many non-governmental organizations offer voluntary psychosocial support, the fact that some of those affected by the earthquake have access repeatedly but intermittently, while others have not been able to access it at all, emphasizes the importance of organizing this support and distributing its power effectively.

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Definition and Biological, Psychological, Social Determinants of Impulsivity

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Definition

Impulsivity is generally defined as actions that are expressed prematurely, risky, or inappropriate to the situation and are not adequately designed. It is a multidimensional concept that includes cognitive, emotional, and behavioral components. Impulsivity can be classified as trait-state and functional-dysfunctional. Impulsivity affects various domains, including human behavior, decision-making processes, mental health, interpersonal relationships, academic and occupational success, and physical health. Impulsivity is a concept that consists of more than one dimension, but it has yet to be clearly defined. Understanding the mechanisms underlying impulsivity will assist in comprehending this complex concept and elucidating its relationship with human behavior and many mental disorders.

Biological Determinants

Studies on the neural structures underlying impulsivity support the central role of the prefrontal cortex and the interaction between the hippocampus and striatum in impulsivity. Genetic predispositions and environmental factors interact to shape impulsive behaviors. Twin and family studies and candidate gene studies have proven effective in elucidating the genetic contribution to impulsivity. Monozygotic twins showed higher concordance rates for impulsivity. Candidate gene studies have shown that some genetic variations in genes involved in neurotransmitter systems, such as dopamine, serotonin, and noradrenaline, are associated with impulsivity. Due to the complex nature of impulsivity and the involvement of many genes with minor effects, findings from candidate gene studies are often mixed. Serotonin, dopamine, noradrenaline, glutamate-GABA, and cannabinoids are neurotransmitters associated with impulsivity, but serotonin and dopamine are the neurotransmitter systems with the most data on their association with impulsivity.

Psychological Determinants

Impulsivity is associated with various emotional, behavioral, and cognitive factors. Individuals with high levels of impulsivity are more likely to engage in risky behaviors, have difficulty managing their emotions, and are more prone to behavioral addictions. Some emotional factors, such as negative affect and emotion regulation difficulties, have been associated with increased impulsivity. Cognitive models suggest that various cognitive factors, including poor impulse control, impaired decision-making, and biased information processing, cause impulsivity. Furthermore, impulsivity is associated with many personality traits, such as extraversion and novelty seeking, and impulsivity is observed in many mental disorders, such as attention deficit hyperactivity disorder, substance use disorders, personality disorders, and mania.

Social Determinants

Impulsivity is not only a result of personality traits, biological factors, or cognitive processes. Instead, external social factors heavily influence the way individuals live and interact. Various socioeconomic factors such as education level, employment, family dynamics, family environment-related variables such as parenting styles and upbringing, cultural factors, social support, childhood traumas, early traumatic experiences such as exposure to physical violence, and high levels of chronic stress are associated with impulsivity. Impulsivity can affect an individual’s relationships, interactions, and overall functioning. Increased impulsivity leads to relationship and communication difficulties, susceptibility to risky behaviors, inability to pursue long-term goals and low academic development.

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Lifetime Patterns of Impulsivity

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Impulsivity is the tendency of individuals to make split-second decisions and to act quickly. It is related to both developmental periods and psychopathologies. Impulsivity, which emerges as a developmental stage in childhood, becomes a trait that needs to be controlled over time. However, impulsivity continues to manifest itself in various forms later in life.

Childhood and Adolescence
In childhood, impulsivity often manifests as a desire to explore and learn. However, when uncontrolled, it can lead to conditions such as attention deficit hyperactivity disorder (ADHD). In adolescence, it is associated with increased risk-taking behaviors and social maladjustment. In adolescence, impulsivity begins to be balanced by the development of self-control and decision-making skills.

Adulthood
Impulsivity is an essential factor in social and professional interactions. Impulsive decisions in work and relationships can negatively affect quality of life and success. Impulsivity is also strongly associated with psychiatric disorders such as borderline personality disorder and bipolar disorder in adulthood.

Elderly
Although impulsivity is observed to decrease with age, neurological diseases such as dementia and Parkinson›s disease can lead to an increase in impulsive behaviors. Impulsive behaviors can make activities of daily living and social interactions more difficult.

Treatment and Management
The management and treatment of impulsivity varies depending on the individual›s life stage and the underlying causes of impulsivity. Educational and behavioral therapies are recommended in childhood and adolescence, while psychotherapy and, if necessary, pharmacological treatments are recommended in adults. In the elderly, management of the neurological conditions that trigger impulsivity comes to the forefront. Individual differences, environmental effects, and biological factors play an important role in impulsivity, a lifelong condition. With appropriate interventions in each period, the negative effects of impulsivity can be reduced, and the quality of life of individuals can be improved.

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Looking At Impulse And Impulsivity From The Downside; The Bottoms

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Abstract
Efforts to define and classify impulses and impulse control require a definition of impulse. The use of the title "Impulse Control Disorders Not Elsewhere Classified" in the DSM-IV classification without a distinct category of Impulse Control Disorders reflects this uncertainty. In DSM-5, the classification of disorders related to impulses has been changed and it is seen that they are handled under the heading of "Disruptive, Impulse Control and Conduct Disorders". Under this heading, harmful actions due to individuals' inability to control, regulate and direct their own actions are examined.

Impulse control disorders and impulsivity have been historically known for a long time and have often come to the fore with their criminal aspects. Impulse and impulsivity, which includes motoric, emotional and cognitive components, will be examined in this presentation from the perspective of vegetative functions, which are vital functions of the nervous system.

Paul Mac Lean's work on the limbic system led him to develop the concept of the "Triune Brain" and proposed that mammalian brains have three layers with different functions;

1. Protoreptilian Brain: This layer contains ganglionic structures found in many different species from reptiles to mammals. These structures have the task of regulating daily behavioral routines. This layer is vital functions of an autonomous nature that control basic survival functions.

2. Paleomammalian Brain: Overlapping with the limbic system, this layer plays an important role in regulating traits common to mammals. These traits include maternal behavior, vocal communication and play. It forms the basis of mammalian social and emotional behavior.

3. Neomammalian Brain: This includes the neocortex and the thalamus, which are connected to these structures. This brain layer is the most developed brain layer of mammals and makes up a large part of the human brain. It allows us to interact with the outside world and supports complex thought processes. It also houses the ability for language, which helps people express their emotional states.1

Since the definition and classification of impulse and impulsivity-related disorders is mainly done at the sociocultural level, we think that the Triune brain concept, especially the role it assigns to vital and vegetative functions, will be useful in understanding the nature of impulse disorders.

It is clear that impulsivity has a complex relationship with vegetative symptoms and that it is important to understand this relationship at psychological, neurological and physiological levels. In particular, in cases of increased impulsivity, activation of the sympathetic nervous system is increased. Understanding this complex interaction between impulsivity and vegetative symptoms may contribute to a better understanding of psychophysiological mechanisms and clinical applications.

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Forensic Aspects of Impulsivity

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Impulsivity refers to the tendency to react rapidly and without requiring much thought to internal or external stimuli. This tendency is associated with ignoring the negative consequences of one's actions for oneself or others and reflects a complex and multifaceted psychological structure influenced by multiple factors. Impulsivity is closely linked to psychological characteristics such as impatience, inattention, easy risk-taking, excitement and pleasure-seeking, low consideration of the probability of harm, and extraversion, leading to the emergence of behaviors that are inappropriate or excessively risky, immature, rapid, poorly planned, and often result in unwanted outcomes.

Impulsivity has been consistently associated with antisocial behavior and other negative outcomes. In this context, impulsivity may underlie socially disapproved or even criminal behaviors such as risky sexual behavior, substance use, and gambling, and may be a core dimension of many psychiatric disorders (e.g., schizophrenia, bipolar disorder) or associated with violence, criminal behavior, or legal capacity. It is a core feature of antisocial and borderline personality disorders and is the main cause of easy risk-taking behavior and a risky lifestyle in these personality disorders, reflecting a lack of resistance to impulses, instincts, or seduction to perform an action that could be harmful to oneself or others. Impulsivity is an important risk factor that has found its place in different risk assessments in forensic psychiatry practice. However, it is not clear how different dimensions of impulsivity are related to various psychopathology problems in forensic populations, and it is evident that more studies are needed on this subject. In this regard, there is a need to clarify the relationship between different impulsivity dimensions and common psychopathological dimensions in forensic populations and possible predictive validity. Future research should focus on the possible relationships between impulsivity dimensions and the risk of criminal behavior, as impulsivity is associated with high and stable levels of criminal behavior.

Comprehensive impulsivity models can be used to create individual risk profiles for risk assessment and management for use in assessment inventories in forensic psychiatry. During forensic psychiatric assessment, the impact of cognitive functions and thought disorders on behavior should also be considered. Depending on the subject for which a report is requested in forensic psychiatric care, evaluations should be made and expert reports should be prepared in accordance with the relevant legislation. In patients who have committed a crime and are in mandatory treatment, if impulsivity is part of a serious mental illness or comorbid personality disorder, it should be carefully considered by the clinician in terms of reoffending.

In this lecture, impulsivity will be discussed in terms of its forensic aspects, highlighting its importance in both criminal law due to its relationship with violence and criminal behavior, and civil law due to its impact on individuals' and their environment's lives through risky behaviors. The presentation will focus on the forensic aspects, emphasizing the importance of impulsivity in expert witness assessments and treatment.

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Neurobiological Studies in Bipolar Disorder

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This presentation explores recent advancements in the neurobiology of bipolar disorder (BD), a complex mood disorder affecting millions worldwide. A thorough examination of the latest research sheds light on the intricate mechanisms underlying BD, paving the way for improved diagnostics and therapeutic strategies. A key focus is the integration of biomarker data with patient-reported information, which holds promise for enhancing diagnostic accuracy in bipolar disorder. This approach offers a more precise means of distinguishing BD from other mood disorders, such as major depressive disorder, particularly during depressive episodes. Additionally, research into reward-related abnormalities in the brains of individuals with BD and their unaffected relatives has uncovered potential endophenotypes. These deviations in brain function, particularly in reward processing, may serve as early indicators of BD risk and could be utilized in future diagnostics. Another important area of study is oxidative stress-generated nucleoside damage, which appears to be a trait phenomenon associated with familial risk for bipolar disorder. Elevated levels of oxidative stress in BD patients and their relatives suggest potential links to cardiovascular diseases, highlighting the importance of early diagnosis and intervention (Coello et al. 2024). Recent findings also suggest a connection between infections, particularly those related to inflammation, and the onset and course of psychiatric conditions, including bipolar disorder (Zheng et al. 2023). This emerging area of research opens avenues for exploring the impact of infections on BD and potential therapeutic targets. In animal models, researchers have identified common molecular pathway alterations related to synaptic structures in cases of schizophrenia and bipolar disorder (Aryal et al. 2023). These findings provide valuable insights into the shared pathophysiology of these disorders and may inform the development of targeted treatments. Overall, the studies highlighted in this presentation offer a multifaceted understanding of the neurobiology of bipolar disorder. By investigating biomarkers, endophenotypes, oxidative stress, infections, and molecular pathway changes, researchers are paving the way for more precise diagnostic tools and personalized treatment options. This ongoing research holds great promise for improving outcomes for individuals with bipolar disorder and their families.

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Genetic Studies in Bipolar Disorder

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Mood disorders(MD) are common serious health problems worldwide that significantly impact individuals' quality of life. In recent years, studies have helped us better understand the impact of genetic factors on the pathogenesis of MD. This speech will discuss the importance of genetics in this disease and scientific findings by addressing important genetic studies of the past year in MD. A meta-analysis of a genome-wide association study covering a dataset of >1.3 million individuals, including 371,184 individuals with depression, identified 243 risk loci, with 64 loci being new, pointing to genes encoding glutamate and GABA receptors, targets of antidepressant drugs.Last year, genetic mechanisms of cardiovascular diseases, the most common cause of mortality and morbidity in MD, were extensively investigated. Common genetic factors between the two diseases have been emphasized. Additionally, pathway enrichment studies have highlighted immun dysfunction.

A transcriptome study comparing the degree and magnitude of changes in immune-related genes directly within psychiatric disorders, particularly focusing on bipolar disorder, aimed to elucidate the immunity-related pathophysiology of psychiatric disorders. Understanding the genetic basis of MD is critical for developing new approaches to their treatment and prevention. Advances in genetic research allow us to better understand the biological mechanisms of MD and offer more effective treatments to patients. Therefore, there needs to be a greater focus on research in this area and integrating findings into clinical practice.

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Important Research of the Past Year in the Field of Mood Disorders: Studies on Treatment Options in Bipolar Disorder

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Bipolar disorders (BD) are a spectrum of disorders that affect more than 4% of the population, characterized by recurrent mood episodes that can negatively impact functioning and lead to disability. Although manic/hypomanic episodes are necessary for a bipolar disorder diagnosis, depressive symptoms, and major depressive episodes often dominate the disorder's clinical course. Furthermore, there are limited effective treatments available for major depressive episodes, and the first-line treatments of mood episodes recommended by guidelines are often not well-tolerated, resulting in numerous side effects. These factors make treating BD particularly challenging. To address this need, new and effective therapies for BD have been developed in recent years, particularly for the treatment of major depressive episodes. Some of these treatments, such as esketamine for treatment-resistant depression with suicidal ideation, cariprazine for depression with mixed symptoms, brexanolone and zuranolone for postpartum depression, and lumataperone for major depressive episodes in BD-I and BD-II, have been proven effective.

This presentation aimed to review emerging or over-the-horizon therapies for treating BD. Published in 2023 and the first period of 2024, systematic reviews and meta-analyses related to BD treatments, the efficacy of new antipsychotic agents such as lumateperone, olanzapine/samidorphan, and aripiprazole 2-month long-acting injectable in BD treatments, duration of use of antidepressant add-on treatments in bipolar depression, cannabidiol add-on strategies in bipolar depression, the effect of age on the anti-suicidal efficacy of lithium, the effectiveness of esketamine in treatment-resistant bipolar depression, the effectiveness of psilocybin-assisted psychotherapy in treatment-resistant bipolar depression, the role of anti-inflammatory agents in the adjunctive treatment of bipolar mania and bipolar depression and many other issues related to the treatment of BD will be discussed.

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A New Diagnosis in ICD-11: Complex Posttraumatic Stress Disorder
Historical background and clinical features of complex PTSD

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The psychological impacts of trauma were initially documented following World War II, but the formal recognition of post-traumatic stress disorder (PTSD) was introduced in DSM-III based on research conducted with Vietnam veterans throughout the 1970s. According to DSM-5, trauma is described as the direct personal experience of a distressing event, observing distressing events happening to others, receiving information about a distressing event happening to a family member, or being repeatedly exposed to distressing aspects of the incident in an intense or recurring manner. According to Çoban and Gündoğmuş, the DSM-5 reclassified PTSD from being categorized as an anxiety disorder to being categorized as a trauma and stressor-related disorder (Çoban and Gündoğmuş 2019). PTSD primarily refers to a circumscribed psychological condition that arises following a singular or particular traumatic incident. It has been reported that the psychopathology and symptoms that occur as a result of various chronic and recurrent traumatic events are much more complex. Judith Herman (1992) was the first to propose the definition of complex trauma. Herman discussed the enduring adverse effects of persistent stress on an individual's emotional regulation, self-regulation, self-perception, and interpersonal functioning, referring to it as 'complex trauma'. Complex trauma, previously not included in the DSM system, has gained attention as a newly recognized diagnosis called complex post-traumatic stress disorder (CPTSD) in the ICD-11 categorization system. CPTSD is believed to be linked to enduring, recurrent, or multiple instances of traumatic exposure, such as genocidal campaigns, childhood sexual abuse, child military service, severe domestic violence, torture, or enslavement. Research has indicated that risk factors for CPTSD include a past experience of childhood sexual abuse, negative thought patterns connected to trauma, low tolerance for stress, and being unemployed. Moreover, CPTSD has a greater risk than PTSD in relation to depression, anxiety, borderline personality disorder, and suicide. Generally, CPTSD is considered to be a more severe and detrimental condition, which is more likely to develop as a consequence of prolonged and enduring traumatic experiences. Evidence from the developmental and attachment literature suggests that chronic forms of trauma during childhood, particularly sexual and physical abuse by caregivers, may be strong risk factors for negative outcomes in later life due to the substantial adverse effects they have on the healthy development of socioemotional competencies and a coherent and positive sense of self (Cloitre et al.). It is crucial to raise awareness about CPTSD, a recently recognized diagnosis, in order to thoroughly investigate the variables that contribute to its development, distinguish it from other similar conditions, and understand the most effective approaches for treatment. This lecture will provide an overview of the literature about the historical evolution and clinical aspects of CPTSD.

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Diagnosis and Treatment Differences of Complex Post-Traumatic Stress Disorder

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Complex Traumatic Stress Disorder (CTSD) has emerged as a prominent term in the field of mental health in recent years, defined as a distinct clinical phenomenon separate from Post-Traumatic Stress Disorder (PTSD). CTSD typically arises as a result of chronic and ongoing traumatic experiences, often associated with traumatic experiences beginning in childhood and persisting over time. In this context, it is anticipated that exposure to various and continuous traumatic events throughout one's life increases the risk of CTSD more than the risk of PTSD. Additionally, CTSD has been associated with additional psychopathological symptoms such as depression, anxiety, personality disorders, addictions, and risk of suicide. However, a significant distinction exists in that while CTSD is included in the ICD-11 diagnostic framework, it is not recognized in the DSM-5.

Distinct features of CTSD that differentiate it from PTSD notably include the observation of prolonged and chronic trauma exposure within interpersonal relationships. Furthermore, the symptomatology of CTSD extends beyond the symptoms observed in PTSD, encompassing a complex structure; in addition to core PTSD symptoms such as re-experiencing, avoidance, and hyperarousal, CTSD may also present with additional symptoms such as impaired self-esteem, emotion dysregulation, interpersonal relationship problems, and an intense sense of shame or guilt. However, the absence of a separate classification for CTSD in the DSM-5 complicates the diagnostic process.

Treatment for CTSD typically involves the integration of various therapeutic interventions including trauma-focused therapies, stabilization and safety-building interventions, addressing attachment and relationships, and complementary holistic approaches. Additionally, pharmacological treatments targeting symptoms are also an integral part of the treatment approach.
In conclusion, CTSD emerges as an intriguing and complex phenomenon in the field of mental health. Understanding the challenges and complexities associated with CTSD will be important for mental health professionals and researchers alike. Efforts to clarify diagnostic criteria, develop treatment approaches, and raise awareness of CTSD are critical in improving the quality of life for individuals exposed to prolonged and intense trauma. This discussion aims to delve into CTSD in depth and identify the needs of individuals associated with CTSD.

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Conceptual Framework and Long-Term Consequences of Developmental Trauma

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The inclusion of posttraumatic stress disorder (PTSD) in diagnostic systems is a significant milestone, as it establishes a clear connection between traumatic experiences and mental disorders. However, diagnosing PTSD in children and adolescents can still be challenging because the diagnostic criteria are based on the symptoms in adults, and these symptoms require a verbal description by the patients. Moreover, traumatic experiences in childhood, such as maltreatment, sexual abuse, and neglect, may not fulfill the 'strict' diagnostic criteria of PTSD [1].

Traumatic experiences in childhood often occur in close environments and can be complex. Recent research has demonstrated individuals who experienced chronic interpersonal trauma as children are affected differently from those who experienced an assault, disaster, or accident during adulthood. Apart from classic symptoms of PTSD, childhood experiences of interpersonal violence in the context of inadequate caregiving systems may result in heterogeneous symptoms, including somatization, negative self-image, and disturbances in emotional regulation [2]. Moreover, due to these experiences, children may receive different diagnoses, such as attention deficit hyperactivity disorder, conduct disorder, separation anxiety, and phobia [3]. Overall, empirical evidence exhibited that the current diagnostic system is not adequate for many traumatized children receiving psychiatric care; thus, a need has emerged for a novel diagnosis that can capture the clinical presentations of children exposed to chronic interpersonal trauma.

Developmental trauma disorder is a childhood syndrome that is formulated to complement and extend the diagnosis of PTSD. It is characterized by a set of symptoms that include emotional/somatic, cognitive/behavioral, and self/relational dysregulation. These symptoms are documented sequelae of traumatic interpersonal victimization and disrupted attachment bonding with primary caregivers [3].

The purpose of this presentation is to elaborate on the definition of developmental trauma and raise awareness regarding its long-term consequences.

Keywords: childhood, complex trauma, developmental trauma disorder, posttraumatic stress disorder, PTSD

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Difficulties Encountered in the Outpatient Clinic for Schizophrenia Cases

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Schizophrenia is a disorder characterized by significant impairments in thoughts, emotions, behaviors, mental abilities, self-perception and functionality. It is more likely that the patient's symptoms will disappear with appropriate treatment used regularly during the first attack. However, treatment resistance is approximately 30%, with a best optimistic word, in patients with schizophrenia. While the response rate to clozapine for symptoms that do not respond to at least two antipsychotics used in the right dosage for the appropriate period of time varies between 30-60%, the probability of responding to a third antipsychotic other than clozapine is less than 10% (APA Guideline 2021).

An accurate evaluation becomes our most valuable guide in the process of addressing positive symptoms in schizophrenia patients who apply to the outpatient clinic. During a complete psychological examination, a comprehensive anamnesis completed with information from his/her relatives, includes information about the age and nature of first symptoms and first episode, triggers and social factors which cause psychological strain, family dynamics, accompanying physical symptoms, medical diseases, physical and neurological examination findings, laboratory findings. Previous treatments, side events, outcomes, compliance and periods without medication should be bring into light.

Other reminders that can help you carry out this process in the best way: being aware of the concept of treatment resistance as a separate entity, making the diagnosis early, evaluating the dopamine hypersensitivity associated with the increase in D2R number or affinity caused by previous treatments, simplifying the treatment and also actively using the evidence pyramid in clinical practice.

One of the spontaneous consequences of treatment unresponsiveness in clinical practice during the treatment of schizophrenia is polypharmacy. Therefore, in this presentation, the concepts of add on/augmentation therapy, and the evaluation of differences between multiple drug use and polypharmacy in terms of effects, side effects, risk of treatment resistance, and medical side effects will be discussed.

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Difficulties Encountered in the Outpatient Clinic for Schizophrenia Cases

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Primary negative symptoms are very resistant to treatment and closely related to functional outcome. A person may simultaneously have deficit symptoms and be quite psychotic, or have deficit symptoms in the absence of positive symptoms (Fischer BA and Buchanon 2024). Negative symptom severity in schizophrenia has been consistently linked to worse functional outcomes in areas such as impaired occupational and academic performance, household integration, social functioning, participation in activities, and quality of life. Clinicians should be mindful that up to 60% of patients with schizophrenia have prominent or predominant negative symptoms that are clinically relevant and need treatment (Correl ve Schooler 2020). To date no agent is approved for the treatment of negative symptoms.

Several neurocognitive deficits apear such as attention, speed of processing, verbal and visual memory, working memory, executive functions, emotion processing and social perception in schizophrenia. Like negative symptoms, cognitive symptoms are important symptom cluster that determines functionality for patients. Cognitive symptom cluster still remains a major therapeutic challenge and no comprehensive treatment guidelines for cognitive impairment in schizophrenia are implemented (Vita and Gaebel 2022).

In this meeting, what can be done to cope with negative and cognitive symptoms in the outpatient clinic, especially practical psychosocial interventions will be discussed within the framework of questions from the audience.

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Treatment-Resistant Obsessive-Compulsive Disorder

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Obsessive-Compulsive Disorder (OCD) is a condition affecting approximately 2-3% of individuals worldwide, characterized by distressing and repetitive thoughts (obsessions) and behaviors (compulsions) leading to functional impairment (Kessler et al., 2005). OCD can be effectively treated with serotonergic antidepressants and cognitive-behavioral therapy (CBT). Selective serotonin reuptake inhibitors (SSRIs) and serotonin reuptake inhibitors (SRIs) are considered first-line pharmacological agents in OCD treatment. Generally, SSRIs and clomipramine as an SRI provide significant improvement in 40-60% of OCD patients. However, treatment resistance is common in OCD cases. It has been noted that 40-60% of OCD patients do not respond to typical SSRI/SRI treatments or do not respond as quickly as required. Treatment resistance in OCD should be considered when there is inadequate or partial clinical response or non-response to pharmacotherapeutic agents from three different SSRI groups, one of which is clomipramine, at the optimal dose and duration of use (Kutlu Cansever H & Devrimci Özgüven H, 2022).

When faced with treatment-resistant OCD, the first priority should be to review the patient's OCD diagnosis. The presence of possible psychiatric comorbidities should be investigated. Secondly, the patient's treatment should be reviewed. Ensure that first-line treatments are used for an adequate duration and at an appropriate dose, and that treatment adherence is adequate. Treatment dose and trial duration should be optimized. If no result is achieved with these measures, switching to a different agent (such as another SSRI or SNRI), followed by augmentation with other medications (adding antipsychotic agents, amisulpride, aripiprazole, clonazepam, buspirone, lithium, pindolol, clomipramine, trazodone, mirtazapine, tryptophan, D-cycloserine, topiramate, memantine, N-acetylcysteine, nicotine, riluzole) should be considered. Monoamine oxidase inhibitors, clonazepam, buspirone, venlafaxine, atypical antipsychotics, aripiprazole, carbamazepine, duloxetine can be considered as alternative monotherapy. Intravenous SSRI applications hold promise. Research has been conducted on experimental drug treatments such as D-amphetamine, thyroid hormones, oxytocin, antiandrogens, aminoglutethimide, Hypericum perforatum, inositol, gabapentin, oral morphine, naltrexone, sumatriptan. Biological treatment approaches such as electroconvulsive therapy, sleep deprivation, light therapy, surgical interventions, transcranial magnetic stimulation, and deep brain stimulation can be considered (Songur, 2008).

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Comorbidity of OCD and Schizophrenia Spectrum Disorders

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Obsessive Compulsive Disorder (OCD) and schizophrenia are among the oldest known psychiatric disorders. These two disorders are significantly different from each other in terms of their underlying brain mechanisms, clinical presentation, and treatment. However, some demographic, clinical features and pathophysiological bases of both disorders are common. Both begin in adolescence and early adulthood, have similar distribution between the sexes, and show earlier age of onset in male patients. In patients diagnosed with OCD and schizophrenia, it has been shown that structural and functional brain anomalies are similar according to brain imaging studies and neurophysiological studies, and there is a significant overlap in the pathophysiology of these diseases in terms of the relationship of neurotransmitter systems. The prevalence of schizophrenia is 1% and the prevalence of OCD is 2-3% in the general population. Obsessive-compulsive symptoms and OCD comorbidity are higher in schizophrenia than the coincidence of these two disorders.

Clinical experience shows that OCD and schizophrenia can be seen together or follow each other. While it has been suggested that some patients with chronic obsessive symptoms actually have schizophrenia, other researchers have reported that OCD can occur before schizophrenia. While obsessional perseveration or compulsive phenomena can be seen in the prodromal period of schizophrenia, OCD symptoms can also occur at different stages of the schizophrenia process.

Researchers have approached the relationship between OCD and psychosis from two directions. The first is the examination of obsessive-compulsive symptoms in patients with psychotic disorders, and the second is the examination of psychotic symptoms in patients primarily diagnosed with OCD1.

When we look at the treatment approaches, Cognitive Behavioral Therapy (CBT) and Selective Serotonin Reuptake Inhibitors (SSRI) or clomipramine together are the most effective and well-established treatment strategies for adult OCD. SSRI's and clomipramine have similar effects, but SSRI's are better tolerated due to side effects. In OCD, 40-60% of patients are resistant to treatment2.

It has been shown that treatment-resistant OCD patients have high rates of personality disorders, especially schizotypal personality traits. The combination of low doses of antipsychotics such as olanzapine with SSRIs has been reported as an effective treatment strategy in patients with schizotypal personality disorder and OCD coexistence.

Although there are very few studies, the combination of antipsychotics with anti-obsessive drugs is probably the best treatment option for the comorbid schizo-obsessive group.

Many researchers have reported that second-generation antipsychotics, especially clozapine, induce obsessive-compulsive symptoms (OCS) in schizo-obsessive patients. In addition, it has been shown that they can cause the emergence of new (de novo) OCS that did not exist before. In the literature, it has been reported that 70% of OCS induced by antipsychotics are related to drugs with strong anti-serotonergic effects such as clozapine, olanzapine and risperidone. This situation limits the use of 2nd generation antipsychotics in schizo-obsessive patients3.

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Obsessive–Compulsive Disorder Comorbid With Bipolar Disorder

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Obsessive-compulsive disorder (OCD) is a disabling disorder known to be highly comorbid with mood, anxiety, and other disorders. Comorbidity with other psychiatric disorders increases functional impairment, while comorbidity with bipolar disorder (BD) is thought to be particularly disabling and difficult to treat.

In population-based surveys, the lifetime prevalence of OCD with a diagnosis of BD ranges from 11% to 21% (Marikangas et al. 2007). Because symptoms may be hidden during depressive and manic episodes, studies of euthymic BD patients report up to 40%. This high rate of association has been interpreted as these two disorders being subtypes of each other or being predisposed to each other. There are theories suggesting that this cyclical pattern may be associated with bipolar disorder in cases of so-called "episodic OCD," in which symptoms suddenly appear and then disappear, similar to mood episodes. The co-occurrence of OCD and BD alters the unique clinical presentation of each disorder. This has important implications for treatment response. In a recent meta-analysis, it's shown that patients co-diagnosed with OCD-BD showed significantly fewer contamination obsessions and more sexual obsessions than those diagnosed with OCD without BD in (De Prisco et al. 2024). More frequent suicidal ideation and suicide attempts, persistent functional impairment during periods of euthymia, more frequent hospitalizations, and a poorer response to treatment were found in patients co-diagnosed with BD-OCD than in those diagnosed with BD without OCD. In depressive episodes, confounding obsessive symptoms with depressive rumination and interpreting compulsive behaviours as increased goal-directed action may lead to diagnostic difficulties. In cases of co-diagnosis, it is assumed that the BD usually began earlier and the OCD symptoms were added later, and that the OCD symptoms are particularly severe during depressive episodes and less severe during manic/hypomanic episodes, and that the priority of treatment should focus on the prevention of mood episodes rather than on the OCD symptoms. The diagnosis of comorbid bipolar disorder should be considered, especially in treatment-resistant OCD patients.

The main goal of treating comorbid BD and OCD is to stabilize mood episodes of BD firstly and then control OCD symptoms without inducing manic shifts and cycle acceleration. Treating these conditions in a comorbid setting is challenging because serotonin reuptake inhibitors (SSRI), the first-line treatment for OCD, may worsen BD symptoms, and mood stabilizers are generally not effective for OCD. In appropriate patients, SSRIs or atypical antipsychotics (AAP) may be added to the treatment regimen with caution. In addition to their efficacy in treatment-resistant OCD, AAPs have also been shown to have mood-stabilizing effects, making them the first choice in the comorbidity of OCD and BD. If treatment with an AAPs is preferred, quetiapine, risperidone, and aripiprazole can be used, as there are positive reports with these medications (Amerio et al. 2019). First-generation antipsychotics such as haloperidol and pimozide are not preferred in patients with BD because of the vulnerability to extrapyramidal symptoms and the possible depressive effects of these drugs on mood.

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Hypomania in Ten Questions

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Bipolar disorder is a chronic illness characterized by episodes of illness and wellness, leading to significant impairment in quality of life and functioning, affecting about 2-3% of the population, with an estimated 1.5 million people in our country believed to have bipolar disorder. One of the major factors delaying diagnosis is the oversight of hypomanic episodes. Hypomania, as part of the bipolar disorder spectrum, falls into the same category as mania. However, the symptoms of hypomania are milder and less pronounced than those of mania, and patients may be satisfied with this period, with no significant impairment in functioning, which reduces their mention of these periods. Additionally, due to the lack of specific biological markers for the disease, the time from onset to diagnosis can be up to 10 years. Distinguishing hypomania from symptoms of adolescence can sometimes be challenging because adolescence is already a period of frequent emotional fluctuations and mood changes. However, there are some differences between symptoms of adolescence and hypomania.

The distinction between personality traits and hypomania generally relates to the severity and duration of symptoms. Hypomania is characterized by distinct mood changes, increased energy levels, decreased need for sleep, increased rate of speech, and increased rate of thought, and these symptoms must persist for at least 4 days. Personality traits, on the other hand, are more stable and generally follow a certain pattern. The validity and specificity of hypomania depend on diagnostic criteria and the severity of symptoms. When correctly diagnosed and evaluated, hypomania is considered to represent a specific condition. The diagnostic stability of hypomania is generally good when a correct evaluation is conducted. However, distinguishing between hypomania and symptoms of adolescence can sometimes be complex and can affect diagnostic stability. Antidepressants can trigger hypomania and may need to be considered as part of bipolar disorder. Antidepressants can trigger mania or hypomania in individuals with bipolar disorder, emphasizing the importance of accurate diagnosis and appropriate treatment. The neurobiology of hypomania is similar to that of mania, but the symptoms are milder. Changes in brain chemistry, genetic factors, and environmental influences play a role in the development of hypomania. Screening scales for hypomania can be used to detect and evaluate symptoms. However, relying solely on a scale's results for a definitive diagnosis may not be accurate. A comprehensive clinical assessment is often required. Hypomania can impair psychosocial and cognitive functioning. Symptoms can lead to difficulties in work and social relationships and negatively impact quality of life. Treating hypomania is similar to treating mania, but milder treatment methods are generally used due to the less severe symptoms. Treatment should be tailored to the severity and frequency of symptoms and the individual needs of the patient.

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Discrimination against Migrants and Refugees: Life Between Borders

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Migration has been one of the most significant events affecting society throughout human history. People have migrated to new settlement areas for various reasons, and this process not only impacts the migrants themselves but also transforms both the migrating individuals and the societies that accept them.

According to the 2022 Migration Report by the International Organization for Migration (IOM), the number of international migrants worldwide is continuously increasing, and these figures are expected to rise further due to armed conflicts, political pressure, and environmental changes. Turkey has hosted the world's largest refugee population for nine consecutive years, with nearly 4 million refugees and asylum seekers under international protection.

It has long been known that migration, even when voluntary and driven by socioeconomic reasons, increases the prevalence of mental illnesses. However, unlike those who migrate by choice for better living conditions, refugees exhibit significantly higher rates of mental health problems. Factors related to refugee mental health are examined in three main stages of the migration process: pre-migration, migration, and post-migration phases. It is known that traumatic events experienced before migration negatively affect physical and mental health. Historically, research has primarily focused on pre-migration and trauma-related risk factors and their impact on refugees' mental health. However, in recent years, the focus has shifted towards the effects of post-migration challenges faced by refugees in host countries on their mental health.

Migrants, many of whom become ethnic minorities in their new countries, often face perceived discrimination, which is associated with anxiety, depression, and post-traumatic stress disorder (PTSD). Studies show that even after controlling for pre-migration and other post-migration factors, perceived discrimination remains strongly linked to depressive symptoms among refugees.

Discrimination against refugees and migrants manifests in various forms:

Social Discrimination: Refugees and migrants face the risk of exclusion due to differences in language, culture, and lifestyle. This can hinder their access to fundamental rights such as employment, education, and healthcare services.

Economic Discrimination: Refugees and migrants are often forced to work in low-wage jobs, lacking job security and fair wages, which can lead to poverty and social exclusion.

Political Discrimination: Refugees and migrants are frequently targeted by political propaganda and manipulation. Political leaders may use them as a "vote strategy" or portray them as a "threat" to distract from real issues.

To combat discrimination and protect the rights of migrants and refugees, strong legal frameworks must be established, and public awareness increased. Additionally, providing psychosocial support services and assisting these individuals in their integration processes can help them adapt to society and cope with the discrimination they face. In this way, societies can become more inclusive and just, enabling migrants and refugees to achieve the living conditions they deserve.

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Transitional-Age Youth And Mental Health Problems

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The term transitional-age youth (TAY) typically describe those whose ages range from late adolescence (15-16 years) to emerging adulthood (18-25 years). At this stage, the youth face new challenges and new experiences which may increase the risk for having mental health problems, and tackle new environments without prior knowledge and most probably in the absence of proper guidance. The transition to adulthood is a challenging stage of development for many young people. This developmental period contains adjusting to new situations, such as gaining and maintaining independence, identity formation, exploring sexuality and relationships, demands of post-secondary education, career development, and changes in legal status. TAY is a particularly vulnerable time for the new onset of major psychiatric disorders. It is critical to understand how adverse mental health and functional outcomes evolve during this life stage in order to identify points of intervention. It is important to recognize and address these potential barriers to treatment.

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Bipolar Disorder with Mixed Features

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Mixed episode introduced to daily psychiatric practice with DSM-III, was described as mixed features specifier in the diagnostic categorization systems in DSM-5. Even though symptoms of mixed episode are originated from both episodes, in the last diagnostic categorization main episode is prioritized, thus weight of the symptoms are changed. Not only the content of the symptoms but also mixed features have impact on the outcome of bipolar disorder. In bipolar patients with mainly mixed features, comorbid conditions are frequently seen. Anxiety disorders are more often comorbid in these patients. Moreover, these patients have more risk for comorbid alcohol-substance use disorders. Patients with mixed features have high risk for suicide. Especially in patients with mixed features prescribed antidepressant treatment have the highest suicide risk. The outcome of bipolar illness in patients with mixed features is more severe. It has been reported that these patients have more recurrences, longer hospitalizations, higher number of hospitalizations. On the other hand, there are some distinctions in the usual treatment regimen. Higher rates of response with anticonvulsants rather than with lithium are reported. Valproate is especially the first optionSecond generation antipsychotics are more often prefered and they are used more often in prophylactic treatment. Antidepressants should especially be avoided. In this session, presenting a patient with mixed features as most of his episodes, diagnosis and treatment of patients with mixed features will be discussed. The diagnosis of the patient will be reviewed, first in terms of mixed episode before DSM-5, and then in terms of mixed features specifier according to DSM-5, and lastly predominant polarity of mixed episode will be discussed. In addition, through the treatment outcome and response of the patient presented, treatment options for patients with mixed features will be evaluated.

General Introduction to Behavioral Addictions and Management of Pathological Gambling Disorder in Clinical Practice

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Although there are different opinions about the definition of behavioral addiction, it is defined as having an unstoppable desire to show a certain behavior despite the damage it causes to the person's life and repeatedly showing pleasurable behavioral patterns. Behavioral addiction; It refers to excessive behavior accompanied by basic addiction symptoms such as tolerance, withdrawal, loss of control and craving. Examples of behavioral addictions are frequently given such as gambling, buying, eating, physical exercise, working, technology use, sexual behavior, but behavioral addictions are not limited to these.

Pathological gambling disorder (PG), one of the most common behavioral addictions, is a mental disorder characterized by resistant maladaptive and repetitive behaviors with serious psychological and social consequences. One of the most important elements in pathological gambling is the loss of control over gambling and the continuation of gambling behavior despite the knowledge of its harmful consequences. Loss of control can result in craving behavior. PG shows similar characteristics to substance addictions in terms of neurobiological and genetic similarities, behavioral consequences, and treatment response. Pathological gambling and drug addiction appear to have similar characteristics in brain imaging studies, especially in terms of response to reward (gain) and loss, responsiveness to stimuli, impulsivity and decision-making process. Negative consequences of PG include high rates of suicide attempts, job loss, marital and family problems, legal problems, and criminal behavior. Therefore, its treatment is of great importance.

There are many different methods in the treatment of PG. In the treatment of PG, there are treatment methods such as reducing supply, reducing demand, joining self-help groups, various therapy methods (cognitive behavioral therapies, motivational interviews, psychoeducation, etc.) and drug treatments.

Neurobiological mechanisms are the basis of pharmacological treatments. In the treatment of PG, there are treatment methods such as reducing supply, reducing demand, joining self-help groups, various therapy methods (cognitive behavioral therapies, motivational interviews, psychoeducation, etc.) and drug treatments.

Neurobiological mechanisms are the basis of pharmacological treatments. Three main classes of pharmacological approaches exist based on clinical features and neuropharmacological effect. These; antidepressants, opioid antagonists and mood stabilizers. From a neuropharmacological perspective, the drugs studied have pharmacological effects on the neurotransmitter pathways of the opioid, serotonergic, dopaminergic or glutamatergic systems involved in the pathophysiology of PG. In addition, the similarity of PG to mood disorders such as compulsive-impulsive disorders and bipolar disorder also guides drug treatments.

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Management of Behavioral Addictions in Psychiatry Outpatient Clinic Practice Internet Addiction And Internet Gaming Disorder

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Internet Addiction (IA): The internet is an important, necessary and useful technology for education, entertainment, communication and information sharing. Over the past 20-30 years, along with the widespread use of the internet, it has been observed that it can have negative consequences. Although not yet included in The Diagnostic and Statistical Manual of Mental Disorders (DSM) and The International Classification of Diseases (ICD), various definitions such as internet addiction, technology addiction, and digital addiction have been made in the literature. Some researchers have established diagnostic criterias such as intense preoccupation with the internet, tolerance, loss of control, loss of interest in other activities and continued use despite negative consequences. IA is dimensionally categorized into specific pathological internet use and general pathological internet use. Due to the lack of common diagnostic criteria and the prevalence of internet use in daily life, the exact prevalence of internet addiction is not known. Approximately half of the identified cases are accompanied by psychiatric diagnoses such as substance use disorder, mood disorder, anxiety disorder, attention deficit hyperactivity disorder, etc. Although it is reported to spontaneously remit within 2 years, it needs to be treated due to the potential familial, occupational, social and academic problems it may cause. While there is no specific treatment, multimodal approaches such as cognitive-behavioral psychotherapy, family therapy, psychoeducation, and psychopharmacology are applied in treatment.

Internet Gaming Disorder (IGD): Games are activities as old as human history. With the emergence of the first digital games in 1970, approximately one-fourth of the world's population now plays digital games. Digital games are played for many reasons such as providing pleasure/enjoyment, being easily accessible, facilitating socialization also have potential harms. Violence-oriented games that do not consider developmental characteristics can be harmful. Besides the content of the games, negative consequences due to spending long periods at the game console also arise. It causes important health problems such as musculoskeletal system problems, dry eyes, vision problems, inability to meet sleep needs, cognitive problems, immobility. It leads to disturbance in the balance between life areas leads and neglect of responsibilities. The most significant potential harm is addiction. Neuroimaging studies have reported structural changes in the brains of individuals with IGD compared to healthy adults. Thus, ICD-11 includes "gaming disorder" and DSM-5 includes "internet gaming disorder". Being an adolescent male, having close friends who play digital games, having family problems, weak social support, weak interpersonal relationships are defined such as risk factors. The goal of treatment is to reduce or eliminate gaming behavior that impedes the individual from taking care of themselves, relationships, and other areas of life. Cognitive and behavioral therapy, family therapy and pharmacotherapy are used in treatment. Data on pharmacological treatment approaches are limited, and comprehensive research is needed.

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Management of Behavioral Addictions in Psychiatry Outpatient Clinic Practice Smartphone and Social Media Addiction

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Smartphone and social media addiction is a condition that has been increasing in recent years and affects individuals of all age groups and demographic structures. Symptoms of smartphone addiction include obsessively checking phone, losing track of time while using the device, and neglecting other activities or people in favor of time spent on the smartphone. Smartphone addiction is associated with increased anxiety levels and leads to physical symptoms such as sweating, tremors, and heart palpitations when someone is without their phone for long periods of time. The constant barrage of personalized ads on social media platforms can lead to overconsumption and financial stress, further increasing anxiety and stress levels. The business model of social media platforms, which involves collecting and selling user data for targeted advertising, may also contribute to mental processes of paranoia and mistrust. As mental health professionals, it is crucial to understand the impact of these technologies on our patients' mental health and develop effective strategies to manage addiction. This panel aims to explore the current state of smartphone and social media addiction, its impact on mental health, and best practices for managing addiction in psychiatric practice.

The first step in managing smartphone and social media addiction is accurate assessment and diagnosis. Psychiatrists should be aware of the signs and symptoms of addiction, including overuse, withdrawal symptoms, and effects on daily life and mental health. It should be kept in mind that standardized assessment tools with Turkish validity and reliability studies can assist the evaluation process.

Psychoeducation is a critical component of managing smartphone and social media addiction. Patients must understand the negative effects of overuse on mental health, including the link between addiction and conditions such as depression, anxiety, and stress. Various psychotherapy methods can help patients recognize and combat maladaptive thoughts and behaviors associated with addiction. People can develop coping strategies, set boundaries, and learn healthier ways to manage mental processes such as stress, anxiety, anxiety, and restlessness without relying excessively on their devices.

Medication may be necessary to manage some of the underlying psychopathology that contributes to addiction. For example, antidepressants or psychostimulants may be used to treat disorders that co-occur with addiction, such as depression or attention deficit hyperactivity disorder. A comprehensive treatment plan that addresses both addiction and co-occurring psychiatric disorders is essential for effective management.

Encouraging patients to take breaks from technology and engage in mindfulness practices may be helpful in managing addiction. A digital detox, in which patients take a complete break from technology for a period of time, can help patients reconnect with the world around them and develop healthier habits. Mindfulness practices can help patients manage their stress and anxiety, reducing the need for excessive technology use.

It is not difficult to predict that smartphone and social media addiction will change in size as technology continues to develop. Managing smartphone and social media addiction in psychiatric practice requires a comprehensive approach that addresses the psychological, behavioral and medical aspects of addiction. Psychiatrists can support patients in developing healthier relationships with technology and improving their mental health by using assessment tools, psychoeducation, psychotherapy, medication and mindfulness practices.

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Exercise Addiction

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Exercise addiction refers to a condition where regular exercise becomes harmful rather than beneficial for health. In diagnosing addiction, the frequency, intensity, duration, and compulsive nature of exercise are important. Exercise addiction is a behavioral disorder that negatively impacts an individual's functioning and health. Primary and secondary exercise addiction are distinguished in diagnosis. In primary addiction, exercise is performed to avoid negative emotions, while secondary addiction is associated with an underlying psychopathology, typically linked to eating disorders. Secondary exercise addiction, which is more common in women, is often associated with eating disorders, while primary exercise addiction is more prevalent in men (Vardar et al., 2012). Risk has been identified in various sports contexts: endurance sports (14%), ball sports (10.4%), gym-goers (8.2%), strength sports (6.4%), and the general population (3%) (Di Lodovico et al., 2019). Various scales have been developed for the diagnosis of exercise addiction, with the Exercise Addiction Inventory-21 (EAI-21) being one of the most widely used. Determining excessive amounts is crucial in diagnosis, especially when exercise addiction co-occurs with an eating disorder, as excessive amounts are evaluated differently. Exercise addiction is associated with the dopaminergic reward pathway in the brain, similar to substance addiction. While it may present with obsessive symptoms, it differs from impulse control disorders. In treatment, addressing accompanying comorbidities is prioritized. If an eating disorder is present, it is addressed first, followed by Cognitive Behavioral Therapy (CBT) for exercise addiction. Late diagnosis can negatively impact treatment success, underscoring the importance of awareness among professionals working with athletes. In summary, exercise addiction is a condition where healthy exercise habits reach harmful levels, negatively impacting an individual's life. Diagnosis and treatment require careful consideration.

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Title of Session: Approach to OCD and Anxiety Disorders Accompanying Adult Autism Spectrum Disorder

Proposed Session Chair: Prof. Dr. Şebnem Pırıldar

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The symptoms and signs may also overlap with those of other psychiatric disorders. Although it is well defined in the paediatric group, there is a paucity of data on its prevalence and clinical features in adulthood.

Despite the existence of conflicting data, the three most prevalent psychiatric comorbidities are depression, attention deficit hyperactivity disorder (ADHD) and anxiety disorders. A systematic review indicated that approximately 40% of patients with ASD were accompanied by at least one comorbidity, with specific phobia (30%) and OCD (17%) being the most common.

Furthermore, the presence of milder autistic features (mild cognitive impairments and mild language impairments) in family members of individuals with autism has been postulated to reflect an intermediate phenotype or an endophenotype for autism. Subsequently, this phenomenon was designated as the Broad Autism Phenotype (GOF).

Comorbidity of Obsessive Compulsive Disorder in Adult Autism Spectrum Disorder

(Speaker: Dr. Yunus Akkeçili, Afyon Dinar State Hospital, akkecili@gmail.com, 05068866042)

When the prevalence of OCD in the general population is estimated to be around 1.6%, it appears that OCD is more common in ASD patients than in the general population (17%). As both conditions are partly characterised by repetitive thoughts and actions, it is not easy to determine which behaviours can be attributed to ASD and which indicate an additional diagnosis of OCD. Difficulties in assessing comorbid OCD symptoms may be exacerbated by ASD-specific impairments such as communication and insight deficits and high rates of alexithymia. There is empirical evidence that the repetitive behaviours of people with ASD are often egosyntonic and often serve a function. Despite these findings, the differences between OCD and ASD compulsions are not always clear and there appears to be considerable phenotypic overlap. Therefore, in clinical settings such as outpatient clinics, it may be difficult to distinguish between OCD and ASD compulsions.

Comorbid Anxiety Disorders in Adult Autism Spectrum Disorder

(Speaker: Dr. Cenan Hepdurgun, Ege University Faculty of Medicine, Department of Psychiatry, cenanhep@gmail.com, 05326357377)

The prevalence of comorbid anxiety disorders in individuals with autism spectrum disorder (ASD) is reported to range broadly from 11% to 84%, depending on the diagnostic criteria utilized. This comorbidity is influenced by neurobiological and genetic factors, as well as clinical aspects such as the inflexible attitudes characteristic of ASD, deficits in social cognition, and difficulties in adapting to the complexities of social interactions. In individuals with ASD who exhibit higher levels of functioning, social anxiety disorder is more frequently observed, whereas specific phobias and panic disorder are more commonly reported among those with lower functioning levels. The high prevalence of anxiety disorders in ASD, coupled with the challenges patients and their families face in articulating their symptoms, underscores the importance of meticulous investigation into these disorders. This presentation will focus on the etiology and diagnosis of anxiety disorders in adults with ASD.

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Neurocognitive Functions in OCD and Anxiety Disorders Associated with Adult Autism Spectrum Disorder

(Speaker: Dr. Aybüke Aydın, Izmir Bakırçay University Çiğli Regional Training and Research Hospital, aybukeaydin@gmail.com, 05419690180)

Theories of complex information processing deficits and weak central coherence in ASD suggest deficits in the processing of social stimuli. Brain imaging studies have demonstrated that deficits in information transmission result from inadequate connectivity between frontoposterior cortical regions in tasks related to higher cortical functions.

Impairments in social cognition have been observed in other psychiatric disorders, including the ability to recognise social cues such as facial emotions, the ability to understand the mental states of others (theory of mind, ToM), the capacity to regulate emotional responses to others, as well as the ability to share the experiences and feelings of others. Impairments in these social cognitive abilities are significant predictors of social and functional impairments in psychiatric disorders.

The comprehension of neurocognitive dysfunctions in ASD and comorbid conditions has facilitated the comprehension of the difficulties encountered in the treatment of these disorders.

Approach to the Treatment of OCD and Anxiety Disorders Associated with Adult Autism Spectrum

(Speaker: Dr Selin Tanyeri, Isparta Yalvaç State Hospital, selintanyeri@yahoo.com.tr , 05545025412)

A substantial body of evidence indicates that the prevalence and severity of autism symptoms decline with age. The main social difficulties experienced by individuals with autism spectrum disorder (ASD) persist throughout their lives. These difficulties include difficulties in social interaction and the development of social relationships. Nevertheless, it is evident that there is an improvement in this area with advancing age. Furthermore, research indicates that stereotypical and repetitive behaviours and limited interests are observed at similar rates in both men and women in adulthood.

Treatment approaches for OCD and anxiety disorders accompanying ASD necessitate an effort to comprehend ASD in a dimensional manner. This has resulted in a notable surge in GOF studies involving families, twins, siblings, and the general population. This is because an understanding of the aetiology of individual differences in autistic traits in the general population is thought to facilitate an understanding of the causes of clinically diagnosed ASD and comorbid disorders. Furthermore, autistic features, which are frequently observed in patients with other psychiatric disorders, particularly in those with anxiety disorders, may be of great importance in understanding the differences in the course of diseases in individuals and even intermediate states in nosological definitions.

Neurocognitive Functions in Adult Autism Spectrum Disorder Accompanied by OCD and Anxiety Disorders

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Autism Spectrum Disorder (ASD) is a neurodevelopmental disorder characterized by significant variability in cognitive symptoms. Difficulties in social interaction, repetitive behaviors, and restricted interests are some of the cognitive symptoms associated with ASD. There are three main hypotheses explaining the cognitive symptoms in ASD: weak central coherence, deficits in theory of mind abilities, and impairments in executive functions. Executive functions are a broad term used for functions such as planning, working memory, impulse control, inhibition, and mental flexibility. Executive function impairment in autism has been demonstrated through both laboratory-based neurocognitive tests and tests providing information on real-world executive function issues, such as the Behavior Rating Inventory of Executive Function (BRIEF). This impairment in executive functions persists even when the effect of IQ is excluded. The most prominent impaired executive function domains in autism are cognitive flexibility and planning.

Studies have shown that comorbid anxiety disorders negatively contribute to executive function impairment in autism. Comorbid anxiety is particularly associated with cognitive flexibility and insistence on sameness, while depressive symptoms are associated with impairments in planning. Repetitive behaviors are a common symptom cluster in both obsessive-compulsive disorder and autism. It is suggested that repetitive behaviors in both conditions are related to impaired cognitive flexibility. There is no study investigating the effect of comorbid obsessive-compulsive disorder on executive functions in autism.

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Approach towards OCD and Anxiety Disorders Associated with Adult Autism Spectrum
Treatment Approaches for Comorbid OCD and Anxiety Disorders in Adult Autism Spectrum

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Obsessive-compulsive disorder (OCD) and anxiety disorders are common comorbidities in individuals within the adult autism spectrum. Meanwhile, the significant overlap of autism spectrum disorder (ASD) features with anxiety and OCD symptomatology makes differential diagnosis of these disorders particularly challenging. On the other hand, though several treatments for anxiety have been adapted for youth with ASD, pharmacological therapies and treatments for adults are still marked undeveloped.

Research shows that individuals at any age with ASD are two times more likely to be diagnosed with OCD than the general population. Similarly, anxiety disorders such as generalized anxiety disorder or phobias are prevalent in patients with ASD. However, both OCD and anxiety disorders and ASD have overlapping behaviors that could be difficult to differentiate. Moreover, concurrent difficulties with communication and other behavior problems, as well as the lack of standardized assessment tools specific to diagnosing patients with ASD and psychiatric comorbidities, may shadow the implementation of adequate treatment regimes.

Practical clinical guidelines, therefore, suggest that it is essential to remember that OCD and anxiety disorders are common in patients within the adult autism spectrum but frequently go undiagnosed. The use of well-standardized, validated, and reliable assessment tools and multiple sources of information is of great importance. Considering the evidence for the effectiveness of treatment in reducing anxiety symptoms along with the risk of side effects when prescribing medications and integrating psychosocial treatments are also necessary. Research in treating adults with anxiety and ASD is preliminary but suggests that cognitive behavioral therapy (CBT) approaches and mindfulness techniques might be promising. Behavioral treatment for individuals with OCD and ASD has received much less attention in the literature, but existing research suggests that OCD symptoms can improve with CBT. Selective serotonin reuptake inhibitors (SSRIs) or serotonin-norepinephrine reuptake inhibitors are considered the first line of psychopharmacological treatment for OCD or anxiety disorders in the general population. However, research on the use of SSRIs in individuals with anxiety or OCD and ASD is lacking, and individuals with ASD seem to be particularly vulnerable to the increased behavioral activation side effects of SSRIs, such as insomnia, impulsivity, and overall increased activity. Prescribing SSRIs for individuals with ASD and OCD or anxiety disorders should, therefore, be approached cautiously.

Despite the high prevalence of OCD and anxiety disorders in ASD and some recent advances in assessment and treatment, research is needed to clarify the multifaceted relationship of these conditions and develop useful and appropriate treatment approaches for a full range of individuals within the adult autism spectrum.

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Challenging Cases and Gray Areas in Forensic Psychiatric Evaluation and Reporting

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A security measure is ordered for protection and treatment purposes for the person who was mentally ill at the time of committing the act then these mentally disordered patients are are taken under protection and treatment in high security health institutions. This procedure is regulated by the first paragraph of article 57 of the Turkish Penal Code (TPC) in our country. In addition, according to the first paragraph of article 16 of the Law on Penalties and Security Measures (LPSM), the execution of the sentence of the mentally disordered offender can be reprieved until after the completion of the treatment. The mentally disordered offender is taken under protection and treatment in the health institution specified in article 57 of the TPC. The time spent in a forensic psychiatry service is considered to have been spent in prison. This decision must be performed by the Forensic Medicine Institute or the health boards of full-fledged hospitals determined by the Ministry of Justice and approved by the Forensic Medicine Institute.

In current practice, we encounter offenders who are sent to High Security Forensic Psychiatry Units (HSFP) to be hospitalized with the decision to reprieve their sentences, even though no mental illness has been detected. These cases were evaluated in psychiatric clinics of university hospitals or training and research hospitals. These are the people who are then presented to the health boards of university hospitals or training and research hospitals and a decision is made about them. In the detailed psychiatric examination of these people, it could determined that they did not have any mental illness that would cause the sentence to be reprieved.

Mental health practices in prisons are included in the Nelson Mandela Rules, which were also included in the Mental Health in Prisons report prepared by the World Health Organization in 2014 and accepted by the United Nations in 2015. First of all, it is emphasized that every prisoner has the right to benefit from mental health services, regardless of religion, language, race, gender, sexual orientation, ideology or socioeconomic status. However, a crucial consideration for clinicians in these practices is the potential for deception. Detainees and convicts may attempt to mislead the evaluating physician. To give examples of these situations: Staying in wards of hospitals or rehabilitation services, eliminating criminal responsibility for the crime they committed, or access to green prescription drugs . In the forensic psychiatry approach, psychiatrists should both care about the patient's benefit and take into account malingering. Recognizing malingering and how to manage it is one of the important issues of forensic psychiatry. It is important that the clinician is qualified and an expert in his field. In other words, when erroneous expert decisions in forensic psychiatry are taken into consideration, the active role of the psychiatrist becomes even more important.

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What Would You Do: Challenging Cases and Gray Zones In Forensic Psychiatry Practice For Evaluation and Reporting

Uz. Dr. Eldem Güvercin
T.C Sağlık Bakanlığı Tavşanlı Doç.Dr. Mustafa Kalemli Devlet Hastanesi

In the daily practice of the mental health specialist, the demand from various institutions for the forensic psychiatric evaluation of the cases and the reporting of the findings and conclusions as a result of the evaluation in a psychiatric framework and translating into legal language has an important place. Forensic evaluation is considered an expert examination for mental health specialists and medical doctors, and when demanded by legal authorities, it is obliged to report.

It is possible for the mental health specialist to face some difficulties during the evaluation of the cases and reporting the findings as legally demanded. Sometimes, psychiatric observation and psychiatric measurement tools used with anomalous symptoms and findings of the cases to be evaluated cannot give sufficient clues about the cases in a limited time. In some cases, the legal or official language and the medical language may have difficulty communicating with each other, and findings and conclusions may not clearly adapt to corresponding legal demands. Sometimes, the information provided from cases may not reflect the clinic framework that available in the current diagnostic systems.

In this presentation, a case will be discussed about a person who referred to the outpatient clinic via legal authorities, demanding a forensic evaluation and report. Contents explaining the steps, what was done during the evaluation process, and the findings and conclusions obtained as a result of the evaluation. After being introduced to the case, interactive discussion and reevaluation will be planned. In this way, in the light of different ideas and experiences, it is aimed at gaining alternative perspectives on challenging cases for judicial evaluation and reporting that may be challenging in daily routine medical practice.

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Alcohol Abuse in Child Custody Cases

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Introduction

There are some studies in the literature reporting that there is a strong evidence linking alcohol with domestic abuse or domestic violence (Gadd et al. 2019) International evidence reveals a similar pattern with men tend to cause worse assaults after drinking and women are more likely to suffer from abuse with living partners who are heavy drinkers (Sontate et al. 2021).
Alcohol/substance use is not only a reason for divorce, but also plays an important role in determining which parent will be given custody of the child and regulating the personal relationship between parent and child (Cakir et al. 2022).

Case

The case was a 44-years-old man who was sent to Forensic Psychiatry outpatient clinic for mental evaluation by court. After 9 years of marriage he has filed for divorce two years ago and married with third wife. His wife accused him of consuming excessive alcohol and inflicting psychological and physical violence on his10 years old daughter. The mother had custody of the child and she did not want her to see his father. The father has request a change in the current custody orders and the court was asking whether the father had a mental disorder that prevented him from seeing the child.
What investigations would you do in this situation?

Discussion

Legal custody refers to the parents' authority to make important decisions about their children's care and upbringing, such as medical care and education. Physical custody refers to where the children will live. Within each of those categories, one parent may have sole custody, or both parents may have joint custody.

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Challenging Cases and Gray Areas in Forensic Psychiatric Evaluation and Reporting

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Forensic psychiatry is often described as "the branch of psychiatry that addresses matters at the intersection of psychiatry and the legal system." (1). Forensic psychiatry occupies a pivotal role in the intersection of mental health and the legal system. In forensic psychiatry practice, scientific and clinical expertise is applied in legal contexts involving civil, criminal correctional regulatory or legislative matters (2). In brief forensic psychiatry is a branch of psychiatry that acts as a bridge between psychiatry and law. It sometimes requires direct contact and close collaboration between legal professionals and psychiatrists. Forensic psychiatrists provide expert opinions for a medical basis for the decisions of legal professionalls. This generally includes the psychiatric evaluation of patients in accordance with the provisions of the articles of the Turkish Penal Code and the Turkish Civil Code (3). Evaluations within the scope of Turkish Civil Law include evaluation of discernment, legal and action capacity, being placed under guardianship, and involuntary treatments. Evaluations made within the scope of the Turkish Penal Code include evaluations of criminal responsibility. Additionally, forensic psychiatrists are involved in implementing security measures and providing treatment and rehabilitation services within High-Security Psychiatry Units for mentally disordered offenders, as regulated by Article 57 of the Turkish Penal Code (3). In addition to diagnostic evaluations regarding legislation and providing treatment for mentally disordered offenders, forensic report preparation is also an important area of interest for forensic psychiatrists.

It takes longer than expected for clinicians to gain experience in this field, which has a very broad scope and complex nature. In clinical practice, psychiatrists come across challenging cases that highlight the nuanced nature of forensic psychiatric evaluations. In this presentation, we aim to broaden the discourse by exploring examples of challenging cases encountered in forensic psychiatric evaluations, further highlighting the intricacies of this specialized field and the importance of ongoing research and professional development within it.

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The Role of Transcranial Magnetic Stimulation in the Treatment of Treatment ResistantDepression and the Most Common Protocols

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Major depressive disorder (MDD) is a common psychiatric mood disorder affecting more than 280 million people worldwide. Severe depression can lead to suicide and is currently the fourth leading cause of death among 15-29 year olds. First-line treatment options for MDD include antidepressants and forms of psychotherapy such as cognitive behavioral therapy. Approximately one-third of patients with MDD do not respond adequately to treatment despite receiving two or more evidence-based antidepressants. Failure to respond to two or more medications at adequate dose and duration is called treatment-resistant depression (TRD) in MDD. Failure to respond to first-line pharmacologic and psychotherapeutic antidepressive treatments is an important problem. The need for fast-acting treatments for these patients is urgent. Studies in the last 10 years have shown that repetitive Transcranial Magnetic Stimulation (rTMS) is an effective and safe treatment option for patients with MDD or TRD. TMS is currently indicated for the treatment of TRD and was approved by the FDA in 2008.The first uses of TMS in psychiatry were applied to the vertex region as a single stroke, but no qualitative benefit was observed. Current use of TMS targets the dorsolateral prefrontal cortex (DLPFC), which has the highest anticorrelation with the subgenual anterior cingulate cortex, in high frequency pulses.In MDD, rTMS is typically delivered once daily in a 1Hz or 10Hz protocol for four to six weeks.While low frequency stimuli such as 1 Hz act as inhibitory to the neural tissue, high frequency stimulations above 5 Hz have been observed to be excitatory.In addition, different protocols have started to be applied recently. In current studies, stimulation between 90%-120% of the motor threshold was applied. In terms of the number of pulses, there are studies ranging from 600 to 18,000 pulses per day. However, daily application for 4-6 weeks limits the treatment in many ways. Newer TMS applications such as accelerated theta burst stimulation (aTBS) are trying to increase efficacy and shorten response time. TBS is an rTMS paradigm that increases synaptic transmission and excitability by mimicking cortical theta rhythms. TBS delivers 600 pulses in only 40 seconds to 3 minutes instead of 18-25 minutes. Compared to rTMS, equivalent antidepressant results have been shown. Two main types of TBS have been identified: intermittent TBS (iTBS), in which 192 s of TBS is applied at 8 s intervals for 2 s for 600 pulses, and continuous TBS (cTBS), in which TBS is applied continuously for 40 s. iTBS produces neuronal excitatory effects reminiscent of high-frequency rTMS applied to the left-DLPFC in the treatment of depression, whereas cTBS is applied in the right hemisphere at a frequency of 1 Hz and produces the opposite result of a suppression on neuronal excitability.

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Accelerated Transcranial Magnetic Stimulation

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Major Depressive Disorder (MDD) affects over 300 million people worldwide and is a leading cause of disability globally. Over 800,000 people commit suicide each year, or one every 40 seconds, due to MDD. Therefore, improving public health requires developing effective and accessible MDD treatments (Sonmez et al. 2019). A significant number of depressed patients, around one-third, do not respond to initial pharmaceutical and psychotherapy. This condition is referred to as treatment-resistant depression (TRD). There is a pressing demand for prompt and efficient therapies for TRD. Transcranial magnetic stimulation (TMS) has been FDA-approved for TRD for over a decade and is widely utilized in clinical practice. Since 2016, the Canadian Network for Mood and Anxiety Treatments has advised TMS for MDD once antidepressants fail (Massé-Leblanc et al. 2024). Intermittent theta-burst stimulation (iTBS) targeting the left dorsolateral prefrontal cortex for up to six weeks has also been approved by the FDA for TRD. Compared to conventional TMS, iTBS appears to deliver similar antidepressant effects but in a significantly shorter duration (approximately 3 minutes vs. approximately 37 minutes). To reduce TMS's financial and time burden, accelerated treatment schedules have been developed involving higher dosing and multiple sessions per day. Accelerated TMS (aTMS), a protocol that provides more than one daily TMS session, is an emerging delivery schedule for TMS that aims to reduce treatment duration and improve response time to achieve similar (or superior) levels of efficacy. The Stanford Neuromodulation Therapy (SNT; formerly known as Stanford Accelerated Intelligent Neuromodulation Therapy, SAINT) protocol is a recently cleared aTMS protocol for depression. The SNT protocol consists of five days of 10 sessions of iTBS per day and delivers 18,000 pulses per day, which is six times more than previous FDA-approved TMS protocols. In a current systematic review, iTBS sessions applied more than three times daily were considered aiTBS. Additionally, randomized studies are recommended regarding the interval between sessions, the number of pulses per day, and the number of sessions per day (Neuteboom et al. 2023).

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The Most Common Accelerated Transcranial Magnetic Stimulation Protocols

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Transcranial Magnetic Stimulation (TMS) is a therapeutic technique used to treat various neurological and psychiatric disorders. The United States Food and Drug Administration (FDA) has approved high-frequency, 10-Hz TMS as a treatment for major depressive disorder (MDD) since 2008. Intermittent Theta-Burst Stimulation (iTBS) is a new and promising form of TMS for treating Major Depressive Disorder (MDD). iTBS is an excitatory form of TMS that applies 50Hz stimulation in brief triplets, with each session only requiring 600 pulses. This is an attractive feature of iTBS as it significantly reduces the treatment duration from 37.5 minutes in 10-Hz TMS to less than 4 minutes in iTBS. Studies have shown that applying 600 pulses of iTBS to the motor cortex can increase motor excitability, thus researchers have now started using iTBS over the dorsalateral prefrontal cortex (DLPFC) as a therapeutic approach for MDD (Caulfield 2020). A clinical experiment conducted at multiple sites indicated that iTBS (600 pulses) for depression produced similar benefits as 10-Hz TMS (3000 pulses), sustaining response rates of roughly 50%. Based on the results of that experiment, the FDA approved the use of iTBS in depression treatment in 2018. Since there is no significant difference in effectiveness between iTBS and 10-Hz TMS, the shorter duration of stimulation in iTBS sessions could lead to increased usage of iTBS as the primary treatment for MDD. In contrast to the 600 pulses per day used in iTBS, Williams et al. administered a high dosage of 18,000 pulses across ten sessions per day (1,800 pulses each session and one session per hour for 10 hours) for five treatment days within a week (90,000 total pulses in one week). The accelerated, high-dose treatment demonstrated remarkable efficacy, resulting in complete remission for five out of the six patients. The remission rate of 83.3% achieved by Williams et al. (2018) in accelerated, high-dose iTBS treatment is particularly remarkable when compared to previous findings (Williams et al. 2018). Research has shown that continuous theta burst stimulation (cTBS) applied to the right DLPFC can be a helpful treatment for individuals with treatment-resistant depression (TRD). Accelerated continuous theta burst stimulation (a-cTBS) and accelerated intermittent theta burst stimulation (a-iTBS) are both promising options for treating depression and suicidal ideation in TRD patients. These protocols are often applied more than once a day, and in some cases, iTBS and cTBS are applied together. One study found a-cTBS to be more effective in reducing suicidal ideation and anxiety than a-iTBS (Zhao et al. 2023). However, it is still unclear how many daily sessions of accelerated TMS should be applied, how long the interval between sessions should be, or how long maintenance should be done.

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Community Mental Healthcare in Europe: Different Countries, Challenges, Alternative Methods What Community Mental Health Centers Have Achieved, What They Can Achieve?

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Abstract
In Türkiye, the implications of community-based mental health services started in 1960s with Mental Health Dispensaries. After the 1980s, dispensaries were replaced by day hospitals affiliated with a Mental Health Hospital or University Hospital. In 2000s, the mental health policy changed and in 2011, the National Mental Health Action Plan was brought into force.

The objectives of the Action Plan were: 1) To implement an integrated community-based mental health service model, 2) To monitor, protect and improve the mental health of individuals. Two major elements of this approach were Community mental health centers (CMHC), the second one is Community mental health teams, formed by a group of mental health professionals, for ambulatory health care services. As of now, the total number of CMHC has reached 186, and the service users have almost reached 100.000.

The main service users were defined as patients with severe mental disorders, such as schizophrenia and bipolar disorder. Every service user is guided by a case manager (a social worker, psychologist or a nurse). Case managers form a care plan, based on individuals needs and capacity. They are expected to organize the relationship between the primary care or inpatient units and ambulatory health care services like home services.

According to the CMHC Task Force report of the Psychiatric Association of Türkiye (2020), CMHCs have been beneficial to the followings:

- improvement in the conditions of mental health services
- better follow-up of patients with chronic severe mental disorders
- capability of in-home services
- decrease in the number of admissions
- increased social involvement of patients with severe mental disorder
- promoting social rehabilitation, employment status
- redress of stigmatization

In 2020, the last report of the Action plan was announced by the Ministry of Health (2020). When compared to objectives, the current performance of CMHCs felt short of several domains of mental health care. First, only 52% of the CMHC teams have completed the CMHC trainings. Second, integration with primary care and inpatients services has not been established yet. Third, standardized work flow algorithms, preventive strategies, and action plans for stigmatization have not been determined. Last but not least, quality standards of CMHCs are based on number of service users or admissions to CMHC. These standards contribute to a misconception, portraying these centers as profit-making units rather than rehabilitation or preventive care facilities.

Recently, CMHCs in Türkiye were faced with two big challenges: The Pandemic and the February 6 Eathquakes. CMHCs may have some advantages to sustain mental health care. They can be Covid-free areas and continue their services. They can continue face-to-face care by home visits. They can use telepsychiatry and provide remote consultations to keep in touch with patients and their care providers. Regarding the earthquakes on February 6, CMHC network enables the organization and follow-up patients who moved to other cities.

In conclusion, CMHC have significant opportunities despite the shortcomings confronted in practice. To optimize the effectiveness of CMHC, it is essential to review the current challenges faced by CMHCs with active involvement and support from patient-driven organizations and national psychiatric associations.

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Challenging Scenarios in Mood Disorder Management: What Would You Do? Solutions and Strategies

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Bipolar disorder refers to a group of affective disorders characterized by alternating depressive and manic or hypomanic episodes. Diagnosing bipolar disorder, especially in its early stages, is challenging. Only 20% of patients experiencing a depressive episode are diagnosed with the disorder within the first year of seeking treatment, with an average delay of 5–10 years between the onset of symptoms and diagnosis. Furthermore, individuals with 'atypical' clinical presentations face significant treatment limitations even after diagnosis. Despite initially positive responses, the effectiveness of evidence-based treatments can diminish over time due to changes in the illness course or poor tolerance.

Patients with bipolar disorder often suffer from coexisting psychiatric conditions: approximately 71% have anxiety disorders, 56% struggle with substance use, 36% have personality disorders, and 10-20% have attention deficit-hyperactivity disorder (ADHD). They also have higher rates of chronic medical conditions compared to the general population, including metabolic syndrome (37%), migraine (35%), obesity (21%), and type 2 diabetes mellitus (14%). The risk of death for these patients is nearly double that of the general population, attributable to both suicide and a higher prevalence of physical diseases.

Given the prevalence of bipolar disorder and the ongoing challenges in diagnosis, treatment, and management, we, as part of the Mood Disorders Post-Specialization Training Program, aim to discuss various cases with renowned experts in the field, incorporating recent research findings into our discussion.

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Challenging Scenarios in Mood Disorder Management: What Would You Do? Solutions and Strategies

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Bipolar disorder is a chronic mood disorder characterized by recurrent episodes that affect approximately 2% of the world's population. In this disorder, there are manic episodes characterized by high and excited moods, as well as depressive periods marked by sadness, low energy, and hopelessness. The illness typically begins in young adults and is a leading cause of disability and premature death. Diagnosing bipolar disorder in the early stages can be challenging, and misdiagnoses are common. Especially diagnosing bipolar disorder type II accurately in clinical practice can be quite challenging. The main reason for this is the frequent misdiagnosis as unipolar depression in patients experiencing bipolar depression, since the diagnostic criteria for depressive episodes are the same for both disorders. This can lead to missed early intervention and harm to patients.

In bipolar disorder, psychiatric comorbidities are quite common. The most frequently accompanying psychiatric disorders to bipolar disorder are anxiety disorders, substance/alcohol use disorders, attention deficit hyperactivity disorder, and obsessive-compulsive disorder. The psychiatric comorbidity of bipolar disorder is strongly associated with poor treatment response, more frequent mood episode recurrences, suicide attempts, rapid cycling, worsened functionality, and quality of life. Additionally, the likelihood of medical comorbidities such as metabolic syndrome, obesity, migraines, and diabetes mellitus is higher in bipolar disorder compared to the general population. The high prevalence of comorbidities constitutes one of the fundamental challenges in the treatment of bipolar disorder.

As the Mood Disorders Working Group, based on the challenges in prevalence, diagnosis, treatment, and management, we aim to discuss two different cases diagnosed with Bipolar Disorder, which are struggled with in clinical practice, with specialized experts in the field. Additionally, we aim to incorporate the latest research findings into our discussions and provide our audience with a new perspective.

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Course: Standards and Current Practices in Psychiatry Education
Title: Proficiency Exam

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Board qualification represents that a person is practicing his/her profession within the framework of the most up-to-date and highest professional standards and that he/she has the necessary knowledge and skills to do so. A certificate of proficiency indicates continuous professional development, being up-to-date with innovations, and continuing to learn.

In Türkiye, psychiatry proficiency is assessed and certified by examinations administered centrally by the Proficiency Board of the Psychiatric Association of Turkey. The qualifying exam has been administered once a year since 2006 and has a validity period of five years. When this period expires, re-certification is made upon application and proof of continuing professional education.

Psychiatry specialists who are not restricted from working in Türkiye and residents in the last year of their specialty training can apply for the written part of the proficiency exam. Successful psychiatrists in the written exam can apply for the practical exam. The scope of the exam topics is based on the Curriculum Development and Standards Determination System of the Board of Medical Specialization (TUKMOS). The second stage of the practical exam, the Objective Structured Clinical Examination (OSCE), is held once a year after the written exam. The OSCE consists of stations where standardized (simulated) patients are interviewed in a similar setting. Candidates are evaluated in terms of psychological examination, interview, history-taking skills, laboratory test planning, diagnostic considerations, psychoeducation, and follow-up treatment plans.

In this presentation, detailed information will be given about the Proficiency Exams implemented by the Proficiency Board of the Psychiatric Association of Turkey every year. Sample questions and sections from the interviews will be shared with the participants, and the participants' questions about the exams will be answered.

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Experiences through the Eyes of Residency Students

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In this talk, an evaluation will be made for medical specialty students from the perspective of the specialty student regarding the Psychiatry Specialty Training Curriculum and TUKMOS (Medical Specialty Board Curriculum Creation and Standard Determination System), Accreditation of Educational Institutions and the Concept of Competence in Psychiatry.

Mental health and diseases specialty training curriculum is designed to set minimum standards by forming the basis of mental health and diseases specialty training. This curriculum also aims to serve as a guide that will help institutions to reach the minimum standards and to make manpower planning in this direction.

Specialty training aims to develop the student's competencies by acquiring knowledge, skills and appropriate attitudes in the etiology, diagnosis and treatment of psychiatric diseases and prevention of diseases. Specialists who complete the training are expected to be qualified specialist physicians as health care providers, educators, managers and health protectors.

Appropriate educational environments and learning methods have been identified in the curriculum. Although it is not expected that the knowledge and skill level of a mental health specialist will be completed in 4 years of training, this curriculum aims to provide the minimum conditions for the provision of effective mental health services.

Accreditation processes in the institutions where specialty training is received is also a practice that directly concerns specialty students. The fact that last year specialty students can take the theoretical part of the qualifying exams is also a concept that we put on our agenda during our training process.

It is very important for a specialty student to have taken the qualifying exam and to have a qualification certificate in the future, and for the institution where we receive education to be accredited.

In this presentation, a member of the Assistant Physician Committee (AHK), who will apply for a certificate of competence in the near future and whose institution is accredited and has taken part in these processes, will provide information, and the opinions and expectations of the AHK will be included.

Components of the Consent Process and Evaluation in Terms of Refusal of Treatment

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Consent is the acceptance or rejection of a certain intervention by an informed patient or individual, based on his or her own free choice, without any external coercion. The indispensable elements of informed consent are the information being explained clearly (provision of information), voluntariness, and decision-making capacity (competence). The informed consent process includes not only providing information but also enlightening the patient in a way that will enable him/her to make his own decision. The other element "voluntariness" means being able to decide and act with free will, without being influenced by others. The last element "decision-making capacity" is the ability to understand the benefits, risks, and alternatives of a proposed treatment or intervention. Feelings of fear and discomfort regarding health care, being under 18 or over 85, chronic neurological and mental illnesses, low education level, and significant cultural or language barriers are conditions increasing the likelihood of impairment in medical decision-making capacity. When evaluating decisional capacity, physicians need to obtain a mental status examination and formal assessment of cognitive function. The final determination on decision-making capacity should be made by the treating physician. However, consultation with a psychiatrist may be helpful in some cases. The steps of informed consent are as follows: The informed consent process is explained to the patient. An attempt is made to reveal the patient's perception of the problem. The condition and treatment options are explained by the physician in detail in an appropriate language. The short and long-term consequences of the choices are explained by the physician and the patient is made sure that he/she understands. The patient is guided to evaluate the alternatives offered. The physician makes a recommendation to the patient. The patient reaches a positive or negative decision. It should not be forgotten that at the end of the consent process, the person can also refuse the treatment, and there is no rule that this process will necessarily result in approval. Exceptions to the duty to disclose and informed consent include real emergencies, situations where the person lacks competence and refuses to be informed, situations where there is evidence that giving information would harm the person, and public health emergencies.

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Evaluation Of Consent In Obesity Surgery And Transplantation

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Informed consent is the patient's acceptance (or rejection) of a certain intervention based on his or her own free choice, without any external coercion. Giving consent is also an important part of a successful physician-patient relationship from a practical perspective. This process requires people to have sufficient information about the goals, benefits and risks of the treatment in question, as well as the patient's ability and freedom to give consent. Decision-making capacity includes the components of patients' ability to understand relevant information, evaluate the situation and its consequences, judge treatment options, make a choice, and communicate the choice.

Obesity
Obesity is still an important health problem all over the world. Numerous studies conducted in recent years show that bariatric surgery is one of the best treatment options for morbid obesity. Since this surgical method is not a hit-run surgical method, it covers a process that has lifelong effects. In this respect, detailed psychosocial evaluation during the preoperative evaluation process is important to ensure postoperative weight loss and sustainability of the treatment. In the evaluation process of candidates seeking bariatric surgery, a medical chart review, a comprehensive clinical interview, psychological testing, as well as psychological evaluation should be part of a multidisciplinary approach aimed at careful evaluation of the risks and benefits associated with surgery for patients.

Transplantation
In recent years, the development of surgical methods in the field of organ and tissue transplantation and the development of new treatment methods have led to an increase in the number of patients receiving organ and tissue transplants all over the world and to patients being able to access these opportunities more easily. Psychiatric consultation and evaluation are an important part of selecting candidates for organ transplantation. The main purpose of this evaluation is to ensure that the transplant is beneficial to life expectancy and quality of life and to enable optimization of the candidate and transplant outcomes. The content of psychosocial assessments is determined by evidence regarding pretransplant psychosocial determinants of transplant outcomes. Psychiatric interviews are necessary to assess patients' ability to give informed consent and to identify possible psychological problems or psychiatric disorders that may disrupt the transplant process. Adequate knowledge about the transplantation process, perceived understanding, and the ability to make independent decisions can be considered as three basic elements in evaluating the ability of a patient with a transplant plan to give informed consent.

In summary, psychosocial evaluations of patients before the treatments are an important determinant in the success of treatments applied in both obesity surgery and transplantation.

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Difficult Case Examples in the Consent Process in Consultation Liaison Psychiatry Practices

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In this panel, three cases that are seen from time to time in the practice of consultation liaison psychiatry and are difficult to manage clinically in terms of consent processes are mentioned.

In the first case, who applied to the organ transplantation unit of our hospital as an unrelated kidney donor candidate and whose suitability was requested by us for evaluation by the ethics committee is discussed. The 28-year-old female patient, primary school graduate, unemployed, applied to be a kidney donor to her partner who is not legally married. In her past life history, it was learned that she had difficulties with emotion regulation and psychiatric admissions from time to time, and that she frequently had conflicts in interpersonal relationships. In the psychometric evaluation, the MMPI result was reported similar to the story as “difficulty in anger control, distrust in interpersonal relationships, skepticism, hypersensitivity to criticism, resistant to being treated unfairly, tension caused by a rigid thought pattern, difficulty in family relationships.” Assessment processes regarding psychiatric suitability as a kidney donor were mentioned in the panel.

In the second example, the multidisciplinary evaluation process of a patient with Prader Willi syndrome who applied to our hospital’s obesity center with a request for bariatric surgery is discussed. 25-year-old female patient, diagnosed with moderate mental retardation, known diabetes and sleep apnea, her parents are hearing impaired, and she has previously attempted to lose weight with diet, sports and medications. However, sufficient weight loss was not achieved. In this panel, psychiatric evaluation in terms of bariatric surgery as a treatment option for obesity in patients with genetic syndromes is discussed with case examples from the literature.

In the third example, the evaluation processes of a patient who was consulted in terms of her adequacy in giving consent because she refused further examinations and treatments while she was in the internal medicine intensive care unit were discussed. 78-year-old female patient, her husband has passed away, she has 2 children, she is a university graduate, previously worked as a pathology technician, and lives alone. It was learned that the patient, who had no known psychiatric diagnosis or follow-up in her history and was admitted to the our hospital with loss of appetite, abdominal pain and dyspeptic complaints, then she was admitted to the intensive care unit to investigate malignancy, and stated that she did not accept the planned medical examinations and wanted to be discharged. A psychiatrist was consulted to evaluate the patient’s decision-making ability. In this panel, considerations and general approaches in the evaluation of a patient who refuses treatment are discussed.

As a result, it may be difficult to evaluate the adequacy of consent in the practice of consultation liaison psychiatry in some patient groups. In these cases, multidisciplinary evaluation is important.

Neoliberal World's "As if" Individuals: Impostor Phenomenon

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The Impostor Phenomenon, refers to a psychological pattern in which individuals doubt their accomplishments and have a persistent fear of being exposed as frauds, despite evidence of their competence. It's characterized by feelings of inadequacy and a belief that one's success is due to luck or external factors rather than genuine ability.

The term was first coined by Pauline Clance and Suzanne Imes in 1978 in their paper "The Impostor Phenomenon in High Achieving Women: Dynamics and Therapeutic Intervention." Regarding the terms of "phenomenon" and "syndrome," in this context, they are often used interchangeably, but there's a subtle distinction. A phenomenon typically refers to a fact or event that can be observed, while a syndrome typically refers to a pattern of symptoms or behaviors that collectively indicate a particular condition. So, while "Impostor Phenomenon" emphasizes the experience itself, "Impostor Syndrome" highlights the collection of symptoms associated with it.
As for the relationship between neoliberalism and the Impostor Phenomenon, some scholars argue that the competitive nature of neoliberalism, which emphasizes individualism, meritocracy, and constant self-improvement, can exacerbate feelings of inadequacy and self-doubt. In neoliberal societies, there's intense pressure to succeed, and individuals may feel that they must constantly prove themselves in order to achieve recognition and success. This pressure can contribute to the development of the Impostor Phenomenon, as individuals may feel that they don't measure up to the high standards set by society.

Furthermore, neoliberalism can contribute to the perpetuation of social inequalities, as it tends to benefit those who are already privileged and exacerbate disparities in wealth and opportunity. Individuals from marginalized groups, who may face systemic barriers to success, may internalize feelings of impostorism as they navigate environments where they are underrepresented and undervalued. Research on the Impostor Phenomenon highly focused on gender issues and and also there is a considerable literature on the occurrence of imposter syndrome in academia. The manifestation of the phenomenon may vary across different groups due to factors such as cultural expectations, social norms, and institutional barriers. Therefore, understanding the Impostor Phenomenon requires considering its intersectionality with factors such as class, gender, race, and other dimensions of diversity.

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Imposter Phenomenon among Mental Health Workers

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The "epistemological uncertainty" surrounding these entities is also reflected in the developing nature of psychiatric classification; this is partially owing to the absence of pertinent clinical biomarkers, "fuzzy boundaries," and unknown etiologies. A mental illness cannot be definitively diagnosed. Personal stories continue to be a part of psychiatry. On the other hand, psychotherapy is frequently an ambiguous process, and it is not unusual for therapists to feel self-doubt: in a full 25% of their sessions, therapists have been shown to question their own efficacy. Psychiatry is a scientific field that is susceptible to subjectivity in the interpersonal domain, frequently lacking an algorithm, and wherever diagnostic and therapeutic interviews are crucial. As psychiatrists in this situation, their careers are accompanied by an ongoing learning process as well as imperfect diagnostic and therapeutic interviews. Doctors who work in the mental health area could be left thinking all the time about this issue. This sense of uncertainty has been given several names by psychiatrists who practice both in the therapeutic setting and in the clinical setting. Among these are the terms "imposter phenomenon," which affects a lot of talented psychiatrists from good training programs who nonetheless think they're inadequate and are afraid of being exposed by their colleagues. While positive outcomes, like heightened awareness and a drive to learn, may be linked to some degree of self-doubt, negative outcomes can result in feelings of hopelessness, alienation, and detachment from the patient as well as possibly other mental health professionals. However, psychiatrists feel a wide spectrum of intense emotions while doing clinical work and use themselves as "tools" in their profession. The phenomenon of imposter and the burnout caused by this difficulty are strongly related. The limit established by the responses to the query, "Who is a psychiatrist?" might help lessen feelings of inadequacy.

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The Imposter Phenomenon and Its Impact on Mental Health

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The phenomenon of imposter syndrome is a multifaceted psychological construct deeply intertwined with various psychiatric disorders, prominently including anxiety disorders and depression. Imposter syndrome manifests as a persistent and pervasive belief that one's achievements are merely a result of luck or circumstance rather than genuine ability or merit. Individuals grappling with imposter syndrome often find themselves ensnared in a perpetual cycle of self-doubt, fearing that they will be exposed as frauds despite external evidence of competence and accomplishment. This profound sense of inadequacy and unworthiness creates fertile ground for the development of anxiety disorders, as individuals are plagued by incessant worry and apprehension about their perceived shortcomings and the potential consequences of being unmasked as imposters.

Moreover, imposter syndrome frequently coexists with symptoms of depression, as individuals internalize their perceived inadequacies and experience a pervasive sense of worthlessness and despair. The relentless self-criticism and negative self-talk characteristic of imposter syndrome contribute to a distorted self-image and exacerbate feelings of hopelessness and despondency. Additionally, the pressure to maintain an illusion of competence and perfectionism perpetuates a cycle of stress and burnout, further predisposing individuals to depressive episodes.

Furthermore, imposter syndrome often correlates with perfectionistic tendencies, wherein individuals set unattainably high standards for themselves and experience profound disappointment and self-recrimination when they inevitably fall short of these expectations. This perfectionistic mindset not only exacerbates feelings of inadequacy and self-doubt but also fosters a chronic state of anxiety and hypervigilance. The constant fear of failure and the relentless pursuit of perfection exact a toll on mental health, contributing to the development and perpetuation of both anxiety disorders and depression.

The interplay between imposter syndrome and psychiatric disorders is complex and multifaceted, with individual experiences shaped by a myriad of factors including personal temperament, social context, and cultural influences. Nevertheless, there exists a prevailing consensus that individuals grappling with imposter syndrome are disproportionately predisposed to developing psychiatric disorders, underscoring the importance of early intervention and targeted therapeutic interventions to mitigate the adverse impact on mental well-being.

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A Diagnosis Challenging the Clinician with the Coexistence of Epilepsyand Dementia: Hippocampal Sclerosis

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Hippocampal sclerosis is a post-mortem diagnosis of neurodegenerative diseases that is frequently encountered both in young adults and in the 85 years and older age group, but has not been adequately included in routine clinical practice due to diagnostic difficulties.

Although ageing itself is the primary etiological factor, febrile convulsion in childhood is an important risk factor. In addition, low-grade tumours, vascular malformations and hemiatrophy, which are considered as 'dual' pathologies, may be seen together. Clinical findings may mimic those of other dementias such as Alzheimer's disease and frontotemporal dementia and may challenge the clinician in terms of diagnosis and treatment. Although the fact that it is a neurodegenerative disease with a slow course seems to be an advantage, it is observed that clinical complaints and findings may change over the years and laboratory results may not meet the criteria, such as the case mentioned in this presentation.

Additionaly, the different points, clinical findings and laboratory results of the clinic, which started with memory symptoms and mild psychiatric symptoms over a period of ten years, will be discussed. At the end of the talk, the audience will be informed about the clinicopathological features, neuroimaging and laboratory findings of Hippocampal Sclerosis.

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Men's Mental Health: Epidemiology, Etiology, and Access to Mental Health Care

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Both men and women experience psychiatric issues; however, there are differences in the problems that affect them and the contributing factors.Men's mental health is an essential but often overlooked health concern, which can affect them differently compared to women.Numerous studies have indicated that men are facing a silent crisis in mental health. Men may exhibit different symptoms or copingmechanisms, which can lead to misdiagnosis. Biological factors such as genetic predisposition, hormonal changes, and neurochemical imbalances contribute to mental health issues in men. Additionally, psychosocial and cultural factors like gender roles and expectations, cultural norms, and social pressures can influence men's mental well-being. Men commonly suffer from untreated anxiety disorders and depression, in addition to frequent cases of suicide, alcohol, and substance use disorders.

In men, depression may be experienced and expressed in different ways. Studies suggest that depression in men may be concealed by substance abuse problems and other externalising behaviours.

The limitation of emotional distress by traditional notions of masculinity may explain why depression in men is often hidden, overlooked and not discussed.

Men are also less inclined than women to accept that they are living with depression.

Although there is no distinct type of 'male depression', some symptoms may be different and more common in men than in women. These include sleep problems, intolerance, sudden anger, self-harm, gambling, increased loss of control, inappropriate sexual behaviour, risk-taking and aggression.

Men may also be more likely to use alcohol and substances instead of talking to cope with depression. Major depression is one of the most important risk factors for suicide.

Alcohol abuse promotes impulsive behaviour as a means of emotional inhibition, reduces self-esteem in social roles and relationships, and leads to social isolation and loss of support. This increases the risk of depression and suicide.

Personal and social barriers to help-seeking, inadequate coping mechanisms, and high suicide rates have been cited as concerns about men's mental health. Women tend to attempt suicide more often.

However, men are 3.5 times more likely to die from suicide than women.Men's mental health faces challenges in terms ofaccess to care, including perceptions of seeking help as a sign of weakness due to gender-related beliefs, less utilization of social supportsystems compared to women, reluctance to express emotions even when seeking help, shorter interactions with healthcare providers during treatment consultations, lower and briefer explanations, a lack of societal empathy towards men's mental health, and media portrayal thatoften criticizes men rather than encouraging them to speak up and seek help.

Keywords: men's mental health, epidemiology, access to mental health care

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Gender Roles and the Psychodynamics of Masculinity

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While gender refers to whether a person is born male or female, gender refers to psychological, social and cultural characteristics that are strongly associated with the biological categories of "woman" and "man". Gender roles are behaviors that are enacted in accordance with socially constructed stereotypes of masculinity and femininity.

Men are socialized by society towards independence and achievement (instrumentality), avoidance of traits associated with femininity and homosexuality (interpersonal dominance), and restriction or suppression of emotional expression (rationality). Men are expected to conform to these norms in order to be considered sufficiently masculine.

It is known that men are less likely than women to seek help for mental health problems and may not have symptoms that fit standard measurement tools.

The field of psychoanalysis and gender is fraught with conceptual, terminological, technical and sociopolitical challenges, making it difficult to establish a direct relationship between behavior and the unconscious during psychodynamic assessment.

It is known that Freud, the founder of psychoanalysis, did not use the terms gender or gender identity. Several generations of psychoanalytic theorists after Freud have attempted to address contemporary questions of gender in their work through Freud's original ideas. Although the history of the concept of gender is a minefield with its history of suffering and oppression, it is nevertheless clear that today we have research tools that were not available in Freud's time.

Whereas in classical psychoanalytic theory the emphasis was on the male child's fear of castration by the powerful father as a punishment for his oedipal desires, many contemporary psychoanalysts now use the term castration not literally but symbolically "to refer to the generally feared punishment and powerlessness at the hands of a powerful figure". Furthermore, a clearer distinction is now made between the anatomical penis and the symbolic phallus, and the phallus is recognized as a symbol of psychic organization for both men and women. It is also recognized that the penis often serves as a metaphor for power and therefore leaves many men vulnerable to narcissistic humiliation and degradation as they question and measure their achievements and sexual performance against other men. The term castration is therefore used today not only to refer to the fear of damage or loss of genitalia, but also metaphorically to denote the threat or loss of any valued human trait or function.

Understanding the early traces of the male child's interactions with primary attachment figures, internalized object relations, dominant sociocultural determinants and their unique responses to basic biological development are essential for psychodynamic assessment.

In psychiatric practice, thinking with the concept of gender is an important tool to understand the roles attributed to each individual through gender identities, how personal history is shaped in relation to these roles, to recognize repetitive defenses, to distinguish the relationship between symptoms and behaviors, and to distinguish current wants and needs.

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A Year in Schizophrenia Research: Pharmacology Research

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The most important expectation regarding the pharmacological treatment of schizophrenia is drugs that will act outside the dopamine receptor system. Xanomelin, which is effective on muscarinic receptors, is gradually coming to an end. In the presentation, after giving brief information about drug studies effective on different receptor systems, a clinical study on Xanomelin will be presented (Kaul 2024).

Reproducible data is needed to make personalized treatment arrangements in the treatment of schizophrenia. Even if we can not solve the mechanism by generating big data, research will help the clinician in predicting the response to treatment. Structural and functional brain imaging studies will have an important place in personalized treatment. Clinical, cognitive symptoms, structural and functional imaging studies are rapidly taking their place in the literature in terms of predicting response to treatment. In the presentation, a study compiling structural and functional imaging data in terms of predicting response to treatment will be presented (Chen 2023).
Although they are not used frequently in our country due to economic reasons, many commercial polygenetic pharmacogenomic tests have been developed to provide personalized treatment. The clinical implications of these tests were evaluated in a trial conducted this year and positive results were revealed.

Another problem in the pharmacological treatment of schizophrenia is the lack of evidence-based data on the continuation of antipsychotic medications after response to treatment or dose reduction/discontinuation strategies in the balance of benefit and harm. In a study published this year, this problem was evaluated and it was shown that antipsychotic dose reduction did not have a positive effect on social functioning (Moncrieff 2023).

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Suicidal Behaviour is Psychological

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The World Health Organization defines suicide as the intentional taking of one's own life or engaging in self-destructive behaviour. These actions are often associated with factors such as the individual's weakened coping skills or the weight of environmental stressors.

There are various theories about suicide. Durkheim's sociological theory suggests that suicide is related to social factors and is associated with the weakening of social ties. Conversely, Beck's cognitive theory posits that suicide is primarily driven by negative thought patterns and feelings of hopelessness. Another theoretical framework, the diathesis-stress model, emphasises the interaction between genetic predisposition and environmental stress factors. Research on the biological aspects of suicide generally indicates that there is a cause-and-effect relationship following a stressor. However, a biological mechanism triggered without a stressor has not yet been proven. Moreover, the inadequacy of existing treatments further emphasises this weakness. Currently, there is no pharmacological or non-pharmacological biological treatment known to prevent suicidal behaviour or ideation. Furthermore, lithium, which is recommended for individuals with chronic suicidal ideation, seems unlikely to be effective without psychosocial intervention.

From a neurobiological perspective, the concept of suicide can often be explained in the light of psychosocial interventions. Although it is assumed that suicide is primarily a psychosocial phenomenon, neurobiological mechanisms and the hypotheses underlying these mechanisms continue to be investigated.

In conclusion, suicide often occurs as a result of complex and multifaceted factors. The interaction of psychosocial, environmental and biological factors may increase the risk of suicide and require the development of more effective interventions. From a biological perspective, the limitations of current research and treatment inadequacies suggest that the neurobiological mechanisms of suicide are not fully understood and treatment is ineffective.

Consequently, psychosocial interventions and environmental support are of great importance in suicide prevention. Future research will play an important role in better understanding the biological basis of suicide and developing effective treatments. However, these efforts should also take into account the psychosocial and environmental factors inherent in suicide.

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Suicide is Psychological

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A person decays from us by ending his life and throwing the lock of the chest containing the facts about his death into the oceans.
In this regard, the community also deals with the environment close to the family. As mentioned by Durkheim in his sociological definition of suicide, the feeling that the individual belongs to a society, the belief that he can find the necessary support, the idea that they will not be left alone has the effect of saving the individual from despair and preventing suicidal behavior. Suicide is a result of a Decadence of the relationship between the individual and society.

If we look at Freud’s psychoanalytic theory, he sees suicide as a problem of depression. An important part of his work consists of the concepts of objects of love and their loss. He explains this situation in terms of grief and melancholy. The loss of the object of love, the disappointments and injuries caused by the lost object of love start a process. Melancholy and grief are a result of this process. Disturbances in self-esteem and self-worth and the fact that object orphans are unconscious are the specific features that distinguish melancholy from mourning. Self-esteem is not affected in mourning. Object losses are in the realm of consciousness. There is an inner deprivation in melancholy, an environmental deprivation in mourning.Disappointments and injuries caused by the loss of the object of love give rise to hostile feelings. These hostile feelings and impulses arise from the desire to take revenge on the object of love, to destroy it, to kill it. With the loss of the object of love, the idle libido turns to the self and is used to identify with the lost object of love in the self. This identity gives the self the qualities of the lost love object. The part that criticizes the self, punishes, Decries conscience, that is, the superself does not distinguish between the object of love and the self. Therefore, self-accusations is self-punishment, and condemnations is actually the condemnation, accusation, and punishment of the lost object of love. Thus, melancholy teaches us how a person sees himself as someone else, how he behaves like a person who is hostile to him.

Beck explains it in terms of hope and despair. There is a significant correlation between negative symptoms related to the future and the severity of suicide. Hopelessness determines the suicidal act more than depression. When despair is controlled, the correlation between depression and suicide disappears.

Lacan suggests that the thought of death is connected to the feeding relationship between mother and child, and this connection can occur in forms of passive suicide, such as anorexia or drug addiction. Suicide is valued as an attempt to return to the linguistic transition, which is a condition for the baby to be structured as a separate object from the mother, and to reunite with the mother.

Suicidal Behavior is a Psychological

Alperen Yıldız
Bakirkoy Prof. Dr. Mazhar Osman Training and Research Hospital for Psychiatry, Neurology and Neurosurgery, Psychiatry Unit, Istanbul, Türkiye

According to estimates by the World Health Organization, there are approximately 785,000 suicides annually worldwide, with a rate of 10.6 per 100,000 population in 2016. Global suicide rates have fallen by approximately 30% in the 21st century. In general, key influences on oscillating trends in suicide include periods of economic recession (often associated with increases), changes in access to commonly used highly lethal methods of suicide, periods of war (often associated with declines in suicide), and media coverage of celebrity suicides (which can lead to temporary increases in suicide rates).

Life stressors such as traumatic experiences, losses, and unemployment can increase the risk of suicide. This is related to the fact that psychologically traumatic experiences can negatively affect an individual's mental health, triggering suicidal thoughts. The decision to commit suicide is often the result of an individual's personal internal conflicts. Psychological factors such as a lack of self-esteem, identity crises, and feelings of worthlessness can contribute to an individual's suicidal ideation.

Social isolation and a lack of support systems can increase an individual's risk of suicide. A lack of psychological support can cause an individual to feel lonely and develop suicidal thoughts. Social isolation due to anxiety, bereavement, or social exclusion is a significant contributor to suicide risk. Conversely, clusters of suicide deaths can occur through social contagion, especially in young people, accounting for 1-2% of child and youth suicides.

Psychological factors can lead to feelings of hopelessness and helplessness. One of the main drivers of suicidal ideation and suicidal behavior is the concept of unbearable psychological pain. The importance of factors such as perceived lack of belonging, increased burden on others, and acquired capability, hopelessness, and knowledge or comfort with lethal means, cognitive characteristics, and proximate influencing factors is increasingly recognized. These feelings may negatively affect an individual's life perspective on the future, increasing the risk of suicide.

Suicidal behavior is more prevalent in certain occupational groups. For instance, health workers and police officers are at elevated risk of suicide due to the intense stressors inherent to their professions. However, it is well-documented that doctors do not commit suicide as a result of illness, but rather due to the stressors they face in their profession. Women are more likely to attempt suicide, but this does not indicate a biological problem. This discrepancy is typically attributed to the fact that women are more susceptible to psychosocial stressors and life challenges.

In conclusion, although suicide is related to a multitude of factors, including psychological, social, cultural, and biological influences, the majority of interventions against suicide are psychosocial in nature. In recent years, there has been a notable shift in the approach to suicide prevention, moving away from the assumption that treating underlying psychiatric disorders will eliminate suicidal impulses and thoughts. Instead, there is a growing recognition that suicidespecific treatments are necessary in addition to interventions for primary psychiatric disorders.

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Understanding Suicide and its Biological Complexity for Prevention

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Almost 1 million people die from suicide worldwide each year, making it a global public health problem. To develop more holistic and effective strategies to reduce suicide-related mortality, we need to understand that it is a multifaceted phenomenon. Yet, there is a common idea that suicide is solely a psychological issue. However, more recent studies emphasize the role of biological substrates in the etiopathogenesis of suicidal behavior.

The stress-diathesis model hypothesizes that suicide results from an interaction between environmental stressors and a trait-like diathesis or susceptibility to suicidal behavior. This susceptibility is increasingly associated with neurobiological factors. The biological basis for this susceptibility is indicated by post-mortem studies, genomic research, and neuroimaging. Neuroimaging and post-mortem studies show structural or functional changes associated with suicidal behavior.

Epigenetic mechanisms and early-life adversity, generally defined as parental neglect or childhood physical, sexual, or emotional abuse, shape brain circuitry and neurochemistry. This diathesis is characterized by abnormalities in the hypothalamic-pituitary-adrenal axis and the serotonin neurotransmitter system. Reduction of specific brain regions' volumes, abnormal connectivity among brain regions such as the prefrontal cortex, amygdala, and anterior cingulate cortex, and neurotoxicity caused by excessive glutamate and cortisol also contribute to this diathesis, leading to increased emotional reactivity and decreased cognitive control. This manifests as poor problem-solving, impulsive decision-making, emotional pain, pessimism, and over-reactivity to negative social signs.

The goal of suicide prevention is to identify these patients before they make an attempt, as one-third of suicide fatalities occur from the first attempt. Treating the underlying and enduring susceptibility to suicidal behavior is also important.

It is crucial to consider suicide as a complex event with a biological basis and to highlight the importance of neurobiological screening and interventions in suicide prevention. Neuroimaging can also help us monitor the effectiveness of treatments, and being able to detect biochemical disturbances helps us classify suicides by intent and lethality, facilitating the management of suicidal behavior. However, neuroimaging and biological screening are not routine and feasible. Current promising findings suggest that we should focus on increasing research into neurobiological markers. As research on this subject increases and the etiopathogenesis becomes clear, evaluations can be made after determining susceptibility to prevent suicide in the future, paving the way for the development of new treatments for suicidal thoughts and behavior.

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The Importance Of The Biological Causes Of Suicidal Behavior

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Suicide behavior is a global health priority with complex biological, social and psychological risk factors and multidimensional clinical presentation.Although suicidal behavior has a heterogeneous structure, it is similar in demographic, clinical and neurobiological aspects and is therefore thought to be a common diathesis.

To date, various neurobiological models have been proposed to elucidate the etiology of suicide.Especially in family studies, genetic transmission, serotonergic system dysfunction, hypothalamo-pituitary-adrenal axis hyperactivity, stress system, lipid metabolism, noradrenergic hyperactivity, anomalies in glial cells and signaling defects have drawn attention to the relationship between suicidal behavior.However, the results of many studies using post-mortem and in-vivo techniques point to important roles for serotonin transmission, noradrenergic transmission and the hypothalamic-pituitary-adrenal axis in the diathesis for suicidal behavior.About 30 years ago, deficits in serotonin function, such as low cerebrospinal fluid concentrations of 5-HIAA (5-hydroxyindoleacetic acid), were first associated with suicide attempts in people with major depression, bipolar disorder, schizophrenia and personality disorders. In parallel, changes in serotonin and 5-HIAA concentrations in the cell bodies of serotonin neurons in the brainstem of individuals who died by suicide were noted independent of psychiatric diagnosis. The hypothalamic-pituitary-adrenal axis regulates physiological responses to stress, mainly through the regulation of cortisol. Individuals who have experienced distress at an early age are usually those in whom the hypothalamic-pituitary axis is hyperactive and the stress response is enhanced. This is partly due to reduced hippocampal expression of glucocorticoid receptors and is associated with increased DNA methylation both in central nervous tissues and in peripheral tissues such as blood or saliva.

Some models have been proposed to examine the relationship between these biological markers and suicidal behavior. A widely accepted explanation comes from the stress-diathesis model, which posits an interaction between life stressors and biological susceptibility to suicidal behavior.Stressors such as life events and psychiatric disorders are important risk factors for suicide, but the diathesis concept explains why few individuals exposed to these stressors attempt suicide.Early life adversity can have long-term effects through epigenetic changes, also associated with epigenetic modification of genes involved in neuronal plasticity, neuronal growth and neuroprotection. Thus, genetic and epigenetic pathways to suicidal behavior may link genes to clinical and cognitive manifestations of biological-intermediate phenotypes.The epigenetic effects of adverse childhood experiences (e.g., life events such as physical or sexual abuse) may also increase an individual’s risk of suicidal behavior by influencing diathesis and increasing the risk of mood disorders.

Understanding the biological correlates of diathesis may provide biomarkers for suicide risk that can be distinguished from biomarkers of comorbid psychiatric disorders and may help predict risk after exposure to stressors such as acute psychiatric disorder or adverse psychosocial events.The stress-diathesis model offers an opportunity to integrate neurobiological phenotypes with clinical and cognitive perspectives in the study and prevention of suicide. Biomarkers of diathesis may help inform risk assessment procedures and treatment selection in suicide prevention. Therefore, it is important to elucidate the neurobiological basis of suicidal behavior. Therefore, in this debate we will focus on the biological causes of suicide.

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Biological Basis for Suicide

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Various neurobiological models have been proposed to elucidate the etiology of suicide. The widely accepted model is the stress-diathesis model. According to this model, predisposing factors such as genetic and other neurobiological risk factors, combined with stressors and clinical conditions, may lead to the emergence of suicidal behavior in individuals. Furthermore, vulnerable individuals have been shown to exhibit abnormal or exaggerated responses to normally neutral stimuli within this model.

Although suicidal behavior exhibits heterogeneous characteristics, studies have demonstrated that suicide deaths and non-fatal but highly lethal suicide attempts share similar demographic, clinical, and neurobiological features. Fortunately, findings from post-mortem studies of the suicidal brain and in-vivo neuroimaging studies have highlighted a neurobiological basis for the diathesis, involving changes from cellular to neuronal circuitry levels and larger structures.

Disturbances in the serotonin system have been highlighted as influential factors in the development of suicidal tendencies. Factors such as decreased serotonin activity, dysfunction of serotonin receptors, and genetic variations in serotonin receptors seem to correlate with suicidal behavior. While research on other neurotransmitter systems like noradrenaline, dopamine, GABA, and glutamate in relation to suicidal behavior is relatively scarce compared to the serotonin system, there is evidence of impaired inhibition in the prefrontal cortex associated with the GABA system in suicidal individuals. Additionally, the observed decrease in suicidal ideation following treatment with ketamine, an NMDA receptor antagonist, underscores the significant role of neurotransmitter system dysfunction in the neurobiology of suicidal behavior. Alterations in BDNF levels and the functioning of the HPA axis also contribute to the understanding of the neurobiology of suicidal behavior.

About 50% of the risk of suicide due to diathesis is inherited. Family studies have linked a family history of suicidal behavior to an increased risk of suicide in individuals. Among the reasons for this association could be modeling or shared environmental stressors (such as abuse, grief, or separation). However, alongside these factors, there appears to be a significant role of genetic factors in familial transmission of suicidal behavior. Studies have shown an increased risk of suicide when there is a history of suicidal behavior in the family, even when controlling for chaotic environments and the adversities of psychopathology.

In this debate, we will argue based on the most robust and recent evidence regarding the biological basis of suicidal behavior. Suicide is a complex human behavior, and it may not be attributable to a single cause. The influence of environmental factors cannot be denied. However, it can be argued that the impact of these environmental stressors on suicidal behavior is minimal in the absence of neurobiological predisposition. The demonstration of similar neurobiological predispositions among individuals who die by suicide further supports this claim. Acknowledging the biological nature of suicide will provide us with greater insight into understanding and preventing this behavior. Increasing the importance of studying suicide from a biological perspective and adapting the neurobiological markers of suicide to clinical practice will enable us to take preventive measures against suicidal behavior in at-risk individuals earlier.

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Pharmacotherapy of Attention Deficit and Hyperactivity Disorder Across the Lifespan Case Presentation

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Attention Deficit Hyperactivity Disorder (ADHD) is a neurodevelopmental disorder characterized by persistent patterns of inattention, hyperactivity, and impulsivity that significantly impact daily functioning. While ADHD is often associated with childhood, it can persist into adulthood, presenting unique challenges and treatment considerations across different life stages. Pharmacotherapy, including stimulant and non-stimulant medications, is a cornerstone of ADHD management at all ages. Yet, the choice of drugs and treatment approach must be tailored to individual needs and developmental factors (1).

During childhood, ADHD symptoms may become apparent in preschool or early school, disrupting academic performance, social interactions, and family dynamics. Stimulant medications such as methylphenidate and amphetamine derivatives are commonly prescribed as first-line treatment for children with ADHD. These medications work by increasing neurotransmitters like dopamine and norepinephrine levels in the brain, helping to improve attention, impulse control, and hyperactivity. Non-stimulant medications like atomoxetine and guanfacine may also be considered, particularly for children who do not respond well to stimulants or have comorbid conditions (2).

As individuals with ADHD transition into adolescence, the challenges associated with the disorder often evolve. Academic demands increase, peer relationships become more complex, and the risk of substance abuse and other risky behaviors rises. Pharmacotherapy remains an essential component of treatment during this stage. Additionally, comorbid conditions such as depression, anxiety, or substance use disorders may emerge, requiring integrated treatment approaches (3).

Into adulthood, ADHD symptoms can persist and continue to impact various aspects of life, including education, employment, relationships, and mental health. While some individuals may experience symptom improvement or remission over time, others may struggle with ongoing impairments and functional deficits. Pharmacotherapy remains a mainstay of treatment for adults with ADHD. However, the choice of medication and dosing strategies may differ from those used in childhood. Long-acting formulations of stimulant medications are often preferred to provide sustained symptom control throughout the day. At the same time, non-stimulant options like bupropion or modafinil may be considered for individuals who prefer or cannot tolerate stimulants (4).

This case presentation illustrates the importance of tailoring pharmacotherapy for ADHD to individual needs and developmental factors across different life stages. By incorporating medication management, behavioral interventions, and ongoing support, healthcare providers can optimize treatment outcomes and improve the overall well-being of individuals with ADHD throughout their lifespan. A collaborative and patient-centered approach involving multidisciplinary care teams, families, and individuals is essential to address the diverse challenges associated with ADHD and promote long-term success.

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Personality Dimensions and Personality Disorders in Men

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The concept of personality is a topic of great interest in the field of mental health today, with numerous perspectives on the subject. Approaches to personality can be broadly categorised as dimensional and categorical models.

Dimensional models do not consider personality solely as a component of psychopathology, as is the case with categorical models. Instead, they view personality as a concept that encompasses the general functioning of the psyche. Recently, guidelines such as the DSM 5 (Diagnostic Statistical Manual 5) and ICD 11 (International Classification of Disease) have emerged that attempt to integrate these two approaches, rather than viewing them in opposition to each other. In both approaches, gender seems to be an important predictor of clinical differences. However, while some researchers suggest that this apparent difference may be related to measurement methods, others suggest that it is a difference that transcends the problems of measurement methods. The personality disorder (PD) that is consistently over-reported in men is antisocial PD. Theoretical approaches are becoming increasingly important in understanding and studying the difference between the sexes. In this article, general views within the psychoanalytic approach on how personality development may differ between the sexes are also discussed. In particular, it has been proposed that the differentiation in the development of the superego may be a significant factor in explaining the observed differences between the sexes. There is evidence that the experience and management of emotions such as shame and guilt may be explanatory for the observed differences between the sexes in the concept of personality. It is also thought that personality traits may offer a complementary perspective that supports this view. Furthermore, it is postulated that personality traits may offer a complementary perspective that supports this view. The clinician's ability to develop understanding and sensitivity to these differences will not only facilitate the clinical management of the manifestations within the framework of this concept, but also mediate the prevention of risks. Both the quality and quantity of personality-related problems may show unique characteristics in the male gender.

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Violence and Suicidal Behaviors in Men

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Violence is the intentional use of physical force with the aim of inflicting harm. Research has demonstrated that the male gender is a risk factor for both perpetrating violence and being a victim of violence. Factors such as prior exposure to violence, recurring victimisation from violence, and a background of childhood neglect and abuse contribute to an increased risk. Suicide is another type of violent behavior for which male gender is a risk factor. Suicide is the deliberate act of ending one's own life voluntarily. According to epidemiological findings, females have higher rates of suicidal ideation and attempts than males, while male suicides outnumber female suicides. The "gender paradox" pertains to the worldwide ratio of completed suicides between males and females, which currently stands at 1.8. It has been the subject of numerous studies, yet it has not been fully explained Major risk factors associated with male suicides include older age, psychiatric disorders, alcohol and substance abuse disorders, social isolation, economic difficulties, and family dynamics. Furthermore, the male gender role appears to exert an influence on this paradox in suicide rates. Men may have a higher vulnerability to illness and death caused by mental disorders because they are less likely to seek help. In addition to risk factors, protective factors such as perceived social support, family cohesion, and access to mental health services appear to apply to males. In addition to risk factors, protective factors such as perceived social support, family cohesion, and access to mental health services also extend to men. However, despite numerous findings, we have yet to establish a predictive model that predicts suicides in both genders. The primary approach still involves individualised suicide assessment with comprehensive history-taking and mental health evaluations. Furthermore, when formulating suicide prevention strategies as a public health concern, it is imperative to account for gender and sexual identity distinctions.

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Working with Men in Psychotherapy: Practical Suggestions to Overcome Difficulties

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In order to overcome the difficulties of working with men in psychotherapy, it is necessary to understand the most basic difficulties that men experience in applying for psychotherapy. If we consider that masculinity, masculine norms, the internalization of masculine characteristics and the acquisition of gender roles starting from childhood, and that all these experiences shape emotions and cognitions, it becomes easier to find our way to overcome difficulties and challenges. Coming to psychotherapy requires opening our inner world and trusting the other person. An experience of loss is one of the primary reasons why men seek psychotherapy. It has been shown that masculine ideals defined for men affect help-seeking behavior and cause difficulties in expressing emotional experiences. Seeking help, communicating with other people, disclosing oneself, showing that one needs help, getting suggestions, getting information and accepting problems are diffucult to accept because of masculine norms. Men experience ambivalence about seeking psychotherapy/ seeking psychiatric support. One of the most effective ways to enable men to participate and sustain the psychotherapy process is to feel that their emotional experiences are truly understood and met with compassion. One of society's most challenging advice, 'boys don't cry', advises boys to put a significant obstacle in front of their emotions as they grow up. Some technical suggestions for the use of therapeutic language when working with male patients have been shown to strengthen the therapeutic alliance. It is recommended to use language that respects the male gender, choose action-oriented words, and use informal language in conversations and situations where appropriate. It is important that the language used in psychotherapy is short, authentic and clear, that the metaphors used are specific to men and non-verbal communication is used effectively.

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Vaginismus

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Vaginismus is defined as repetitive and continuous involuntary contractions in the muscles surrounding the outer part of the vagina when penetration into the vagina is attempted. Contractions are accompanied by fears and anxieties regarding entry. It may be accompanied by contractions in various parts of the body, or even throughout the body, closing of the legs, tremors, palpitations, sweating, nausea, vomiting, feeling unwell and crying. While the prevalence of vaginismus worldwide is between 1-7%, it is stated that in clinical conditions the rate increases to between 5-17%. It is seen that these rates are much higher in Turkey in different studies. The incidence of vaginismus in women was found to be 15.3%. Vaginismus was found to be the most common sexual dysfunction in female patients applying to the clinic (41%).

The only scientifically proven treatment for vaginismus today is sexual therapy. We can say that it is the sexual dysfunction that responds best and in the shortest time to sexual therapy. There is almost a 100% improvement in vaginismus with appropriate sexual therapy. Sexual therapy is mostly carried out in the form of couple interviews. First, a comprehensive sexual life history is taken, the couple's difficulties are evaluated, and their concerns are investigated. It is a delayed sexual education done in the first sessions. The aim is to inform the couple about sexual health, correct misconceptions, and convey the truth about sexual organs and sexual physiology. Afterwards, the contraction and fears about entry are gradually addressed with exercises. The aim of vaginismus treatment should not be "to have sexual intercourse - to somehow ensure that the penis enters the vagina". The aim of the treatment should be to "ensure that the woman does not experience negativities such as contraction, pain, avoidance, or fear, and that the couple enjoys a satisfactory sexual life for the couple." Psychiatric illness, depression, anxiety disorder, and additional sexual problems in men make treatment difficult. Additional problems are addressed and treated before or during therapy. In this session, we will try to evaluate the diagnosis and treatment of vaginismus from a systematic perspective in the light of the literature. In addition to standard therapies in the treatment of vaginismus, it is planned to address the approaches included in the literature.

The Diagnosis and Treatment of Sexual Dysfunction: A Systematic Overview Hypoactive Sexual Desire Disorder

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Hypoactive sexual desire disorder can be defined as the individual's lack of interest in or complete absence of desire for sexual activities. It is a multi-dimensional sexual issue commonly observed among sexual dysfunctions. Sexual desire consists of biological, motivational (individual and relationship-related factors), and cultural components. In Hypoactive sexual desire disorder, the interaction of multiple factors typically plays a role in the process.

Among biological factors, endocrine disorders are particularly considered. Hyperprolactinemia, hypogonadism, thyroid dysfunction, chronic illnesses, and medication side effects can be listed among the biological factors that can cause decrease in sexual desire. In the diagnostic evaluation and determination of treatment approach, the clinician should first assess the underlying biological conditions.

Mental illnesses can indeed be another cause of decreased sexual desire. Changes in sexual functions and a decrease in sexual desire can occur in depressive disorders or anxiety disorders. In this case, the treatment plan initially focuses on treating the mental illness, followed by a reassessment of the treatment process for decreased sexual desire.

The negative experiences in a person's sexual life, sometimes having a history of trauma, and having incorrect attitudes and beliefs about sexuality are also significant factors contributing to decreased sexual desire. Relational factors such as communication deficiencies, conflicts, and emotional distance between partners, as well as the cultural norms of the society in which the individual lives, can have a negative impact on sexual life and lead to decreased sexual desire. An important point here is that in other sexual dysfunctions, a decrease in sexual desire may occur after a while. Therefore, when evaluating sexual dysfunction, it is essential to first determine which sexual problem has arisen, and then thoroughly examine how the Hypoactive sexual desire disorder developed.

In conclusion, Hypoactive sexual desire disorder is a significant sexual dysfunction that requires a systematic approach in diagnosis and treatment. In treatment, detailed clinical assessment is conducted, followed by planning for sexual therapy involving both partners after identifying underlying conditions.

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A Systematic View of Diagnosis and Treatment of Sexual Dysfunctions
Erectile Dysfunction

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Sexual dysfunction are defined as difficulties experienced by an individual or partners during any stage of normal sexual activity. Erectile dysfunction (ED), which is one of the most common sexual dysfunctions diagnosed in psychiatric outpatient clinics, is defined as the inability to initiate and maintain penile erection, which is necessary for sexual intercourse (1). The frequency of erectile dysfunction is increasing with the increasing healthy elderly population and is a common health problem all over the world. Studies have shown that the prevalence of ED in men between the ages of 40-70 is 52% in the United States and 69.2% in Turkey. (1) In 1995, more than 152 million men worldwide were thought to have experienced ED, while by 2025 this number is estimated to be approximately 322 million. (2)

In addition to medical diseases and drugs that affect vascular, hormonal and neurological structure, psychological factors such as mental illnesses, false beliefs about sexuality, deterioration in body image, performance anxiety, current stressors and relationship problems may be included in the etiology of ED. (3) When performing diagnostic evaluation, factors that may lead to and maintain ED should be evaluated individually. A multidisciplinary approach is required to investigate medical causes and include them in the treatment plan.

The treatment of ED varies depending on the underlying factors. When making a treatment plan, treatment of possible underlying organic problems, lifestyle changes and psychosocial factors that initiate or maintain the problem should be taken into account. Treatment usually involves a combination of psychotherapeutic, pharmacological and behavioral methods.

In this panel, what should be considered in the diagnostic evaluation of ED cases, which is one of the common sexual dysfunctions in psychiatric outpatient clinics, the factors to be considered in the differentiation of organic and psychogenic factors in etiology, and treatment methods will be presented from a systematic perspective. This panel aims to increase the knowledge and awareness of the participants about when to refer their patients who apply for erectile dysfunction to a sexual therapist and when to other branches such as urology or internal medicine

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Historical Perspective on Forms of Masculinity

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Gender studies have shown that being a woman has sociocultural meanings in addition to its biological meaning. However, it has become clear that more than understanding society and women is needed. The issue must be addressed together with the male gender. Factors such as the weakening of traditions, customs, beliefs, industrialization, technological developments, urbanization, and migration have made discussing and redefining gender.

The history of forms of masculinity varies according to human history and culture. Since ancient times, masculinity has been defined and experienced differently in various societies. For example, in ancient Greece, masculinity was often associated with warriors, courage, and physical strength. In medieval Europe, on the other hand, values such as nobility, chivalry, and the continuation of family heritage came to the fore. With the Industrial Revolution and the rise of industrial societies, the concept of masculinity began to change. New job roles, such as factory workers, associated masculinity with labor and productivity rather than greater physical strength. In the 20th century, wars affected society's ideal of masculinity; values such as military bravery and patriotism came to the fore.

Masculinity studies first came to the agenda with feminist theoretical studies, then found its place in sociological studies, and went through three theoretical phases. The first wave emerged after the 1950s. In particular, it includes studies on the adverse effects of trying to conform to social masculinity values on men's lives and the price they pay. The second wave in the 1970s was characterized by studies examining the central role played by male power, especially those that introduced the concept of hegemonic masculinity. The gender debates and research sparked by feminism focused on women and then continued with studies on male identity from the early 1980s. The third wave of masculinity studies was influenced by feminist structuralist and postmodern thought and focused on how men perceive their identity. Thus, in the late 1970s, masculinity studies entered research as a discipline. From the 1980s onwards, the idea that there is no dominant and unchanging model of masculinity has become widespread in masculinity studies; by the 1990s, masculinity studies as an interdisciplinary field had been making outstanding contributions to the awareness and achievements of gender equality.

Today, gender roles and forms of masculinity are changing rapidly, and the existing gender order is transforming. The fluidity of today's power structures weakens the image of the strong man and emphasizes the modern masculinity model that is more fragile and open to sharing. In this way, the trace of traditional masculinity continues through hegemonic masculinity, revealing the model of "new and ideal masculinity." New alternative masculinities represent a type of masculinity that reacts with communication to eradicate violence and inequality. This session aims to present a historical overview of the forms of masculinity and the formation process of the men's movement.

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Who is Equal to Whom: A View of Gender Inequality through Dualism

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Historically, research on men studies has changed over the years. Literature shows that attractiveness and partner preferences were the main topics in the past. Today, the role of interactions on relationships and desire toward varying kinds of masculinities is also being studied. Still, there is a gap in studies on how communication and language affect women in terms of partner choice or feeling attraction to men.

Feminist theories have explained the myth of the ‘’warrior’s rest’’ which classifies women into two types: those for casual sex and those for marital and family purposes. The term is exerted by dominant traditional masculinities. Dominant traditional masculinity (DTM) represents hegemonic men with non-egalitarian attitudes, in other words, ‘’bad boys’’. The oppressed traditional masculinity (OTM) represents men who are non-violent and unattractive. The dualist understanding of gender also categorizes men, while the feminist movement condemns men when they behave in this sexist way.

It is known that some women behave like warriors by having a relationship with DTM to have fun and OTM for rest. In other words, they choose OTM for stable relationships without desire and while feeling attraction toward DTM.

Through qualitative studies, it is explored how language and social interaction among women can lead to the reproduction of the DTM role by women. On the other hand, it is also studied how new alternative masculinities (NAM) offer an alternative through the language of desire.

The analysis of communicative acts provides knowledge evidencing the importance of language use in the reproduction of double standards in gender relations. It also provides an understanding of how the practice is maintained and how to prevent it through language.

This session aimed to present the implications of new alternative masculinities regarding the prevention of gender-based violence.

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Is There an Alternative to Masculinity?

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The definition of masculinity has evolved in response to changes in societal values, norms, and perceptions. Historically, masculinity has been closely tied to traits like strength, competition, and emotional and physical endurance. However, new alternative masculinities have emerged, advocating for communication as a means to combat violence and inequality. This paradigm shift takes a broader perspective on gender roles and norms, associating masculinity not only with traditional traits but also with emotional intelligence, relationship skills, and social responsibilities. In this context, men are encouraged to express their feelings, empathize, and support others.

Studies have analyzed women's use of non-violent language in everyday interactions and how they communicate with violent men. These studies reveal how language and social interaction among women can perpetuate traditional masculine roles, while also shaping new alternative masculinities and influencing desires. Research on the importance of language in perpetuating gender double standards focuses on gender differences in conversation topics, language use, and the impact of social context on interpersonal communication.

The goal is to understand how and why certain practices persist and how language can contribute to their prevention.

Studies have highlighted that humor, particularly jokes bordering on homophobia, not only reinforces power dynamics over women but also creates hierarchies among men, often marginalizing those who do not conform to traditional norms. Men embracing the new alternative masculinity model employ a language of communication that fosters egalitarian relationships, encouraging emotional expression, empathy, and supportiveness. This approach promotes sensitivity, empathy, and the normalization of men sharing vulnerability and concerns, as well as fostering respect, encouragement, empowerment, and egalitarian communication.

The communicative actions of these alternative masculinities challenge dominant attitudes such as ridicule, scolding, and exclusionary communication, offering alternatives for combating gender-based violence, promoting equality in relationships, and building healthier connections. This session aims to explore the implications of new alternative masculinities for preventing gender-based violence.

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Initial Assessment in Psychodynamic Psychotherapy

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The initial assessment in psychodynamic psychotherapy serves several purposes. The primary goal is to understand the patient's current condition and make a diagnostic evaluation. Another objective, as with any psychotherapeutic approach, is to determine whether the patient is suitable for the psychotherapy method the clinician is skilled in and, more importantly, whether this method is appropriate for the patient. An ethical and unbiased approach should be used to make an objective assessment of the most suitable treatment approach for the patient, based on scientific data. Nancy McWilliams (1994) provides a striking example that the Alcoholics Anonymous (AA) meetings are full of individuals who have spent years in analysis or consulted with many professionals without ever discussing substance use or being asked about it.

According to McWilliams (1994), when conducted sensitively and by someone adequately trained, diagnostic studies offer at least five interrelated benefits: (1) aid in treatment planning, (2) information about prognosis, (3) contribution to the protection of mental health service consumers, (4) value in enabling the therapist to establish communication based on empathy, and (5) reducing the likelihood that individuals prone to anxiety might avoid treatment. Additionally, the diagnostic process indirectly facilitates better therapeutic outcomes through other benefits.

The basic information to be gathered during the initial assessment can be summarized as follows: learning sociodemographic details, understanding current problems and their onset, acquiring personal history, performing a current mental status evaluation, allowing the patient to raise points they wish to discuss, collecting their questions, and finally, making dynamic inferences from the data obtained during the interview.

Patients often present with symptoms. They share their stories, thoughts, and emotions related to these symptoms. During this process, the therapist attempts to understand the patient using psychoanalytic theory, allowing for free association without asking too many questions. The therapist, who has knowledge about child development and experience with patients, first needs to learn about the patient's childhood. However, not everything the patient says can be taken at face value; for instance, a patient may discuss their father, but these statements might not be entirely true and could include elements of fantasy. Thus, a comprehensive understanding is formed based on the patient's narratives, interpretations, behaviors, anxieties, and defenses (Köşkdere, 2024).

However, more critical than technical information and also more effective in terms of therapeutic alliance is an empathetic human attitude. Regardless of personality type, an individual with deep religious beliefs will need to see that the therapist respects their beliefs during the consultation (Lovinger, 1984); although interventions based on diagnosis are valuable, they will come second to the respect a therapist shows for the patient's religious beliefs (McWilliams, 1994).

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Monism over Dualism

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The ontological problem of the mind is one of the main problems of philosophy that has survived to this day and is still unsolved. Throughout history, with the progress of science, both philosophy and medicine have progressed and developed various theories about thought, mostly related to human beings, and one of the most important of these theories is the problem of the mind. How and what the mind voccurs, how can we describe and limit the mind, is the mind related to the body or function of the brain or mostly related to the soul, as Descartes and Spinoza who are known with this conceptualisation.

Descartes was an important 17th century thinker who laid the foundations of Cartesian philosophy. Cartesian philosophy is based on a dualistic perspective which is related to the two substances: mental and physical likewise the universe has two basic substances: mental matter and physical matter, that emphasises the distinction between mind and body. Mental matter represents thought, emotion and consciousness, while physical matter refers to the substances that make up matter and space. In particular, the pineal gland in the brain was the area where these two substances interacted. Through its field, mental substance could occur outside the body. But this view raises a number of problems that need to be explained.

Spinoza (1632-1677), as one of the most important representatives of monistic thought, brought a possible solution to this problem. According to the monistic view, the universe consisted of a single substance. According to Spinoza, this single substance could create both physical and mental processes. According to the monistic view, there is no distinction between mind and body, but both are formed by the same basic substance. In this way, many problems arising from dualistic thinking were eliminated. Of course, the monistic view brought with it a number of problems that needed to be explained.

Spinoza's monistic approach solves many problems that arise from dualistic thinking. In particular, problems such as how the mind and body interact, and how mental matter can exist outside the body, can be addressed more clearly under the monistic perspective. According to Spinoza, the fact that the universe is composed of a single substance removes the distinction between the mental and the physical and makes the basic structure of the universe more understandable.

However, the monistic view has many problems that need to be explained. In particular, issues such as how to distinguish mental and physical processes on the basis of a single substance and how to explain complex human experience are debated among monistic philosophers. In addition, the problem of determinism raised by monism should also be considered. The determined functioning of the universe based on a single substance can create difficulties in explaining concepts such as free will and human freedom.

In conclusion, Spinoza's monistic view provides an important framework for dealing with issues such as the mind-body relationship and the fundamental structure of the universe. However, monism also has many difficulties to explain and is still debated among philosophers. For this reason, Spinoza's philosophy occupies an important place in modern thought and continues to be analysed by philosophers.

In this discussion we try to critics both dualistic and monistic view of mind-body problem. This problem still unsolved and it contains many mysteries. So we knew that how difficult this topic but thanks to the philosopers whom are so worked about this problem suggested some solutions. In this session we are not only discuss this problem but also try to explain these philosophers solutions.

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Monism over Dualism

Utku Nayki

The ontological problem of the mind is one of the main problems of philosophy that has survived to this day and is still unsolved. Throughout history, with the progress of science, both philosophy and medicine have progressed and developed various theories about thought, mostly related to human beings, and one of the most important of these theories is the problem of the mind. How and what the mind voccurs, how can we describe and limit the mind, is the mind related to the body or function of the brain or mostly related to the soul, as Descartes and Spinoza who are known with this conceptualisation.

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However, Descartes' dualistic view raises a number of problems. In particular, how the mind and body interact, and how mental matter can exist outside the body, is a matter of debate. For this reason, Descartes' philosophy has led to an in-depth examination of issues such as the mind-body relationship and the nature of consciousness in modern philosophy. Understanding and explaining this duality between the mental and the physical is a major problem of modern philosophy and is still hotly debated among philosophers. These problems have led to criticism of Descartes' philosophical view and the development of a broader understanding.

The ''dualism view'' created contradictions with the problem of ''Occam's razor.'' According to this view, which dates back to the 14th century, if there are two different explanations for a phenomenon, the simpler of the two should be preferred to the more complex one. The dualistic view is complex because when it is proposed as a solution, it brings with it a whole new set of problems that need to be solved. To give some examples of these problems: how do two different substances come into being, how do they interact with each other, and if they have the potential to interact, whether there must be a third substance in the field of interaction. It was therefore necessary to find a simpler explanation in order to minimise the problems that might arise in trying to solve the ontological problem of the mind.

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"Revisiting the Mind-Body Problem: A New Perspective"
"Dualism Group: Mind Theories and an Unresolved Debate"

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The mind-body problem concerns the separate natures of the mind and body, as well as their relationship. Indeed, numerous thinkers from pre-Socratic times to philosophers such as Plato (427-347 BC) and Aristotle (384-322 BC), and from medieval scholars to modern philosophers, have grappled with this issue. However, before the 1600s, specifically until Rene Descartes' analysis in his work "Meditations," the mind-body problem had not been systematically addressed (1). Descartes believes that the mind and body are fundamentally different from each other. According to him, neither the mind possesses spatial properties nor can the body engage in thought. Dualism is one of the primary positions in the philosophy of mind, yet it is often viewed today as antiquated or treated as a pseudo-scientific theory, akin to phrenology. However, modern dualism, initiated by Descartes as a philosophical theory, emerged as a response to a profound question that remains equally relevant today. On one hand, humans possess deterministic knowledge about themselves through natural sciences, while on the other hand, they have experiential evidence of acting, thinking, and feeling freely. This duality in the human condition (primarily due to issues such as consciousness, self-identity, and qualia) remains far from resolved (2). This enigmatic problem, both intriguing and unsettling, prompts introspection.

Dualism, when contemplating the mind and body problem, asserts that these two realms, whether substantial or qualitative, are irreducible to each other. Today, it continues to be a legitimate philosophical position, supported by modern evidence in our medical knowledge and psychiatric clinic experiences. The current necessity of psychiatry to integrate both natural and social sciences for understanding and theory-building, acknowledging heterogeneous factors (biological, social, developmental, existential, etc.) influencing psychiatric disorders, serves as a strong example of this. The bio-psycho-social model, which rejects the reduction of psychiatric etiology solely to brain and physical events occurring in the brain, is both more inclusive of the causes of pathology and far from denying the functions and benefits of our non-pharmacological treatment methods, such as psychotherapies.

In the world of objects, such as trees, stones, and roads, they are physical, but humans possess a non-physical quality absent in these inanimate substances. Although mental events such as intention, belief, and thought occur within those with physical substance, they are not physical; hence, we do not discuss the thoughts of a tree. However, when discussing human mentality, reducing it solely to neuronal, physical states proves inadequate in explaining how we can interact with reality, whether our mind accurately reflects the external world or whether the external world is entirely an illusion. A similar issue arises in our interactions with others. Assuming a physicalist stance, we cannot even be sure that others have minds of their own, as our minds will not be directly accessible to others from this perspective (3). This would again entail disregarding the entire discipline of psychiatry, from psychiatric examinations to our therapeutic methods within the psychotherapeutic relationship. More importantly, presuming that the impaired mechanisms in psychiatric disorders are solely in the brain and material will lead us to a non-medical attitude beyond the ethics of psychiatry, persuading our patients to endure suffering and convincing them that their painful experiences are not reality but merely neurochemical in nature.

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Dualism Monism Debate
Cartesian Group

Yusuf Dökmen

In our daily experiences, we easily accept that mental elements such as our desires, dreams and emotions are in a very different category from physical elements. Descartes' Cartesian dualist account of the nature of the mind is a theory that is very compatible with our common sense in terms of our perception that the physical and the mental are separate, mutually exclusive realities. Cartesian dualism has three main arguments. Mentality is a fundamental element and cannot be reduced to the physical, there is a subject that carries mental elements, and the third is that this subject does not take up space and is separate from the physical. Our explanations of the mind in the modern age have become quite different, and it can easily be thought that Cartesian theory is an explanation that belongs to the intellectual world of the 17th century and has only historical significance for us. Although the Cartesian dualist explanation has provided a comprehensive explanation for the mystery of the mind, it has also revealed many problems that seem very difficult to solve. Despite these difficult problems about the nature of the mind, the view that Cartesian dualism has an ontological basis seems worth defending.

Erik Erikson and the Eight Stages of Life

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Erik Erikson, a theorist within the self-psychology movement, has developed an original development theory that covers the entire human life. It can be said that Erikson's developmental theory has three sources of inspiration: psychosocial perspective, dialectical reasoning principle and epigenetic principle. Erikson's eight stages of life; It is divided into periods as oral, anal, phallic, latent, adolescence and youth, young adulthood, middle age and old age.

In anthropological periods, if young people can prove they are worthy of being a member of society through specific tests, they are allowed to be considered adults and start a family. On the other hand, every young person strives to be similar enough to the other members of the society he wants to be considered a member of, but still to be unique enough not to be confused with anyone else, that is, to remain himself.

This tension is resolved with the development of a sense of identity. Suppose the young person has difficulty making a choice among the endless diversity in front of him. In that case, he experiences identity confusion, which is a dystonic feeling specific to this stage. Identity confusion is resolved healthily as the young individual develops the vitality of loyalty. The primary pathology of this stage is dislike, which refers to dislike of anyone, any job, role, leader, or idea. It forces the young person into an inextricable identity confusion or reverse identity choice.

The young adulthood phase is when a person establishes genuinely close relationships. Establishing closeness in relationships means fusing their identities within the relationship and complementing each other. If the young adult has not reached the phase of closeness with a solid sense of identity, the young adult may withdraw from close relationships due to the anxiety that he will ultimately lose his identity. Loneliness, which is the dystonic element of this phase, is observed. This phase is resolved with the sixth vital force, love. The antithesis of love is exclusivity. Some amount of exclusion is necessary to establish close relationships. Still, when it reaches destructive or self-destructive levels, it constitutes the primary pathology.

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Childhood and Adolescence According to Developmental Theories

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Childhood and adolescence are critical periods in human development, characterized by profound physical, cognitive, emotional, and social changes. Psychiatric understanding of these developmental stages is crucial for assessing and addressing mental health issues that may arise during this time. Developmental theories provide a framework for comprehending the complexities of childhood and adolescence, guiding psychiatric practitioners in their evaluation and intervention strategies (1). Perspectives to understand childhood and adolescence are,

Psychoanalytic Perspective
Sigmund Freud's psychoanalytic theory emphasizes the importance of early childhood experiences in shaping personality development. During adolescence, Freud proposed the emergence of the genital stage, characterized by the awakening of sexual impulses and the formation of identity. Adolescents may experience conflicts related to their sexual desires, social relationships, and sense of self. Psychiatric assessment from a psychoanalytic perspective would involve exploring these underlying conflicts and their potential manifestations in symptoms such as anxiety, depression, or identity disturbances (2).

Cognitive Perspective
Jean Piaget's cognitive development theory emphasizes the role of cognitive processes in shaping a child's understanding of the world. During childhood and adolescence, individuals undergo significant cognitive transformations, including improvements in memory, reasoning, and problem-solving skills. From a cognitive perspective, psychiatric evaluation would assess cognitive abilities and identify potential deficits or distortions that may contribute to psychiatric symptoms such as impaired concentration, disorganized thinking, or poor decision-making (3).

Psychosocial Perspective
Erik Erikson's psychosocial theory emphasizes the importance of social relationships and identity development across the lifespan. Erikson proposed a series of psychosocial stages, each associated with a unique developmental task or crisis that must be resolved for healthy psychosocial functioning (4).

In this presentation, we will explore childhood and adolescence through the lens of prominent developmental theories, including psychoanalytic, cognitive, and socioemotional perspectives. By examining how these theories elucidate the psychological processes underlying these life stages, we can gain insights into their challenges and opportunities for psychiatric practice.

Keywords: childhood, adolescence, psychosocial, psychodynamic, cognitive, theory

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Old Age According to Developmental Theories

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Developmental are theories developed to explain the physical, cognitive and emotional development of humans from prenatal period to old age and the factors affecting this development. Like many things in the universe and nature, understanding its own nature and development has been a fundamental question for humankind. In the early 1900s, Sigmund Freud postulated his psychoanalytic theory of developmental stages, but limited it to early childhood. Nonetheless, old age remained an unexplored territory for Freud and other early psychoanalysts. A broader focus on adult—but not geriatric—development began with a new generation of postwar analysts, including the noted child psychoanalyst Erik H. Erikson, best known for his writings on the human life cycle and theory of the eight stages of man (Erikson, 1950).

Elderly, by mechanical definition, an average age over 60, in physical (organic) structures, "It is a person who has wear and tear in his mental, spiritual and social stabilities. According to Erik Erikson's theory, a person experiences a series of psychosocial conflicts at each stage that may have positive or negative consequences for the development of his personality. If a person successfully completes the conflicts that occur in these stages, he will gain virtues that will benefit him for the rest of his life. However, failure to complete the stages successfully will make it difficult to complete the subsequent stages. The theme of 'Despair versus Self-Integrity' is a process that coincides with the period between the ages after 65. The fundamental virtue is wisdom. Several other developmental theorists have built upon Erikson's writings about the life cycle in adulthood. Later on, Yale psychologist Daniel Levinson detailed early and middle adult tasks and transitions based upon longitudinal interviews with 40 individual men (Levinson et al., 1978). Levinson's stages and transitions hinged mostly on events within their chronological limits, whereas Erikson's stages integrated potential and extant strengths and weaknesses from across the lifecycle. Like Levinson, Harvard psychiatrist George Vaillant based his stage theory both on Erikson's work and on the longitudinal study of aging adults though his extensive empirical research as director of the Study on Adult Development at Harvard (Vaillant, 2002, 2012). In contrast to Erikson, Vaillant's own perspective moves away from emphasizing "stages" and instead focuses on the "developmental tasks" of life that are typically but not always sequential (Vaillant, 2002).

Eye Movements and Pupil Response in Understanding Brain Dynamics Physiology of Eye Movements and Research Methods

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Abstract
Eye movements are examined within various paradigms: smooth pursuit eye movements (SPEM), memory-guided saccades, and prosaccade/antisaccade. These paradigms are designed to evaluate the fundamental behavior of eye movements and measure cognitive control functions(Khayrullina et al., 2022). Particularly, prosaccade/antisaccade tasks have proven to be useful tools for researchers investigating the neurocognitive outcomes of various psychiatric disorders{Hutton, 2008, Cognitive control of saccadic eye movements} (Hutton, 2008). Performance measurements are typically expressed as the percentage of erroneous prosaccades (error rate) and the time taken to initiate correct antisaccades (latency).

Saccades support the reflex-like exploration of our surroundings by swiftly focusing the eyes on an object or location of interest. The neurological basis of saccadic control involves the fronto-thalamo-striatal circuit. Areas involved in saccadic control include the frontal eye fields (FEF), supplementary eye field (SEF), posterior parietal cortex, caudate nucleus, and substantia nigra.

SPEM encompass eye movements made to track a moving object, with the eye movement velocity continuously adjusting to match the object's velocity. SPEM measurements commonly include the ratio of eye movement velocity to target velocity. SPEM is controlled by the FEF and medial temporal cortex along with the medial superior temporal cortex.

Memory-guided saccades involve a paradigm used to examine memory, where participants are instructed to fixate on a central point while a target appears in the peripheral visual field. Participants must remember the target's location without looking directly at it (without making a saccade). When the fixation point disappears, participants must make a saccade to the remembered location of the target. The failure in the memory-guided saccade task can be assumed to be associated with a dysfunction in the executive function of the frontal cortex.

Antisaccade tasks require inhibiting a saccade induced by an unexpected visual stimulus and then generating a saccade in the opposite direction. These tasks provide insights into cognitive control and the examination of specific psychiatric disorders.

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The Importance of Eye Movements in Psychiatric Disorders

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Serbest Hekim

The study of eye movements in psychiatry and psychopathology began in 1908 based on the pioneer research of Allen Ross Diefendorf and Raymond Dodge.

The relationship between oculomotor performance and psychopathology has been a subject of interest, indicating that saccadic eye movements play a significant role in psychiatric diseases. Studies comparing eye movements in different psychiatric disorders have highlighted distinct patterns, suggesting that analyzing eye movements could provide valuable insights into the underlying mechanisms of these conditions

Abnormalities in eye movements have been suggested as non-invasive biomarkers for diagnosing psychiatric disorders like schizophrenia and major depressive disorder (Takahashi et al. 2021). These abnormalities have been described in association with cognitive and emotional deficits across neurological, neurodevelopmental, and psychiatric conditions (Carelli et al.2022).

Saccadic eye movements have been proposed as quantitative biomarkers for a range of disorders and analyzing eye movements, particularly saccadic eye movements, can provide insights into mood regulation, emotional processing, and psychomotor disturbances. (Carvalho et al. 2015).

In conclusion, eye movements play a crucial role in understanding and potentially diagnosing psychiatric disorders. Further research in this area could lead to the development of innovative diagnostic and therapeutic approaches for psychiatric conditions based on eye movement analyses.

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Relationship between Pupil Response and Cognitive Processes

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Perception of the external world requires neural responses appropriate to the color and brightness of visual stimuli. For this, the pupil plays a fundamental role in adjusting the amount of light falling on the retina. In addition, pupillary response plays a role in depth perception. Beyond the visual properties of stimuli, the pupil is known to be an indicator of cognitive load. Numerous studies have shown that pupil dilatation occurs in situations where cognitive load increases, such as directing attention, overt and covert attention, working memory, short-term memory, decision making, and also in the face of obvious and unexpected stimuli. Increased arousal and cognitive load cause activation of the locus ceruleus (LC), one of the main executors of the diffuse modulatory system and the major source of norepinephrine, and increased norepinephrine leads to pupil dilatation. Indeed, animal studies have shown that LC cell membrane potential fluctuations are blunted by fluctuations in pupil diameter over time. Furthermore, several functional magnetic resonance imaging studies have demonstrated a relationship between task-related pupil dilation and LC activation. The direct observation of pupillary response and its relationship with task response points to the importance of pupillometry in the study of cognitive functions and leads to an increase in its use.

Task-related pupillary responses are related to task difficulty and task type. It has been shown that difficult tasks in older individuals cause pupil constriction in contrast to younger individuals. At the same time, there are studies showing that task difficulty causes pupillary constriction above a certain level. Because of these results, the relationship between cognitive load and pupil diameter is thought to be an inverted U-shape. The pupillary response pattern also varies during task switching and task maintenance. According to the adaptive gain theory, the use of attentional resources to maintain a task is related to phasic firings in the locus ceruleus norepinephrine system (LC-NE), while tonic firings are thought to be responsible for shifting attention to another task, searching, and turning to different resources. It has been shown that tonic firing causes high and phasic firing causes moderate pupil diameter increase. In fact, it has been revealed that higher basal pupil diameter predicts lower performance in tasks related to maintenance of attention.

Top-down cortical regulation is also critical in the pupillary response to cognitive load. In a study conducted in macaques, it has been shown that frontal visual field stimulation causes pupil dilation, and when the stimulation level is increased, a saccadic response occurs. This result, together with the results of other studies in which pupil dilation was observed before eye movement towards the stimulus, indicates that pupil dilation is an indicator of cognitive preparation. In another study, a positive correlation was found between the activity of the posterior cingulate cortex, thalamus, orbitofrontal cortex and superior colliculus and pupil diameter during a task requiring constant and continuous use of attentional resources. Further studies are needed to make clearer inferences about the role of cortical organization of the LC-NE system in the task-pupil diameter relationship.

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Treatment In Difficult Cases: Psychiatrist After The Suicide Of A Patient
Psychological Difficulties Experienced by a Psychiatrist After the Suicide of a Patient

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One of the most challenging experiences psychiatrists will face throughout their careers may be the death of a patient by suicide. This experience is not uncommon and likely to happen at least once during a psychiatrist's career. It is reported that more than half of psychiatrists experience the death of their patients as a result of completed suicide during their careers, and one-third of psychiatry trainees experience the death of their patients due to completed suicide during their training period.

Such experiences may lead to severe psychological reactions in psychiatrists. These psychological reactions include shock, denial, depersonalization, sadness, shame, guilt, inadequacy, fear of being blamed and found wrong, anger, relief, and symptoms of post-traumatic stress disorder. Death by suicide of a psychiatrist's patient can be an intensely complex and painful event with a wide range of emotional responses. Various factors, such as the personality characteristics of the psychiatrist, the level and quality of their relationship with the patient, and whether they have had such an experience before, play a role in the differentiation of the psychological responses given.

Certain things that can be done before and after encountering such a traumatic experience to help psychiatrists cope with it are recommended. First of all, integrating this subject into the psychiatry training program is essential. It would be helpful to include in the program the psychological reactions that psychiatrists often experience after completed suicides, how to recognize these reactions, how to create support systems, how to ensure professional solidarity, and how to manage administrative and judicial processes that may arise. Reflecting on the death and accessing good support helps psychiatrists process the emotional impact. It can also increase their resilience in the longer term by giving them a greater understanding of their own and their patients' limitations, strengthening their capacity for compassion as clinicians.

Using an illustrative case, this presentation aims to provide insight into the experience of losing a patient to suicide, acknowledge sources of support for the psychiatrist, and discuss postvention as how clinicians manage the psychological processes after suicide.

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Ontogeny and Phylogeny of Sleep

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In fact, it is still not possible to say that sleep exists at definable levels in all animals. Studies conducted in a limited number of species show that central nervous system restructuring is necessary for sleep. Structural differences in sleep are observed between species depending on brain development, functional differences and environmental conditions. The structuring and development of REM sleep, which joined the evolution process later, seems to have given the brain the opportunity to accelerate development within its multi-layered and connectedness. Evolution has strengthened our sleep structure by placing REM sleep at night, while its duration has become shorter. REM sleep strengthens the increasingly complex and enriching connections of the brain. Our initially primitive cognitive and emotional characteristics have become enriched, making it easier for us to acquire the characteristics of being human. It indicates that REM structuring and functionality is a stepping stone in evolution in the development of cognitive development, sociocultural complexity, intelligence, emotional development and creativity across species.

Sleep, which is a function of the brain, changes in newborn, childhood, adolescence, adulthood and old age, in parallel with the development, maturation and degeneration of the brain. Towards the end of the second trimester development, most of the neuronal structures that produce NREM and REM sleep are completed and sleep begins to be recorded. A significant change is observed in REM sleep in the last three months of development. REM sleep duration increases, especially in the last week before birth, reaching 12 hours. It will never reach this level again at any time in human life. While REM sleep dominance is evident before birth and in the immediate postnatal periods, deep NREM (delta or slow wave) sleep dominance occurs, especially at the end of childhood and the beginning of adolescence. Total sleep time decreases with adulthood, middle age and old age. Although there is a slight decrease in REM sleep, the main decrease occurs in NREM, especially deep sleep.

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Changes in Sleep with Personality

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This presentation will focus on the associations between personality, personality disorders, and sleep. Personality represents general emotional, intellectual, and behavioral tendencies in a person's attitudes toward himself and others. Personality disorders are characterized by a lack of flexibility in adaptation, inadequate emotional stability during stressful periods, and a tendency to constantly put oneself in vicious circles. Sleep is a condition characterized by transient loss of responsiveness in behavioral manners. Stimuli should be more intense than during wakefulness in order to generate responses. Sleep also affects a person's life during the day. Biological, psychological, environmental, and behavioral factors have effects on sleep. In psychiatry, one of the main factors considered to affect sleep is personality. In a systematic review, insomnia was positively related to neuroticism. Reduced levels of extrovertion, conscientiousness, and self-directedness were positively associated with insomnia. Regarding personality disorders, schizotypal and borderline personality disorder features were associated with insomnia (Akram et al. 2023). Sleep continuity disturbance, increased rapid eye movement (REM) pressure, and reduction of sleep depth were associated with borderline personality disorder (Baglioni et al. 2016). Additionally, patients with borderline personality disorders showed higher levels of nightmares and decreased levels of self-reported sleep quality than healthy controls (Winsper et al. 2017). Untreated sleep problems can increase adverse personality features and features of personality disorders through the effects of emotion regulation problems. Vice versa, in clinical settings, ignored management of personality and personality disorder features may have adverse impacts on the sleep of patients via emotion regulation problems. So, the management of personality features, and especially borderline personality disorder features, may deserve attention in psychiatric patients. So, the interaction between sleep and personality should be addressed in managing psychiatric patients.

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Sleep Disorders and Sleep in Attention Deficit Hyperactivity Disorder

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Sleep disturbances are notably prevalent among individuals with Attention Deficit Hyperactivity Disorder (ADHD), affecting both children and adults. These disturbances can exacerbate the symptoms of ADHD, creating a challenging cycle that impacts overall health and quality of life. The characteristics of sleep in ADHD include difficulty in falling asleep, inconsistent sleep patterns, and an overall reduced quality of sleep. Furthermore, people with ADHD are more susceptible to certain sleep disorders, including restless legs syndrome, sleep apnea, and circadian rhythm sleep disorders, which can further disrupt their sleep.

The interplay between ADHD and sleep is complex. ADHD symptoms such as hyperactivity and inattention can make it difficult to establish a calming bedtime routine, leading to prolonged sleep onset latency. Moreover, the stimulant medications commonly prescribed for ADHD, while effective during the day, can contribute to difficulties falling asleep. This creates a paradox where treatment for ADHD symptoms during the day may inadvertently hinder sleep at night.

Understanding and treating sleep disturbances in individuals with ADHD requires a multifaceted approach. Behavioral interventions, such as maintaining a consistent sleep schedule and creating a conducive sleep environment, are foundational steps. Cognitive Behavioral Therapy for Insomnia (CBT-I) has been adapted for those with ADHD to address the unique challenges they face. In some cases, adjustments to the timing or type of ADHD medication can alleviate sleep-related side effects.

Melatonin supplements have also been explored as a treatment option to regulate sleep-wake cycles, particularly in children with ADHD. Emerging research suggests that careful management of light exposure, leveraging its influence on circadian rhythms, could offer additional therapeutic benefits.

Overall, addressing sleep issues in individuals with ADHD requires a comprehensive understanding of their specific needs and the interactions between ADHD symptoms, medication effects, and sleep hygiene practices. Future research is crucial to develop more effective interventions that can improve both sleep quality and ADHD symptoms.

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Sleep and Sleep Disorders in Autism Spectrum Disord

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Autism Spectrum Disorders (ASD) are intricate neurodevelopmental disorders. They are characterized by difficulties in social interaction and communication, along with restrictive and stereotyped behavior patterns.

Sleep disturbances are prevalent in individuals with ASD. These disturbances include challenges in initiating and maintaining sleep, frequent and prolonged awakenings during the night, irregular sleep-wake cycles, short sleep duration, and early morning awakenings. It is reported that between 44% and 83% of children and adolescents with ASD experience sleep abnormalities that negatively affect their daily functioning. While up to 40% of typically developing children and adolescents also experience sleep problems, these issues usually decrease with age. However, in children and adolescents with ASD, sleep problems often persist.

The causal relationship between ASD and sleep disturbances remains unclear. There are three possible etiological explanations: (1) sleep problems could be a result of biological and genetic abnormalities and impaired sleep architecture present in individuals with ASD; (2) sleep problems could be specific to the clinical phenotype of ASD; and (3) sleep problems could be a condition that occurs entirely independently of ASD.

Studies on melatonin synthesis and levels in ASD have been conducted. Additionally, polymorphisms in genes encoding enzymes involved in melatonin synthesis and metabolism have been reported in these patients. Melatonin plays a role in regulating the circadian rhythm, and its levels also fluctuate depending on the circadian system. Animal studies have demonstrated that circadian clock genes influence early synaptic plasticity and that mutations in circadian rhythm genes can cause ASD-like symptoms. Human studies have shown that mutations in circadian rhythm genes are more common in individuals with ASD compared to healthy individuals. However, there is currently insufficient information to comment on the relationship between circadian rhythm and ASD.

Abnormalities in GABAergic, glutamatergic, serotonergic, and dopaminergic systems could also contribute to ASD. Coexisting conditions such as epilepsy, nocturnal gastroesophageal reflux disorder (GERD), anxiety, depression, bipolar disorder, psychosis, and Attention Deficit/Hyperactivity Disorder (ADHD) may further contribute to sleep problems. Core or co-occurring ASD symptoms, such as intellectual disability, sensory integration deficits, ritualistic or self-injurious behaviors, poor communication skills, and limited responsiveness to social cues, can interfere with sleep training and exacerbate or prolong sleep problems.

The severity of sleep disorders is associated with poor physical health and quality of life. Poor sleep quality and inadequate nighttime sleep may exacerbate core and co-occurring ASD features, contributing to adverse effects on mood and emotional regulation, behavior, and cognitive functioning. Children and adolescents with intellectual disabilities and severe symptoms associated with ASD are at particularly high risk for sleep problems. Sleep disturbances can exacerbate ASD symptoms, including abnormal social interaction, repetitive behaviors, emotional problems, and attention deficit/hyperactivity.

In this section, we review the primary literature on sleep disorders and autism, focusing on potential associations between sleep problems and autism, behavioral correlates, and treatment strategies.

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Psychiatric Assessment and Follow-up for Gender-Affirmation in Challenging Cases

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Abstract
Psychological difficulties and distress experienced due to a person's gender being different from the sex assigned at birth are evaluated within the medical diagnostic categories of "Gender Dysphoria" in DSM-5 and "Gender Incongruence" in ICD-11 through specific criteria. The current scientific evidence-based medical approach is the gender-affirmation pathway. This pathway can be defined as the acquisition of physical and social characteristics personally considered appropriate to one's gender. When a person's gender differs from the one assigned at birth, they can request medical support, in which case a psychological, physical, and social evaluation is carried out, and psychosocial, hormonal, and surgical support and interventions can be carried out in line with the person's request. Gender recognition in legal papers is possible under certain conditions. The duties and responsibilities of healthcare professionals related to the process and recommendations for their practices are described in "Standards of Care" prepared by international expert organizations (Başar & Yüksel, 2014; Coleman et al., 2022). People can express themselves in different ways, such as cisgender when their gender coincides with the sex assigned at birth, transgender, transsexual, transgender, transgender, trans, trans man if their gender identity is male, and trans woman if their gender identity is female. People who do not experience their gender within the binary system can express themselves as nonbinary or non-binary gender. The standards of care outline that hormonal and surgical interventions should follow mental health assessment and planning within multidisciplinary teams. It is often difficult for people to cope with self-discovery processes and stigmatization, as well as difficulties in determining their demands in the gender-affirmation procedures, the assessment, and following medical and legal practices. The difficulties experienced by individuals in making requests are accompanied by difficulties in clinicians making appropriate medical recommendations. Autism spectrum traits and disorders, which recent research suggests a higher prevalence in this group than the general population, also pose unique challenges in terms of both access to help and assessment. Both conditions are associated with more negative characteristics in terms of social support and cause them difficulty in developing this support, especially for family members. In this session, evaluation and follow-up processes in the gender-affirmation pathway will be presented with short case presentations from different institutions, accompanied by literature, and possible practices will be discussed.

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The Co-occurrence of Autism Spectrum Disorder Diagnosis and Gender Dysphoria: A Case Presentation

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In the current classification system of the American Psychiatric Association regarding mental disorders, the difficulty experienced when an individual's gender identity differs from the sex assigned at birth is preserved under the term "gender dysphoria," referring not to the identity itself but to the distress associated with having that identity. In the latest version of the International Classification of Diseases (ICD-11) by the World Health Organization, this condition is evaluated in a separate section from mental disorders. Therefore, based on current scientific knowledge, individuals are not considered medically ill solely due to any aspect of their gender identity. The current medical recommendation for gender dysphoria is to provide medical support during the "gender transition process" or "gender affirmation process," allowing individuals to acquire physical and social characteristics that align with their experienced gender and expression preferences. The multifaceted nature of the gender transition process, encompassing not only hormonal and surgical interventions but also social, legal, and psychological aspects, underscores the requirement for a multidisciplinary approach involving professionals from diverse fields. Health professionals involved in medical and surgical interventions must be competent and sensitive to the needs of transgender individuals. In this process, mental health professionals play a crucial role throughout the gender affirmation process, providing referrals to specialists, offering information and support to individuals, and closely monitoring existing or potential mental health issues.

Studies examining autism spectrum disorder (ASD), primarily characterized by limitations in social communication and interaction skills, have suggested a potential association with gender dysphoria (GD). It is speculated that this co-occurrence may pose challenges to following existing diagnostic and treatment guidelines for transgender individuals. Moreover, tailored follow-up and treatment recommendations are currently lacking for this population. Since this situation may lead to increased stigma and discrimination and worsen psychiatric problems, providing adequate social support and appropriate medical approaches for these individuals is of great importance. This presentation will address the psychiatric assessment and follow-up process of a case involving an individual diagnosed with autism and undergoing a gender transition due to gender dysphoria.

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Clinical Assesment of a Non Binary Individual and Follow-up during Gender Affirmation Process

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The World Professional Association for Transgender Health (WPATH) defines non-binary gender identity as individuals who have a gender identity that does not align with the traditional binary categories of male and female. Non-binary individuals may identify as neither strictly male nor female, such as agender or genderqueer, or may experience their gender as fluid, moving between different gender identities (Reisner & Hughto, 2019; Marrow, 2023). WPATH recognizes that non-binary gender identities exist outside the binary constructs of man and woman, and their Standards of Care (SOC) acknowledge and incorporate language on antidiscrimination and equality to support individuals with non-binary gender identities (Marrow, 2023).
For health professionals working in this field, understanding and respecting non-binary gender identities is crucial for providing inclusive and affirming care to individuals whose gender identity falls outside the traditional binary system (Reisner and Hughto, 2019; Marrow, 2023).

In the clinical assessment of non-binary individuals, WPATH suggests that health professionals should adopt an inclusive and affirming approach that respects the diverse gender identities of their patients. This involves recognizing and validating the unique experiences and identities of non-binary individuals, as well as using gender-affirming language and practices during the assessment process (Coleman, 2017).

Furthermore, WPATH recommends that health professionals engage in ongoing education and training to enhance their understanding of non-binary identities and to provide culturally competent care to non-binary individuals. This includes staying informed about the latest research and best practices in working with non-binary patients, as well as seeking supervision or consultation when needed (Coleman, 2017).

Overall, WPATH's guidelines emphasize the importance of creating a supportive and inclusive clinical environment for non-binary individuals, where their gender identity is respected, validated, and integrated into the assessment and treatment process.
In this case report, the evaluation and follow-up process of a 22-year-old non binary patient who presented to the psychiatry outpatient clinic due to gender dysphoria will be discussed.

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High Levels of Internalized Transphobia and Concealment in a Transgender Man

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Transgender individuals experience gender related minority stress, which includes internalizing negative attitudes about themselves that exist in society. Gender-related discrimination and social stigma may contribute to transgender individuals' negative feelings about their gender identity. The gender minority stress model describes proximal and distal stressors. Internalized transphobia, negative expectations and concealment have been identified as proximal stressors. Studies have reported that high levels of internalized transphobia and low levels of gender identity pride are associated with more depressive and anxiety symptoms (Şahin et al., 2023). It has also been reported that high levels of internalized transphobia may predict higher levels of body uneasiness in individuals with gender dysphoria and worse improvement of body image after gender affirming hormone therapy (Castellini et al., 2023)"ISSN":"17436109","PMID":"36763949","abstract":"Background: Given the relationship between interiorized stigma and body image, it could be hypothesized that high levels of internalized transphobia (IT. Self exploration and connecting to a transgender community may be positive coping mechanisms against these stressors (Owens et al., 2023).

In this case presentation, we will discuss a 39-year-old transgender man who presented psychiatric assessment for the first time in response to gender dysphoria. In this case, where proximal stress factors such as internalized transphobia and concealment were found to be high, the importance of various interventions in the assessment and follow-up process will be discussed.Formun Üstü

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Relationship with Inflammation and Depression: Definition of Immunobetabolic Depression

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Activation of inflammatory pathways in depression presents a promising avenue for intervention, as evidenced by burgeoning research in this field. Low-grade inflammation has been associated with poorer treatment response and a more persistent course of depression. The hypothesis of a dysregulated immune system playing a causal role in depression's etiology, initially posited in the early 1990s, has spurred a significant increase in studies investigating the link between depression and inflammation.

Recent findings suggest that alterations in inflammatory, metabolic, and bioenergetic pathways are more consistently associated with atypical depressive symptoms, reflecting disruptions in energy balance such as overeating, weight gain, hypersomnia, fatigue, and leaden paralysis. A novel conceptual model termed immuno-metabolic depression (IMD) has been proposed to encompass these relationships (Milaneschi et al., 2020).

Immuno-metabolic dysregulations, encompassing chronic low-grade inflammation, oxidative stress, disruptions in neuroendocrine regulators (e.g., leptin and insulin resistance), and biomolecular changes related to energy metabolism (e.g., dyslipidemia), have been implicated not only in the pathophysiology of cardiometabolic disorders but also in depression (Dowlati et al., 2010). Meta-analyses consistently demonstrate elevated levels of circulating inflammatory markers, notably interleukin-6 (IL-6) and tumor necrosis factor-alpha (TNF-α), in individuals with depression compared to controls.

The integration of immuno-metabolic dysregulations and atypical symptoms within the framework of IMD underscores the behavioral manifestations of altered energy homeostasis. Moreover, preliminary evidence suggests that these dysregulations may moderate the antidepressant effects of standard or novel therapeutic approaches.

Given depression's heterogeneous presentation, there is growing recognition of distinct subtypes, prompting the development of personalized treatment strategies tailored to subtype characteristics. Identifying IMD represents a crucial step towards refining treatment approaches, with observational studies indicating elevated inflammatory biomarkers in this subgroup. Ongoing clinical trials are investigating the efficacy of anti-inflammatory medications in IMD management.

In this session, I aim to:
Review research elucidating the causal relationship between depression and inflammation.
Present studies exploring the association between depression and inflammation.
Propose methodological approaches to advance our understanding of this complex interplay, paving the way for more effective interventions.
By comprehensively addressing these objectives, we can deepen our understanding of the intricate relationship between depression and inflammation, thereby informing targeted strategies to improve patient outcomes.

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The Microbiome and Impact on Psychiatric Disorders

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Gut microbiota has become an important research area in recent years, with relationships with many different disease groups. Many studies have shown that the gut microbiota can influence the nervous system and stress response-related behaviors, and that compositional changes in the microbiota can lead to local and systemic pro-inflammatory state, increased permeability of the intestinal barrier, and immune system activation. Evidence suggests that dysbiosis and altered intestinal permeability have an important role in the secretion of potentially neurotoxic molecules (e.g. pro-inflammatory cytokines IL-6, TNFα and IL-1β and various chemokines including MCP-1, CXCL-1 and MIP 1α) by activating the immune system.

Most neuropsychiatric disorders in children and adults are considered multifactorial diseases caused by environmental factors in genetically susceptible individuals. The field of immunopsychiatry, which tries to elucidate the deep connections between intestinal health and mental health, has proposed the concept of "immunometabolic depression", which has attracted increasing attention in recent years, in the etiopathogenesis of depression. Some clinical studies have shown that there are changes in the gut microbiota and the brain-gut microbiota axis of patients with neuropsychiatric diseases such as autism spectrum disorders, schizophrenia, major depressive disorder, epilepsy, Alzheimer's, Parkinson's or multiple sclerosis. However, it has not yet been clarified whether this situation is directly proportional to the occurrence of diseases or the severity of the disorders.

The potential effects of probiotics and prebiotics on mental health also help us understand the effects of gut microbiota on the course of psychiatric diseases such as depression and bipolar disorder. The beneficial effects of diets and psychobiotics targeting the brain-gut-microbiota axis in depression are increasingly being addressed in both preclinical and clinical studies. While animal studies confirm these effects, the mechanisms underlying the antidepressant effects of psychobiotics are also being investigated. Additionally, systematic reviews and meta-analyses show that psychobiotics have anxiolytic and antidepressant effects. However, many studies have reported invalid results for psychobiotics and have shown no improvement in depression-like behaviors. Additional studies are therefore needed to fully elucidate complex gene-environment interactions and characterize potential gut microbiota alterations that may precede or worsen the onset (occurrence/progression) of different neuropsychiatric disorders and their symptoms. A better understanding of the role of the brain-gut-microbiota axis in depression and other psychiatric diseases will enable new therapeutic approaches to support mental health.

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The Effectiveness Of Nutrition-Focused Therapy Methods In The Management Of Depression, Anxiety, And Other Psychiatric Disorders

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In recent years, the quantity of research studying the relationship between nutrition and depression, anxiety, and other psychiatric disorders has increased. There are opinions suggesting that nutrition habits influence mental health and may have a determining effect on the severity and frequency of psychological symptoms. Nutritional psychiatry, which is a new field in this regard, provides evidence that the quality of the diet is a modifiable risk factor for mental illness. Essentially, this area examines the effects of nutrition and diet on mental health and investigates how it can contribute to the treatment or prevention of psychiatric disorders (Granero 2022). This effect is achieved through the anti-inflammatory and antioxidant properties of nutrition, support for neurogenesis, impact on the microbiome, triggering immune-regulatory mechanisms, and epigenetic modifications (Adan et al. 2019). In addition to healthy and balanced nutrition, supplementation of micro-nutrients (such as vitamins and minerals) as well as macro-nutrients (such as fatty acids) can provide a range of beneficial effects due to numerous biological roles. Research on probiotics, prebiotics, omega 3 fatty acids, vitamins, minerals, S-adenosyl methionine, Nacetyl cysteine, alpha lipoic acid, coenzyme Q10, their effects and potential to aid psychiatric treatment is increasing. Studies on mood disorders are prominent, and for example there is evidence that the Mediterranean diet, which is rich in fruits, vegetables, fish, and whole grains, can reduce the risk of depression (Conner et al. 2017). In this presentation nutrition-focused therapy methods in the management of depression as well as anxiety and other psychiatric disorders will be discussed and the effects of dietary habits on psychiatric disorders will be adressed.
Key words: nutritional psychiatry, depression, anxiety, mental health

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‘’Aberrant Salience Attribution” Hypothesis in the Etiology of Psychosis

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Psychosis is a cluster of symptoms, mainly involving delusions and hallucinations, which are observed in various disorders such as schizophrenia (Miyata 2019). It has long been recognized that dopamine plays a role in the pathophysiology of psychosis. In meta-analyses, evidence for increased dopamine synthesis, release and increased synaptic dopamine concentrations in schizophrenia has been shown with large effect sizes (Howes and Murray 2014). Although the role of dopamine in the neurobiology of psychosis and the antidopaminergic effect of antipsychotics are widely accepted, it is still unclear how these neurobiological and pharmacological findings relate to the nature of psychosis at the level of the mind. Dopamine is also known to mediate the conversion of an external stimulus from neutral information to an attractive or aversive entity (Kapur 2003). In particular, the mesolimbic dopaminergic system is considered to be a critical component in “salience attribution”, which is involved in the processes of attracting attention, taking action and influencing goal-directed behavior as a result of associating events and thoughts with reward or punishment. The “Aberrant Salience Hypothesis”, first proposed by Kapur (2003), attempts to provide a framework for integrating patients’ experiences, clinical presentations, neurobiological theories and pharmacological interventions. This hypothesis provides a useful framework that attempts to bring these findings together, based on the role of dopamine in salience and psychosis. In psychosis, it is suggested that there is a dysregulated dopaminergic transmission leading to stimulus-independent dopamine release and that this dysregulation disrupts the normal process of contextually guided salience attribution and leads to aberrant salience attribution to external objects and internal representations. In this framework, delusions are considered as a “top-down” cognitive explanation that the individual imposes on aberrant salience experiences in an effort to make sense of them, while hallucinations emerge from a conceptually similar and more direct process namely the aberrant salience of the internal representations of perceptions and memories. In functional neuroimaging studies conducted in schizophrenia patients, increased activity in the ventral striatum in response to neutral stimuli has been shown compared to healthy controls, and in the Salience Attribution Test, increased aberrant salience attribution has been shown in schizophrenia patients with delusions compared to healthy controls (Miyata 2019). In studies conducted in the years following this hypothesis, the Salience Network (SN), which contains the bilateral insula and anterior cingulate cortex, has also been identified as involved in the processing of salience (Miyata 2019). Reduced SN functional connectivity has been reported in schizophrenia patients in some studies (Miyata 2019). Furthermore, some studies have reported a relationship between midbrain-striatal dopamine and insula-anterior cingulate cortex SN. In addition, abnormal connections between salience-related brain regions have been shown to be associated with psychotic symptoms in schizophrenia. In this panel discussion, the concepts, current findings, strengths and limitations of the salience attribution hypothesis, which provides an important framework for the pathophysiology of psychosis, will be discussed.

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Understanding Psychosis In the Perspective of Cognitive Models

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The cognitive model of psychosis implies that cognitive biases and distortions have an important role in the occurrence of psychosis, from subthreshold psychotic experiences to a full-blown psychotic disorder. Although the cognitive model of psychosis seems to draw less attention than neurobiological models in the phenomenology of psychosis, cognitive behavioral approaches and cognitive behavioral therapy practices that originate from cognitive models may improve functionality and psychotic symptoms individuals in the psychosis spectrum and cognitive behavioral therapy is recommended in various treatment guidelines for the entities which take part in psychosis spectrum. Understanding cognitive models in the psychosis spectrum is important. Underlying cognitive biases and distortions, for example Jump to Conclusions (JTC), the Bias Against Confirmatory Evidence (BACE), the Bias Against Disconfirmatory Evidence (BADE) and Liberal Acceptancy (LA), in the basis of psychosis may provide new cognitive approaches and treatment facilities in the psychosis spectrum.

In this presentation, we aimed to discuss the concept of psychosis together with the accompanying cognitive features in order to reformulate the concept of psychosis in the light of cognitive models.

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"Predictive Coding" as a Computational Model

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The need for a better understanding of psychosis and the development of better treatment options continues. One of the models used to elucidate the etiology and phenomenology of psychosis is the predictive coding model. In the current cognitive neuroscience literature, the predictive coding model, which is a computational model based on Bayesian probability theory, has been increasingly used. Accordingly, the prior probability, which can be considered as a prediction, is combined with the likelihood, which is based on the data obtained from the hierarchically lower level, and the posterior probability is calculated. This model is based on the assumption that neural structures that form the basis of mental functions try to minimize prediction error and thus uncertainty by continuously updating prior probabilities at different hierarchical levels. The predictive coding model has mostly been used to elucidate delusions and hallucinations, basic components of psychosis (Sterzer et al. 2019). More recently, it has been suggested that it can also explain features such as disorganization and cognitive impairment associated with the core pathological processes of schizophrenia (Liddle and Liddle 2022). Moreover, there are also data that it may be associated with prodromal symptoms in high-risk patients (Charlton et al. 2022). These symptoms have been tried to be explained within the framework of predictive coding in terms of weakening/strengthening of priors or likelihood in the hypothetical information processing hierarchy, or inadequate learning mechanisms for minimizing the prediction error (Sterzer et al. 2019; Charlton et al. 2022). In summary, the predictive coding model is a computational model that may be useful in understanding the phenomenology and underlying neurobiological mechanisms of symptoms associated with psychosis, prodromal symptoms and core symptoms of schizophrenia.

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Physiological Function of Melatonin and Its Uses in Psychiatry

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Melatonin, often referred to as the "hormone of darkness," plays a crucial role in the regulation of the sleep-wake cycle and is pivotal for maintaining circadian rhythms in humans. Produced by the pineal gland during the night, its production is influenced by the absence of light, signaling to the body that it is time to prepare for sleep. Beyond its primary function in regulating sleep patterns, melatonin has various physiological roles, including antioxidant activity, immune system modulation, and the regulation of blood pressure.

In the field of psychiatry, melatonin's properties have been harnessed to address a range of conditions, particularly those related to sleep disturbances and mood disorders. Its uses extend to the treatment of insomnia, seasonal affective disorder (SAD), and certain circadian rhythm sleep disorders, such as delayed sleep phase syndrome (DSPS) and advanced sleep phase syndrome (ASPS). Given its natural role in the body's sleep mechanisms, melatonin is valued for its relatively mild side-effect profile compared to traditional sleep medications, making it an appealing option for patients seeking alternatives to pharmacological sleep aids.

Moreover, melatonin's potential benefits in psychiatric settings are not limited to sleep-related disorders. Emerging research suggests its efficacy in treating depression, anxiety, and schizophrenia, partly due to its antioxidant properties and its ability to modulate neurotransmitter systems. Additionally, its role in regulating the immune system has sparked interest in its possible use in treating neuroinflammatory conditions.

The fact that melatonin is so interesting has recently brought about uncontrolled applications and uses, and problems with its unconscious consumption have also emerged.

Despite its growing popularity and wide range of potential applications, the use of melatonin in psychiatric practice calls for further research to fully understand its efficacy, optimal dosages, and long-term effects. Clinicians and researchers continue to explore its therapeutic potential, aiming to integrate it more effectively into psychiatric treatments.

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Interpersonal Dependency

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People's relationship styles and how they manage interpersonal closeness vary from person to person, and these individual differences also affect a person's relationship satisfaction, physical and psychological health.

Interpersonal dependence refers to the need for emotional care, support, protection, guidance even in situations where autonomous functioning is possible. These dependent people tend to perceive themselves as powerless and ineffectual in their interpersonal relationships. The "oral fixation " that Freud mentioned in his psychoanalytic theory is the first influential model of dependency that explains dependent personality traits. When behavioral and social learning models come to the fore, it has been shown that parental attitudes and behaviors also play an important role in the development and dynamics of dependency. Authoritarian and overprotective parenting leads to the formation of a helpless self-concept, which is a key element of the dependent personality style.
The cognitive/interactionist model conceptualized by Bornstein, which helps explain the variety of maladaptive and adaptive behaviours exhibited by dependent people, includes four different dependency related responses (motivational, cognitive, affective and behavioral). Perceiving oneself as helpless and powerless increases dependency-related motivations and encourages dependent behavior and emotional response (Borstein 2012).
Dependence in interpersonal relationships can lead to stress and behavioral problems in the relationship. When relationships end, the risk of anxiety and depression may increase (Haggerty et al. 2015). There are studies showing that adults with high levels of dependency and those with dependent personality disorder are among those who use medical and social services most frequently. Also research shows that dependent patients have a higher risk for parasuicide and suicide, compared with non-dependent controls, in addition dependent men have increased risk for perpetration of domestic violence. In contrast to patients with other problematic personality styles (e.g., narcissism, sociopathy, histrionicity), many dependent people seek therapy specifically to address the negative impact of their dependent behavior on friendships, romantic relationships, relationships with parents, siblings, and children.
In treatment, many patients present with multiple dependencies, making diagnosis and treatment planning difficult, so multimodal assessment is key to identifying underlying dynamics in dependent individuals (Widiger and Samuel 2005). In marital and family therapy, it is important to clarify the dependent behaviors of people and the characteristics that encourage these behaviors.

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Exercise Addiction

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Physical exercise is widely recognised as a beneficial activity that contributes to physical health, mental well-being and overall quality of life. Exercise addiction is defined as a compulsive and dysfunctional behaviour pattern in which an individual loses of control over their exercise habits and experiences negative physical, psychological or social consequences. This pattern of behaviour usually involves physical exercise in a rigidly structured way, refusing to reduce or stop the behaviour despite its negative effects on physical and psychological well-being, and experiencing distressing physical and psychological symptoms while reducing or stopping the behaviour. One of the main factors in the development of exercise addiction is that exercise may be experienced as rewarding. Exercise-induced changes in reward-related neurotransmitters have been linked to this mechanism (Colledge and Meyer, 2022)psychological and social consequences, with unsuccessful attempts to reduce or stop the behavior. In this article, the evidence for exercise addiction as a behavioral addiction is presented. Symptoms and psychiatric comorbidities are explained, and recommendations for identification and treatment of exercise addiction are presented.”,”author”:[{“dropping-particle”:””,”family”:”Colledge”,”given” :”Flora”,”non-dropping-particle”:””,”parse-names”:false,”suffix”:””},{“dropping-particle”:””,”family”:”Meyer”,”given”:”Maximilian ”,”non-dropping-particle”:””,”parse-names”:false,”suffix”:””}],”container-title”:”Praxis”,”id”:”ITEM-1”,”issue”:”6”,”issued”:{“date-parts”:[[“2022”]]},”page”:”317-321”,”title”:”Exercise Addiction - Status, Identification and Treatment”,”type”:”article-journal”,”vol ume”:”111”},”uris”:[“http://www.mendeley.com/documents/?uuid=4ec0e4ad-b23c-4d7f-b95c-bcdc6ee03500”]}],”mendeley”:{“form attedCitation”:”(Colledge and Meyer, 2022.

Exercise addiction has a high comorbidity rate with eating disorders, body image disorders, depressive disorders and anxiety disorders. The term secondary exercise addiction has been proposed for exercise in other established disorders, such as eating disorders or various body image disorders. In primary exercise addiction, it has been reported that the reward is directly related to performing the activity. In secondary exercise addiction, excessive exercise is used to achieve some other goal associated with the disorders. Personality traits, emotional factors such as stress, and attitudes towards exercise may also predict the development of exercise addiction (Weinstein and Szabo, 2023).

Treatment of exercise addiction requires a comprehensive approach that addresses underlying psychological factors. Assessment and treatment of exercise addiction requiring clinical intervention should include evaluation of stages of addiction, motivation to change, and comorbid psychiatric disorders. The primary treatment of dysfunctional exercise behaviour is based on a cognitive-behavioural approach. The various symptoms of exercise addiction are treated using multiple psychological interventions in combination with comorbidities or related dysfunctions (Szabo and Demetrovics, 2022)exercise addiction is an obligatory and must-be-done training regimen. This book is the first to attempt to explain the significant differences between passion and addiction in sports and exercise. This book presents an overview of three dimensions of passion and offers a new frame to contextualize exercise addition. The work also addresses the misinterpretation of certain aspects of training (e.g., intensity, frequency, commitment.

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Work Addiction

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Work addiction, also known as workaholism, is a compulsive pattern of behavior where individuals become excessively focused on their work, often to the detriment of other areas of their lives such as relationships, health, and leisure activities. Like other forms of addiction, work addiction involves a strong and uncontrollable urge to engage in the behavior despite negative consequences. Some common signs of work addiction include; obsessive thoughts about work, constantly thinking about work even when not at work, difficulty relaxing or switching off from work-related thoughts, overworking, spending excessive amounts of time at work, often working long hours, taking work home, or working during weekends and holidays, neglecting other areas of life, prioritizing work over personal relationships, hobbies, and self-care activities, physical and emotional symptoms, experiencing physical symptoms such as fatigue, headaches or digestive issues due to stress, as well as emotional symptoms like irritability, anxiety or depression, difficulty delegating, feeling the need to control every aspect of work tasks and being unable to delegate responsibilities to others, risky behavior, engaging in risky behaviors to meet work deadlines, such as skipping meals, neglecting sleep, or using substances like caffeine or stimulants to stay alert (Cristina and Mark 2015).

Work addiction can lead to various health problems, and one of the most significant ones is sleep disorders. Among the factors contributing to sleep disorders, intensive smartphone use has become prominent. Additionally, emotional exhaustion, work-family conflicts are also thought to mediate sleep problems (Spagnoli et al. 2019).
Work addiction is associated with other psychiatric disorders such as attention deficit hyperactivity disorder, obsessive-compulsive disorder, generalized anxiety disorder, and major depression. Although there is not a consensus among clinicians diagnostically, scales related to work addiction have been developed in recent years. The increase in industrialization, fears of losing jobs, and societal expectations have brought the concept of work addiction to the forefront. Considering the impact of work addiction on individuals' lives, there is a need for further research both in terms of diagnosis and treatment (Cecilie et al. 2016).

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The Pharmacotherapy and Somatic Treatment Methods of OCD in Current Treatment Guidelines

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The first-line medications to be used in patients with Obsessive-Compulsive Disorder (OCD) and planned initiation of pharmacological treatment are selective serotonin reuptake inhibitors (SSRIs) and clomipramine (1). When considering the initial treatment, selective serotonin reuptake inhibitors (SSRIs) are often chosen due to their superior side effect profile and ease of use. When selecting among SSRIs, which include fluoxetine, fluvoxamine, sertraline, paroxetine, citalopram, and escitalopram, factors such as each agent's efficacy, side effect profile, drug-drug interactions, patient's past treatment response, and patient preference are determinants.

Before initiating clomipramine, another pharmacotherapeutic agent with proven efficacy in the treatment of OCD, careful evaluation of the individual's past medical history, including cardiac pathologies and epileptic seizures, is necessary. Caution is advised regarding anticholinergic side effects, sedation, weight gain, arrhythmias, and seizures.

Studies suggest that if a medication is tolerated by the patient, treatment should continue for at least 8-12 weeks at the maximum tolerated dose within the therapeutic range, with a minimum duration of 4-6 weeks, as the most significant increase in response typically occurs around the 6th week (2). On the other hand, it has been shown that higher doses of serotonergic agents studied in OCD are associated with a greater response and/or degree of improvement compared to lower doses. However, a meta-analysis supporting this dose-response relationship also found that higher doses were associated with a higher rate of treatment discontinuation due to side effects.

Placebo-controlled trials and systematic reviews have demonstrated that SSRIs and clomipramine are effective in alleviating symptom severity and improving quality of life in the acute treatment of OCD (3). However, it is known that a considerable proportion of patients exhibit resistance or non-response to first-line treatments. In cases where first-line treatment is ineffective, augmentation therapies, alternative single-drug therapies, intravenous serotonin reuptake inhibitor (SRI) applications, and non-pharmacological somatic treatment methods are treatment options that can be applied.
Augmentation strategies include antipsychotic agents such as haloperidol, risperidone and aripiprazole, agents with different mechanisms of action such as dextroamphetamine, caffeine, clomipramine, clonazepam, pindolol, amantadine, onusetron, mirtazapine, memantine, N-acetylcysteine, lamotrigine, topiramate (1).
Among alternative drug treatments to SRIs, the use of agents such as phenelzine, clonazepam, buspirone, venlafaxine, and mirtazapine is considered. Another treatment method that can be applied to patients unresponsive to first-line treatments is intravenous SRI applications. Study results have reported safe and rapid response with intravenous clomipramine or sitalopram treatments.

A subgroup of OCD patients may remain unresponsive to the aforementioned first-line treatments, augmentation strategies, and alternative therapies. Various biological treatment approaches are applied in this group of patients, including transcranial magnetic stimulation (TMS), deep brain stimulation (DBS), and stereotactic lesioning procedures in the brain (1).

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Non-Pharmacological Supplements for Mood Disorders

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Conventional pharmacological therapies may not fully address the diverse needs of all patients with mood disorders, as they may fail to target underlying pathogenic factors such as nutritional deficiencies, inflammation, oxidative stress, neuroprotection, and neurogenesis. Addressing nutritional imbalances and signaling abnormalities through the use of medical foods and dietary supplements offers several adjunctive approaches for treating mood disorders in individuals who do not respond adequately to antidepressants and mood stabilizers.

Omega-3 fatty acids, S-Adenosyl Methionine (SAMe), St. John's Wort (Hypericum perforatum), Rhodiola Rosea, L-methylfolate, amino acids (i.e. L-acetylcarnitine, alpha-lipoic acid, N-acetylcysteine, L-tryptophan), zinc, magnesium and coenzyme Q10 are some of the non-pharmacological supplements being searched and used in the adjunctive treatment of mood disorders. Omega-3 fatty acids, found in fatty fish like salmon and in supplement form, have been studied for their potential benefits in mood disorders. Research suggests that omega-3 fatty acids may help reduce symptoms of depression and bipolar disorder, possibly by reducing inflammation. SAMe is a compound naturally produced by the body which provides methyl and sulfate groups used in the synthesis of deoxyribonucleic acid, proteins, phospholipids, neurotransmitters and the antioxidant, glutathione, that are disturbed in people with mood disorders. Some studies have suggested that SAMe supplementation may have antidepressant effects, with good tolerability, although more research is needed to confirm its efficacy. St. John's Wort, a herbal supplement which contains two bioactive substances, hyperforin and hypericin, has been used traditionally for the treatment of depression. Several studies have shown it to be effective in mild to moderate depression, possibly due to its ability to inhibit the reuptake of serotonin, dopamine, and norepinephrine. Rhodiola Rosea is a herb, with the bioactive ingredient of rosiridin, which is reported to inhibit monoamine oxidases A and B. Rhodiola Rosea has been studied for its potential antidepressant and anxiolytic effects. It's mechanism of action in major depression is thought to be via beta-endorphins, tryptophan and serotonin.

Current evidence suggests that medical foods and other supplements, may play a role in augmenting the treatment of mood disorders and could specifically target aspects of inflammation and other factors contributing to the symptomatology. However, existing studies may have certain limitations, and further research is warranted in this area (Dogaru et al. 2022; Hoepner et al. 2021; Sarris 2017).

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Non-Drug Supplements in Schizophrenia and Other Psychotic Disord

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Schizophrenia, affecting approximately %1 of the population, has always been a fascinating topic in psychiatry due to its broad spectrum of symptoms, signs, and progression. Since the discovery of chlorpromazine in the 1950s, antipsychotic drugs have been the mainstay of schizophrenia treatment. However, 30% of all schizophrenia patients do not respond to current treatments, and 60% show a partial response with lingering symptoms. Moreover, antipsychotic medications have minimal effects on negative symptoms and cognitive deficits (e.g., working memory, verbal memory, attention, executive function), and no medication is currently approved for treating residual psychotic, negative, or cognitive symptoms.

Although psychosocial interventions, such as Cognitive Behavioral Therapy (CBT), are effective in reducing residual symptoms in patients with schizophrenia, they are costly and inaccessible for most patients. Therefore, there is a need for new interventions that can serve as viable adjunctive treatments to promote and sustain full psychosocial recovery.

When used in conjunction with antipsychotics, certain vitamins and minerals may improve the symptomatic outcomes of schizophrenia by addressing nutritional deficiencies, reducing oxidative stress, or modulating neurological pathways. Decreased serum levels of vitamins D and B have been found to correlate significantly with disease severity, particularly in relation to negative symptoms. Oral supplementation of vitamin C with atypical antipsychotics has been reported to reverse decreased plasma ascorbic acid levels, reduce oxidative stress, and improve the Brief Psychiatric Rating Scale (BPRS) score.

Although the literature is limited, it has been reported that omega-3 supplementation improves hippocampal neuronal health, reduces oxidative stress, and is associated with a decrease in negative symptoms in patients receiving antipsychotic treatment. Based on recent studies reporting a decrease in the BPRS and Positive and Negative Syndrome Scale (PANSS) following supplementation with omega-3 fatty acids, vitamin C, and vitamin E, this presentation will review the literature on non-pharmacological supplements in schizophrenia and other psychotic disorders and their effects on symptomatology.

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Non-Drug Supplements for Dementia and Cognitive Disorders

Tayfun Öz

Dementia and cognitive disorders are common health issues in elderly individuals, and non-drug supplements can play an important role in managing these conditions. Specifically, supplements such as omega-3 fatty acids, ginkgo biloba, and B vitamins may offer potential benefits in supporting cognitive functions (Fotuhi ve ark. 2009).

Omega-3 fatty acids, particularly EPA and DHA from fish oil, can support brain health and enhance cognitive functions. Ginkgo biloba, with its antioxidant properties, may protect brain health and have positive effects on memory. B vitamins, especially vitamin B12, can support neurological functions and reduce the risk of dementia.

However, more research is needed to determine the efficacy and safety of non-drug supplements. They may not be suitable for everyone and can cause side effects in some cases. Therefore, it is important to consult with a healthcare professional before using any supplement.

In conclusion, non-drug supplements may offer potential benefits in managing dementia and cognitive disorders, but their use should be carefully evaluated, and guidance from healthcare professionals is important.

Approach to Depression in Neurological Disorders
Approach to Depression in Epilepsy Patients

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Abstract
Depression episodes frequently occur in individuals with epilepsy, with a prevalence ranging from 11% to 62% among patients with this neurological condition. Various factors can contribute to depression in individuals with epilepsy. These include neurobiological and psychosocial factors, the symptoms of epilepsy, neurochemical or iatrogenic mechanisms, a family history of mental illness, lack of seizure control, and iatrogenic causes. Studies have also recognized that the use of antiepileptic drugs and the development of social coping and adaptation skills can contribute to the occurrence of depression in individuals with epilepsy. (1)

A meta-analysis has identified several factors that are associated with an increased risk of depression in people with epilepsy. These factors include older age, female gender, low education level, unemployment, poor antiepileptic drug adherence, polytherapy, stigma, and anxiety. Chronic stress exposure in patients with epilepsy may contribute to the development of depression, resulting in feelings of sadness, loneliness, despair, low self-esteem, and self-reproach. Individuals diagnosed with epilepsy have a significantly elevated risk of experiencing depression and suicidal thoughts, with rates that are 4-5 times higher than those observed in the general population. (1)

Depression can have a negative impact on one's quality of life and may also lead to an increase in seizure frequency, which can potentially reduce the effectiveness of antiepileptic drugs. Research suggests a potential link between depression and the development of epilepsy. There are notable reductions in the size of the temporal lobe, frontal lobe, and temporal lateral neocortex. Additionally, there is a decrease in serotonin binding, dysfunction in the hypothalamic-pituitary-adrenal axis, alterations in tryptophan metabolism, disrupted neurogenesis, and the presence of neuroinflammation. (2)

Depression can occur as a result of the medications prescribed for these conditions. Doctors are cautious when it comes to prescribing antidepressants to individuals with epilepsy. This is because they have concerns about potential negative effects, such as lowering seizure thresholds and harmful interactions between antidepressants and antiepileptic medications. (3)

There is a lack of extensive outcome data regarding the effectiveness and safety of antidepressant drugs in epilepsy. Additionally, it remains uncertain whether individuals with depression and epilepsy experience comparable rates of remission and recovery to those without epilepsy. We must identify additional potential targets for drug development in the fields of epilepsy and depression.

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Approach to Depression in Multiple Sclerosis Patients

Berfu Ünal Nural
Sincan Eğitim ve Araştırma Hastanesi Psikiyatri Anabilim Dalı

Multiple Sclerosis (MS) is an inflammatory and demyelinating disease of the central nervous system that affects the young population, progresses with attacks and remissions, is randomly distributed throughout the brain and spinal cord, and is characterized by focal demyelinated lesions with preservation of partial axons. Depression is the most common psychiatric disorder in MS, and it is suggested that its prevalence is quite high in MS patients compared to the general population and other chronic diseases. Although the reasons for this situation are not fully elucidated, it is thought to develop as a result of the interaction of biological, social and psychological factors. The fact that the disease has a chronic, progressive course and causes disability suggests that depressive mood may be higher. While the point prevalence of depression is 20-50%, the lifetime prevalence is around 50% (1).

The etiology of depression in MS is multifactorial. It is believed to be a reactive contribution to the impact of neurological damage, immune dysfunction, and uncertainty of the disease and associated disability resulting from the disease itself. These problems can predispose a person with MS to depression, but they can also lead to decreased compliance with MS treatment, decreased self-care and quality of life, decreased cognitive function, increased symptom severity, and may even affect the progression of MS. Suicide is twice as common in MS than in the general population. Unfortunately, depression in people with MS is often undetected, untreated, and often undertreated when treatment is initiated. The overlap of symptoms between MS and depression, such as fatigue, appetite changes, altered sleep patterns, and impaired cognitive function, may mean that clinicians attribute symptoms entirely to MS rather than considering depression. It has also been suggested that depression may present somewhat differently in people with MS, with symptoms of irritability and anxiety being more prominent than the anhedonia and sadness commonly seen in people with depression without MS. Beck Depression Inventory (BDI) and Patient Health Questionnaire-9 (PHQ-9) are recommended scales for screening. Most guidelines recommend that antidepressant treatment be consistent with general population depression management guidelines and also recommend that consideration be given to the potential adverse effects of specific antidepressants and the individual's MS symptom profile to guide antidepressant selection. Cognitive behavioral therapy (CBT) is the predominantly recommended psychotherapy (2).

Overall, pharmacological agents have modest effects and CBT is moderately effective in managing depression in people with MS. Exercise training may be beneficial to depressive symptoms in individuals with MS. Examining combination treatments is important because no single treatment appears to be effective in reducing depression and its symptoms in MS patients with depression. However, the feasibility and effectiveness of combinatorial approaches still require examination and development (3).

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Trauma from Generation to Generation: Stress and Epigenetic Changes

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Epigenetics; it refers to heritable changes in gene expression that are not coded by a change in the DNA sequence. It can occur through DNA methylation, histone modifications, and microDNA regulation. The most studied epigenetic process is DNA methylation (DNAm); where a methyl group binds to the cytosine-phosphate-guanine dinucleotide sequence (CpGs) of DNA and typically silences the associated gene. Recent studies have shown some epigenetic mechanisms in psychiatric disorders and their relationship with drugs.

In a study conducted with rats, it has been shown that, maternal stress exposure in the last 10 days of pregnancy impacts the DNA methylation levels in Reelin promoter in the offspring's cortex and causes a decrease in Reelin expression. This has been associated with high anxiety levels and learning and memory defects in offspring rats (Palacios-Garcia et al. 2015). In another study, it was shown that maternal stress leads to increased DNA methyltransferase 1 (DNMT1) expression and DNA methylation at Brain Derived Neurotrophic Factor (BDNF) promoters in the hippocampus of the offspring, decreased BDNF expression, and thus triggered depressive and anxiety-like behaviors (Zheng et al. 2016).

One of the most studied genes in the context of prenatal maternal stress and DNAm is the glucocorticoid receptor gene (NR3C1). It has been determined that NRC31 hypermethylation disrupts the regulation of the HPA axis. A recent study in Italy suggested that prenatal stress associated with the COVID-19 pandemic is correlated with greater SLC6A4 methylation in infant saliva collected at birth, resulting in early mood dysregulation (Azar and Booij 2022). Some of the strongest factors that has inter- and transgenerational consequences can be listed as maternal stress exposure, undernutrition, and environmental toxicants . The impact of these negative experiences before conception or during pregnancy can lead to heritable behavioral, physiological and epigenetic changes, and therefore their consequences are not limited to the child but can extend to several generations . For example, trauma and other forms of early life adversity produce a persistent epigenetic memory that can influence the behavior and mental health of later generations.

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Trauma and Epigenetics
Childhood Trauma and Epigenetics

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Childhood trauma (CT), including physical, sexual, or emotional abuse and neglect, is prevalent worldwide. During childhood, CT can lead to a range of physical, social, cognitive, behavioral, and emotional outcomes. Moreover, it has been found to increase the risk of adult-onset psychiatric disorders, including psychotic disorders, depression, bipolar disorder, anxiety disorders, and posttraumatic stress disorder, as well as suicidal ideation and attempts. It is also associated with an earlier age of diagnosis, greater symptom severity, and a generally poorer prognosis related to the psychiatric condition.

Although CT has been defined as a risk factor for psychiatric disorders observed in adulthood, information about the mechanisms that regulate the interactions of genetic and environmental factors that might play a role in the emergence of these disorders is limited. One of the plausible mechanisms establishing a relationship between early life experiences and mental problems in adulthood is reported as epigenetic changes. Epigenetics is a field of study that examines the mechanisms that can change the expression of genes without changing the genetic code itself. The epigenome is sensitive to the effects of environmental factors that can alter the expression of various genes without changing the genetic code. The most widely investigated epigenetic mechanism in psychiatric disorders is DNA methylation. Methylation contributes to the condensation of chromatin, limiting the access to DNA and the binding of transcription factors at specific sites and eventually causing transcriptional silencing. On the contrary, the demethylation of a genomic site mainly results in transcriptional activation. This kind of altered methylation of genes that express proteins involved in the biological mechanisms of stress and trauma might be associated with a spectrum of psychiatric presentations, such as affective or cognitive symptoms. Individuals in childhood are particularly prone to the neuropsychological effects of trauma due to increased brain plasticity and epigenetic changes seen during critical developmental stages. These changes create structural and functional consequences in brain development and can have lifelong effects on cognitions and behaviors.

Studies on epigenetics have shown that various mechanisms mediate common pathways between CT and psychiatric diseases. For example, it has been reported that methylation in the NR3C1 glucocorticoid receptor gene is associated with CT in mood disorders. Again, methylations in the SLC6A4, BDNF, OXTR, and FKBP5 genes were found to be associated with CT. It is suggested that these changes affect neuronal function, immune and inflammatory processes, chromatin and histone modification, and transcription factor binding pathways.

Although several epigenetic mediators have already been identified in the current literature as being involved in the common pathway between CT and psychiatric disorders, longitudinal studies and consistency in methodological approach are needed to unravel cause-effect relationships.

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Post-Traumatic Stress Disorder and Epigenetics

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Post-Traumatic Stress Disorder (PTSD) is a psychiatric condition that can occur in individuals after experiencing a traumatic event. The symptoms of PTSD include avoidance of distressing stimuli, re-experiencing the traumatic event, and increased arousal. The prevalence and severity of the disorder are closely related to the individual's genetic makeup and environmental factors. While the lifetime prevalence of experiencing a traumatic event is 70%, the lifetime prevalence of the disorder is 9-12%. It is thought that pre-existing factors, such as genetic factors and early life experiences, interact with trauma through epigenetic mechanisms to manifest the disorder.

Epigenetics studies the mechanisms that change gene expression without altering the DNA sequence. Epigenetic studies related to PTSD aim to understand how environmental factors affect genes, particularly how they interact with stress and trauma. Mechanisms such as histone modifications and DNA methylation play significant roles in the neurobiological basis of PTSD.

Specifically, studies on DNA methylation have been identified as critical factors in the epigenetic regulation of PTSD. Demethylation of the FKBP5 gene has been observed in individuals exposed to childhood trauma, and these genetic changes have been shown to increase the risk of PTSD by affecting the regulation of stress hormones. Additionally, inhibition of histone deacetylase has been shown to influence the recall of fear memory, suggesting it as a potential target in managing PTSD symptoms.

Epigenetic studies also reveal the intergenerational effects of trauma. Research on the children of Holocaust survivors has shown the long-term impacts of trauma on epigenetic mechanisms and how these effects can be transmitted across generations.

Finally, the modulation of epigenetic mechanisms in the treatment of PTSD offers significant opportunities for developing new therapeutic approaches. Developing drugs that target epigenetic modifications may help manage the disorder better and provide more effective treatment options. Therefore, a deeper understanding of the epigenetic foundations of PTSD can open new avenues for understanding and treating this complex condition.

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Resilience, Post-Traumatic Growth and Epigenetics

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People react to traumas in different ways. There may be mild and temporary symptoms, as well as severe and permanent reactions such as Post-Traumatic Stress Disorder (PTSD). Some survivors experience post-traumatic growth (PTG), resilience or positive psychological changes as a result of post-traumatic experiences.

Psychological resilience is reported as the most common response after traumatic events and is defined as the ability to maintain pre-traumatic levels of functioning.

PTG is defined as positive psychological changes that can occur in association with responses to a wide range of traumatic experiences, such as recovering from a disaster, an assault, or cancer. The presence of a traumatic event is not sufficient for PTG to occur. PTG is based on a new meaning of the world that develops after trauma.

PTG occurs in five areas such as establishing more meaningful relationships in life, feeling personally strong, determining new possibilities and priorities, acceptance towards life, and a rich existential and spiritual life (Dell'Osso et al. 2023).
Gene-environment interaction studies provide new information about the mechanisms underlying differences in psychological responses after trauma.

Ten common variants in seven genes (BDNF, CACNA1C, CRHR1, FKBP5, OXTR, RGS2, SLC6A4) were examined wether modified associations between Hurricane Katrina exposure and posttraumatic stress and posttraumatic growth (PTG). A significant relationship exist between RGS2, FKBP5 and PTG. An association was found between low hurricane exposure and low PTG scores in individuals homozygous for rs4606, and between medium and high exposure levels and high PTG scores (Dunn et al 2014).

Lower PTG levels were significantly associated with hypermethylation of a non-promoter NR3C1 region and hypomethylation of a promoter-associated NR3C1 region. It has been revealed that NR3C1 and FKBP5 methylation is associated with lower PTG levels (Miller et al. 2020).

Lower levels of resilience were significantly associated with methylation of three NR3C1 sites, whereas higher levels of resilience were significantly associated with methylation of two different NR3C1 sites.

DNA methylation at the cg07485685 CpG site in the FKBP5 gene was associated with greater psychological resilience and lower severity of PTSD. The methylation of different FKBP5 and NR3C1 regions and their association with resilience, PTG, and PTSD seems to support the hypothesis that the epigenome may be altered by traumatic events (Miller et al. 2020).

Hallucinogens: From Past To Present

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Exploring Hallucinogens
A Journey from Ancient Rituals to Modern Medicine
Hallucinogens, substances that alter perception, cognition, and mood, have a rich history dating back thousands of years. From ancient ritualistic use to modern scientific exploration, these substances have played significant roles in various cultures and societies.

Ancient Origins
The use of hallucinogens can be traced back to ancient civilizations across the globe. In cultures such as the indigenous tribes of the Americas, hallucinogenic plants like peyote, ayahuasca, and psilocybin mushrooms were revered for their spiritual and therapeutic properties. These substances were often used in religious ceremonies, healing rituals, and shamanic practices to induce altered states of consciousness and commune with the divine.

Cultural Shifts and Suppression
As civilizations evolved, so did attitudes towards hallucinogens. With the rise of organized religions and the spread of colonialism, many indigenous practices involving hallucinogens were suppressed and demonized. Western societies viewed these substances as dangerous and associated them with hedonism, leading to strict legal restrictions and stigmatization.

Psychedelic Renaissance
The mid-20th century witnessed a resurgence of interest in hallucinogens, fueled by the counterculture movements of the 1960s. Icons like Timothy Leary popularized substances like LSD (lysergic acid diethylamide), advocating for their use as tools for personal growth and spiritual exploration. However, widespread recreational use and concerns about safety led to the criminalization of many hallucinogens, pushing them underground.

Scientific Rediscovery
In recent decades, there has been a renewed interest in the therapeutic potential of hallucinogens within the scientific community. Clinical research has shown promising results in using substances like psilocybin and MDMA (3,4-methylenedioxymethamphetamine) to treat various mental health conditions, including depression, PTSD, and addiction. Organizations like the Multidisciplinary Association for Psychedelic Studies (MAPS) have been at the forefront of advocating for the legalization and responsible use of these substances in therapeutic settings.

Looking Ahead
The future of hallucinogens appears to be shifting towards a more nuanced understanding, balancing ancient wisdom with modern science. While legal and regulatory challenges remain, there is growing acceptance of the therapeutic potential of these substances. As research continues and stigma diminishes, hallucinogens may find their place in mainstream medicine as powerful tools for healing and self-discovery.

In conclusion, the story of hallucinogens is one of ancient rituals, cultural suppression, psychedelic renaissance, and scientific rediscovery. As society reevaluates its relationship with these substances, it may be recommended to approach them with caution, and an open mind. Whether used in sacred ceremonies or clinical trials, hallucinogens continue to captivate our imagination and challenge our understanding of consciousness and human experience.

Recreational Use And Addiction Of Hallucinogens

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Exploring Recreational Use and Addiction of Hallucinogens
Hallucinogens, also known as psychedelics, are a class of psychoactive substances that alter perception, mood, and cognitive processes. While these substances have been used for centuries in religious and spiritual contexts, they are also frequently used recreationally, leading to concerns about addiction and long-term consequences. In this presentation, we will delve into the recreational use of hallucinogens and the potential for addiction.

Recreational Use of Hallucinogens
The recreational use of hallucinogens involves the ingestion of substances like LSD (lysergic acid diethylamide), psilocybin, and MDMA (3,4-methylenedioxymethamphetamine) for non-medical purposes, often in social settings or music festivals. Users seek out these substances for their ability to induce altered states of consciousness, enhance sensory experiences, and promote feelings of euphoria and connectedness. Many individuals report profound insights, mystical experiences, and personal growth as a result of their psychedelic experiences.

Risk of Addiction
Unlike substances such as opioids or stimulants, hallucinogens are not typically associated with physical dependence or withdrawal symptoms. However, psychological dependence and problematic patterns of use can still occur, especially among individuals predisposed to addictive behaviors. Some users may develop a tolerance to the effects of hallucinogens, leading them to increase their dosage in search of the desired experience. This can potentially increase the risk of adverse reactions and psychological distress.

Challenges of Addiction Treatment
Treating addiction to hallucinogens presents unique challenges due to the lack of established pharmacological interventions and the subjective nature of psychedelic experiences. Traditional approaches to addiction treatment, such as cognitive-behavioral therapy and support groups, may be less effective for individuals struggling with hallucinogen dependence. Additionally, the stigma surrounding psychedelic use can deter individuals from seeking help or disclosing their substance use to healthcare professionals.

Harm Reduction and Education
To address the recreational use of hallucinogens and mitigate the risk of addiction, harm reduction strategies and education efforts are thought to be crucial. Providing accurate information about the effects, risks, and potential consequences of hallucinogen use can empower individuals to make informed decisions about their drug use. Harm reduction practices, such as testing substances for purity and potency, practicing moderation, and creating safe environments for psychedelic experiences, can help minimize the potential harms associated with recreational use.

Conclusion
In conclusion, the recreational use of hallucinogens presents complex challenges related to addiction and harm reduction. While these substances can offer profound experiences and therapeutic benefits when used responsibly, they also carry risks for abuse and psychological dependence. By promoting education, harm reduction, and responsible drug use practices, society can work towards minimizing the negative consequences of hallucinogen use and supporting individuals who may struggle with addiction.

The Potential Medical Uses of Hallucinogens and Controversies

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Psychedelics have shown promise for various medical and therapeutic purposes, with ongoing research exploring their potential benefits. Psychedelics like psilocybin and MDMA have demonstrated efficacy in treating depression and various anxiety disorders, including treatment-resistant cases. MDMA-assisted therapy has shown promise in treating post traumatic stress disorder (PTSD). Some psychedelics have shown potential in treating substance use disorders, including alcohol, nicotine, and opioid dependence. Psilocybin has been studied for its potential to alleviate distress and anxiety in individuals with terminal illnesses. LSD and psilocybin have been investigated for their potential to alleviate cluster headaches. Overall, psychedelics hold promise as novel treatments for a range of mental health conditions, with potential benefits including symptom reduction, improved quality of life, and enhanced well-being. However, further research is needed to fully understand their mechanisms of action, optimal dosing regimens, and long-term effects. While psychedelics show promise as potential treatments for various mental health conditions, there are several concerns and considerations that warrant attention. They can induce intense psychological and physiological effects, including hallucinations, anxiety, paranoia, and increased heart rate. Ensuring participant safety through thorough screening, preparation, and professional guidance is crucial. Some individuals may experience adverse reactions to psychedelics, including psychosis, panic attacks, and exacerbation of underlying mental health conditions. Identifying individuals at risk and providing appropriate support and monitoring are essential. The long-term effects of psychedelic therapy, particularly repeated or high-dose use, are not fully understood. Research is needed to investigate potential risks, including cognitive impairment, mood disturbances, and changes in personality. Participants in psychedelic therapy trials must provide informed consent, understanding the risks, benefits, and potential outcomes of treatment. Ensuring participants have access to accurate information and understand the experimental nature of the treatment is essential. Ethical psychedelic research requires robust regulatory oversight to protect participant rights and ensure adherence to ethical standards. They have a potential for misuse, particularly outside of clinical or therapeutic contexts. Addressing concerns about recreational use, diversion, and illicit manufacturing is important to minimize the risks associated with psychedelic substances.

Body Dysmorphic Disorder

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Body dysmorphic disorder (BDD) is characterized by a preoccupation with nonexistent or subtle defects in physical appearance. Patients have beliefs that they have an abnormal, unattractive, ugly or deformed appearance, even though they actually appear normal. People with BDD execute many repetitive behaviors to cope with anxiety about their appearance. While BDD was classified under the title of somatoform disorders before Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), it is now classified under the obsessive compulsive and related disorders section. The reason why BDD is conceptualized within the obsessive-compulsive spectrum in DSM-5 is that it has some overlapping aspects with Obsessive-Compulsive Disorder (OCD) in clinical features and treatment areas (Naomi S et al. 2020).

The point prevalence of BDD in the general population, based upon community studies is as follows: in adolescents 2 to 5 percent, in college/university students 3 percent, in adults 2 to 3 percent. The point prevalence of BDD is higher in younger adults than older adults, and higher in females than males. More than 10% of patients presenting to dermatology clinics may have BDD. In cosmetic surgery clinics the point prevalence of BDD is approximately 13-20 percent (Veale et al. 2016).

The pathogenesis of BDD is not fully known. Biological, psychological and social factors are thought to be effective in the etiology of BDD. That is, BDD has a multifactorial etiology (Naomi S et al. 2020).

BDD is a significant disease that negatively affects a person's quality of life. BDD negatively affects a person's mood, self-esteem, social relationships, family and educational life. BDD also has negative effects on a person's financial situation. BDD negatively affects not only the individual with the disease but also his family and friends (The National And Specialist OCD, BDD. and R. D. S. 2019). BDD is often unrecognized by clinicians. There are many reasons why BDD may not be recognized. However, psychiatrists should keep BDD in mind and ask relevant questions during the psychiatric examination.

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Trichotillomania and Skin Picking Disorder

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Trichotilomania(TTM) is defined as hair pulling resulting in significant hair loss and impairment in functioning. Trichotillomania is one of various body-focused repetitive behaviors such as nail biting and skin picking (Stein et al., 2006).

Stress plays a significant role in the etiology of this disorder. It has been reported that 40% of these individuals experience anxiety and distressing pressure before the hair-pulling behavior, and these unpleasant feelings decrease after the hair-pulling act.

Trichotillomania has been considered an "Obsessive-Compulsive Spectrum Disorder" due to its similar comorbidity with OCD and shared familial and genetic relationship patterns. Therefore, it is classified under "Obsessive-Compulsive and Related Disorders" in the DSM-5.

Due to limited evidence, there is no official treatment guideline for TTM (Chamberlain et al., 2009). Evidence from studies suggests that habit reversal therapies may be the first treatment option for TTM (Bloch et al., 2007).

Skin picking disorder (SPD) is a distinct condition characterized by excessive and repetitive picking at the skin, resulting in damage to the skin tissue without any underlying dermatological problem (Grant et al., 2008).

The onset age of SPD varies widely. (Keuthen et al., 2010) SPD is more commonly observed in females. In some patients, attacks may begin during relaxing activities such as watching TV or reading, while in others, they may be triggered by feelings of distress or anger (Grant et al., 2007; Neziroğlu et al., 1998). The picking behavior typically starts unconsciously and becomes conscious after a certain period of time.

While symptoms persist in the majority of patients without prolonged periods of remission, some patients may experience periods of remission lasting for months or even years (Simeon et al., 1997).

It is believed that having a separate heading for SPD would prevent its diagnosis from being overlooked and ensure that patients receive appropriate treatment.

It has been reported that at least one psychiatric comorbidity is present in 57-100% of patients with SPD, with anxiety and depressive disorders being the most common (Snorrason et al., 2012b).

There are case reports regarding the use of many psychotropic medications, either as monotherapy or in combination with other drugs, for augmentation purposes in psychogenic skin picking. When looking at publications on this topic, it is observed that a limited number of drug studies, some of which are open-label and some controlled, have been mostly conducted with selective serotonin reuptake inhibitors.

Despite methodological limitations in studies, case reports, open-label trials, and double-blind studies have shown that SSRIs are effective in the treatment of SPD (Grant JE et al., 2007).

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Development of Psychiatry, Ethical and Legal Issues in the Field of Psychiatry in Türkiye and in The World-Milestones in the History of Psychiatry

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Compared to other fields of medicine, psychiatry remained far away from the development of medicine for a period of time, but made great progress after the mid-20th century. Advances in genetics, imaging and pharmacology have made mental illnesses more understandable, and developments and changes in their treatment have led to the development of ethical approaches in the field of psychiatry. Psychiatric approaches have passed through important stages since primitive times. It is important to know the history of psychiatry in order to understand the advances in ethical approaches. In the early ages, while the causes of diseases were associated with supernatural forces, false beliefs brought along unethical practices. In the Middle Ages, there was a decline in the field of medicine as in many other fields. With the rise of Christianity, the influence of the church increased, the cause of mental illnesses was attributed to religious deficiencies, and it was believed that people suffering from these diseases should be punished. During this period, more humane approaches were seen to individuals with mental illnesses in the Islamic-Arab world, and the causes of illnesses were tried to be understood. With the end of the Middle Ages and the beginning of enlightenment, punitive and inhumane practices against individuals with mental illnesses decreased, patients were kept in large hospitals, and with institutionalization, patients were tried to be rehabilitated away from society. Towards the end of the 18th century, the French physician Pinel took important steps towards humane approaches to patients, and in the 19th century, psychiatrists, especially those trained in French and German schools, carried out important studies on the causes, classification and treatment of mental illnesses. In the 20th century, although more humane conditions were provided, poor conditions in hospitals continued. The lack of sufficient developments in the field of pharmacology to regulate the treatment of patients made lobotomy practice widespread in the 1930s, and in 1938, ECT was started to be applied to patients using electric current in Italy. In the 20th century, Nazism started to show its influence with the power of the German National Socialist Party, and individuals with mental and mental illnesses were murdered in concentration camps due to the efforts to create a superior race with the concept of eugenia. The committing of crimes against humanity under the name of medical interventions and scientific research during the fascism-Nazism period emphasized the importance of the concept of medical ethics with the end of this period. The decisions of the Nuremberg trials led to the adoption of the Nuremberg codes, one of the important cornerstones of medical ethics. In the second half of the 20th century, with the development of psychopharmacology, diseases started to be treated effectively, and this period was called the golden 50s. Patients who had been isolated from society in mental hospitals for years were able to return to society with pharmacological interventions (deinsitutionalization). With the understanding of the importance of ethical practices in medicine, the World Medical Association adopted the Declaration of Helsinki in 1964 with the title Ethical Principles of Medical Research on Humans, which has been updated nine times, most recently in 2013. Beginning in the 1970s, the World Psychiatric Association began to organize studies on psychiatric ethics, and the Hawaii Declaration (1977) was published in the following period. The World Psychiatric Association adopted the Madrid Declaration on Ethical Standards in the Practice of Psychiatry (1996).

Ethical Principles in Psychiatric Practice: Four Main Principles

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Ethics, the branch of philosophy concerned with delineating moral conduct and values, encompasses both descriptive and normative conceptualizations. The former aims to identify, explicate, and resolve value-laden dilemmas manifesting in practical domains, while the latter seeks to formulate guidelines for appropriate behavior when navigating axiological quandaries within specific contexts. A specialized field known as bioethics is dedicated to scrutinizing the moral conundrums arising in the biological sciences, with clinical ethics constituting a practical subdomain that furnishes a systematic framework to assist medical professionals in recognizing, evaluating, and addressing ethical challenges emerging in patient care and clinical practice.

The foundational tenet of “primum non nocere” (first, do no harm), attributed to Hippocrates, remains a cornerstone of medical ethics. Four cardinal principles underpin this domain: the principle of beneficence, the principle of non-maleficence, the principle of respect for autonomy, and the principle of justice. As ethical practices gained prominence in 20th-century medicine, the formulation of psychiatric ethical guidelines within the mental health discipline garnered increased attention. The nexus between psychiatry and ethics manifests across diverse domains, including the psychiatrist-patient relationship, treatment modalities, research endeavors, professional practices, and societal issues. While medical ethics principles serve as a basis for delineating ethical tenets in psychiatry, the unique characteristics inherent to the field distinguish psychiatric ethics from other specialties. The interplay between psychiatry and ethics is dynamic, intricate, and multidimensional. Studies delving into the realm of psychiatric ethics foster social acceptance of psychiatric practices. Approaches consonant with ethical principles engender public trust in psychiatry, preserve the discipline’s reputation as a branch of medicine, and augment the effectiveness of psychiatric interventions. Consequently, the exploration of ethical paradigms in psychiatry assumes paramount importance in upholding the moral integrity and societal standing of this vital healthcare domain.

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Development Of Psychiatry, Ethical And Legal Issues In The Field Of Psychiatry In Our Country And In The World
Legal Issues in Psychiatry, Interaction of Laws and Ethical Dilemmas

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Ethics is the branch of philosophy that studies moral phenomena, also known as moral philosophy. It investigates the nature of morality and the principles that determine the moral evaluation of behavior, character traits, and institutions. Just as how people should live is the subject of ethics, how medical practices should be is also the subject of ethics, specifically medical ethics. “The Ethical Rules of Psychiatry” were accepted by the Turkish Psychiatric Association, the umbrella organization of Psychiatrists in our country, by the 1st Extraordinary General Assembly on 22 June 2002.

In the application of ethics and morality to social life, laws provide guidance in determining appropriate behavior in people’s relationships with each other and with society. In this context, the legal regulations regarding the practice of medicine in our country were regulated in 1928 with the Law on the Practice of Medicine and Medical Arts (Tababet ve Şuabatı San’atlarının Tarzı İcrasına Dair Kanun). In addition, from the perspective of psychiatric practice, in our country there are various legal articles that can guide psychiatric practice today (such as Turkish Civil Code Article 432, Turkish Civil Code Articles 405, 406, 429, Turkish Criminal Code Articles 32, 34, 57, Criminal Procedure Law Article 74), but there is no spesific Mental Health Law. Despite existing laws and legal provisions, various legal and ethical problems are still encountered in practice. Legal and ethical issues encountered in psychiatry may be related to the patient himself, but also to conflicts between his relatives, healthcare professionals, society and legal authorities. In addition, it may be related to the practice of the profession or interprofessional boundaries. Situations such as boundary problems with various professionals, privacy-related problems, compulsory hospitalization and compulsory treatment practices are frequently encountered ethical and legal problems. This panel aimed to discuss legal and ethical problems frequently encountered in practice with examples.

Side Effects and Management of Antidepressants in Geriatric Patients

Tayfun Öz

The use of antidepressants in geriatric patients is a common practice, but the side effects of these medications can be more pronounced in elderly individuals. Common side effects include dizziness, sedation, constipation, dry mouth, and changes in appetite. Additionally, serious side effects such as hyponatremia, orthostatic hypotension, and cognitive impairment may be associated with antidepressant use in the elderly(Rustad ve ark. 2013).

There are several strategies to manage these side effects. First and foremost, it is important to reduce the risk of side effects by using low starting doses. Attention should be paid to the patient's age, health status, and interactions with other medications. Furthermore, strict monitoring and counseling are necessary for managing side effects effectively.

To cope with common side effects like dizziness, patients are advised to get up slowly (Trifiro G ve ark. 2007). For sedation-related effects, the timing of medication can be adjusted, or other treatments that promote wakefulness may be considered. For issues such as constipation and dry mouth, appropriate treatment methods and dietary changes can be recommended.

In conclusion, the use of antidepressants in geriatric patients may require management of side effects, and a careful approach and individualized selection of treatments are important in this management.

Adverse Effects and Management of Antipsychotics in Geriatric Patients

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Use of antipsychotic medication is common among the elderly and often an essential therapy. Therefore, understanding the adverse effects and management of antipsychotics in geriatric patients is crucial. The adverse effects of antipsychotics in geriatric patients may be attributed in part to age-related changes in pharmacokinetics and pharmacodynamics, as well as to the specific characteristics of the drugs and their diverse receptor binding profiles. The risk of experiencing commonly known side effects of antipsychotics, such as extrapyramidal symptoms (EPS), sedation, orthostatic hypotension and cardiovascular adverse effects are increased in the elderly. EPS, including Parkinsonism-like movement disorders, tics, and dyskinesia are common adverse effects of antipsychotics. These symptoms may be more pronounced in the elderly and can significantly impact their quality of life. The sedative effects of antipsychotics and orthostatic hypotension may increase the risk of falls in elderly individuals. Some antipsychotics can prolong the QT interval, increasing the risk of arrhythmias. Additionally, antipsychotics have been shown to increase mortality in elderly patients diagnosed with dementia.

In order to avoid these side effects, the necessity of antipsychotic use in the elderly should be carefully evaluated. Atypical antipsychotics with lower potency and fewer adverse effects should generally be preferred. Antipsychotic doses should typically start low and be titrated up slowly to minimize adverse effects. Anticholinergic medications may be used to manage EPS. However the use of anticholinergic medications requires careful consideration and close monitoring as elderly patients may be more susceptible to adverse effects such as confusion, cognitive impairment, constipation, and urinary retention. In some cases, alternative treatments such as psychosocial interventions, psychotherapy, or other medications may be considered instead of or in addition to antipsychotics.

The use of antipsychotics in geriatric patients requires individualized evaluation as this population is much more vulnerable to adverse drug reactions, given their bodily changes, risk of comorbidities, and polypharmacy. Prescription of antipsychotics must be done with care and awareness of potential adverse effects is essential for preventing them. Prevention and early management of adverse effects can maximize the overall benefits of antipsychotic treatment, leading to improved quality of life and functional outcomes for patients (Mueller et al. 2021; Nørgaard et al. 2022; Stroup & Gray 2018).

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Side Effects and Management of Hypnosedatives in Geriatric Patients

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The use of hypnosedatives in geriatric patients, primarily for the treatment of insomnia and other sleep disorders, requires careful consideration due to the unique physiological and pharmacokinetic changes associated with aging. Older adults are more susceptible to the side effects of these medications, which can include increased risk of falls, cognitive impairment, daytime drowsiness, and potential for dependency. This vulnerability is partly due to slower metabolism and elimination of drugs, as well as increased brain sensitivity to sedatives.

Benzodiazepines and non-benzodiazepine hypnotics are among the most commonly prescribed hypnosedatives for older adults. However, their use is often associated with adverse outcomes, such as delirium, memory disturbances, and impaired motor coordination, leading to a higher incidence of falls and fractures—a significant concern in this population. Furthermore, the risk of developing tolerance, dependence, and withdrawal symptoms necessitates judicious use of these medications.

Management of the side effects related to hypnosedatives in the elderly involves several strategies. Initially, non-pharmacological approaches to improve sleep hygiene and cognitive behavioral therapy for insomnia (CBT-I) should be prioritized. When pharmacotherapy is deemed necessary, prescribing the lowest effective dose for the shortest duration possible is advisable to minimize adverse effects. Regular monitoring for efficacy and side effects, along with patient education about the risks of long-term use, is essential.

Alternatives to traditional hypnosedatives, such as melatonin agonists, may offer safer profiles for older adults by reducing the risk of dependency and minimizing next-day sedation. Adjusting the timing of medication to align with the patient's sleep schedule and ensuring comprehensive review of the patient's medication list to avoid drug-drug interactions are also critical components of care.

The overarching goal in the use of hypnosedatives in geriatric patients is to balance the benefits of improved sleep quality and duration against the potential for adverse effects, ensuring a cautious and individualized approach to treatment.

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Mental functions: Physical or a World Apart from the Body?

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The nature of the mind has been a major topic of debate for philosophers, scientists and thinkers throughout human history. At the heart of this debate is the question of whether mental processes are a product of the physical body or come from a world beyond the body. Both views have profound implications and form the basis for understanding human experience.

According to the physicalist view, mental functions are entirely the product of physical processes. Structurally and functionally, brain activity and neural interactions determine mental experience and behaviour. Neuroscience and neuropsychology support this view by studying the physical basis of mental processes. Brain injury or chemical changes can directly influence behavioural and mental disorders, which is seen as evidence for the physicalist view.

However, the opposing view, the dualistic approach, argues that mental functions are separate from physical processes and originate in a world beyond the body. According to dualists, there is a separation between mind and body, and mental processes are thought to occur beyond the physical world, perhaps in a spiritual or metaphysical realm. This view may be particularly compatible with religious and mystical beliefs and seeks to explain human experience in a deeper sense.

This debate about the nature of mental functions has had profound implications in many philosophical, scientific and religious fields. In philosophy, there are classical approaches such as Descartes' dualism, as well as diverse views such as Spinoza's monism and modern physicalist theories. In science, neuroscience and cognitive psychology are making progress in understanding the physical basis of mental functions. Religious and mystical approaches seek to explain the mind-body relationship in a spiritual dimension.

As a result, this debate about the nature of mental functions forms a fundamental basis for understanding human experience and existential questions. In scientific research as well as in philosophical and religious thought, studies on this topic will continue to shed light on the fundamental questions of humanity.

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From the Psyche in Ancient Times to the Mind and Brain in the Modern Era

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It is seen that humanity has been questioning the soul-body relationship in various ways since the beginning of known history, and today this has turned into a mind-brain problem. Therefore, in this review, the transition process from “Ancient Psyche” to “Contemporary Mind/Brain” and the current situation will be summarized. In ancient Greek, the word “psyche” means “anima”, “pneuma”, etc., as well as “psyche”. The fact that these words were used shows that the fragmented structure of the soul has been thought about since then. In many cultures, soul(s) are considered as the force(s) that coexist with the material body and give it vitality. While some attribute souls to all living things, some believe that having a soul is unique to humans. Whether the soul joins the body before fertilization, some time after fertilization, or at birth; There are also various ideas about whether the soul disappears after the body dies. Today, both science and neuroscience are based on the idea that there is no need for an extraterrestrial power/spirit for universal movement or for the mind/brain to work. For this reason, it is observed that the word mind is increasingly replacing the soul. French philosopher René Descartes proposed that the human mind is independent of the body and operates without any physical influence. This theory has been unquestioningly pursued under the name of “Cartesian Dualism”, in which the mind is called “immaterial” and the body is called “material”. However, the human mind is not a separate entity from the body. French philosopher René Descartes proposed that the human mind is independent of the body and operates without any physical influence. This theory was pursued unquestioningly under the name of “Cartesian Dualism”, in which the mind was called “immaterial” and the body was called “material”. Just as the body is not whole without the mind, the mind is not whole without the body. Although Antonio Damasio’s research showed the opposite, he actually showed that the mind is greatly influenced by the body. When people experience major trauma to their frontal lobes, there is an incremental change in the person’s outward behavior. Damasio’s efforts in this area have argued that emotions play a central role in decision-making and social adaptation today.

How Can We Know Other Minds: A Review in the Context of Philosophy of Mind and Psychi

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Philosophy of mind is a relatively new subfield of philosophy that focuses on understanding the nature, content and functioning of human reality, which in the past was referred to by terms such as soul or intellect, and today by terms such as mind or consciousness. It aims to systematize mental properties, the nature of consciousness, concepts such as personality, self, subjectivity, the nature of the relationship between human beings and their environment, and the relationship between mind and knowledge. In this context, it is in common with disciplines such as psychology, psychiatry and neuroscience that seek to understand human emotional, behavioral and mental processes. In areas where the empirical method of modern science is limited, one is still inevitably confronted with Descartes' challenging questions (1). Especially in the psychiatric clinic and in the practice of psychiatrists - a medical discipline that seeks to produce knowledge about subjectivity - an understanding of mental phenomena is essential and we need to draw on philosophy in this process of understanding. How is it possible for a psychiatrist to understand a patient in his or her singularity and uniqueness, to make a diagnosis by distinguishing between normal and pathological, to establish a therapeutic relationship by creating an intersubjective space between himself and his patient, and to treat his or her mind?

The question of how to acquire knowledge about minds can be approached in two ways. First, it focuses on discovering what is going on inside our own minds and how we understand it. This problem is called the problem of self-knowledge. The other asks how we can understand whether other people outside of us, even other animals and machines, have a mind (2). This question is also known as the problem of other minds. If we live within the limits of our own minds and others live within the limits of their own minds, how can we understand them in their own context? How can we comprehend other minds beyond our own? (3). Within the discipline of psychiatry, understanding and evaluating other minds is a practical and ethical issue beyond mere theoretical curiosity, as it is closely related to the diagnosis and treatment of patients. For example, a psychiatrist uses empathy to understand the patient's inner world. This helps him or her to better understand the patient's feelings, thoughts and experiences and to formulate an effective treatment plan. Understanding other minds is also important in medical clinical practice. Especially in psychiatric disorders, understanding the patient's mental state is critical for accurate diagnosis and treatment. Various methods are used for this, and intersubjective assessments such as mental status examination and psychometric tests are prioritised. Understanding other minds is also important in therapy processes. Understanding the patient's mind helps the therapist to provide the right support and guidance and positively affects therapeutic outcomes.

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Cancer of Thought :
Subject – Object Dualism

Yusuf Dökmen

It can be seen that the subject in its modern sense was formed by Descartes' desire to re-establish philosophical thought with rational certainty. With the idea of cogito ergo sum, the central position of the subject was determined and at the same time, the establishment of the object that would be the center of objective knowledge was realized. The subject of knowledge and the object of knowledge are absolutely separated. This perspective, which positions the subject in a place separate from the context, had some consequences. Our theories are stuck in problems such as the problem of solipsism or the problem of representation. Existentialist psychiatrist Ludwig Bismwanger calls the subject-object distinction the cancer of thought that emerged in Western thought. Since then it has been a common view that the subject cannot be considered separate from the object. It has revealed itself as the "constructed subject" in the field of human sciences, as the transition from one-person therapies to two-person therapies in the field of psychology, and as the concept of plasticity in the field of neuroscience. However, these developments did not end the subject discussions and it is said that the Cartesian ghost still walks among us.

Mourning and Creativity

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In his seminal work "Mourning and Melancholia" (1917), Sigmund Freud delineated mourning as the profound reaction to the loss of cherished entities, whether they be loved ones or deeply held values intimately linked to one's identity, such as homeland, liberty, or ideals. Throughout the mourning process, individuals come to terms with the stark reality of the absence of the lost object through rigorous reality testing. Gradually, the emotional investment once bound to the lost entity is relinquished, making way for the transfer of affection to new endeavors.

Central to Freud's thesis is the notion that the bond with the departed entity must persist internally, serving as a sustaining force for the ego. This internal communion underscores the intricate emotional labor inherent in mourning, where the individual navigates the delicate balance of embracing new pursuits while honoring the memory of what has been lost.

Remarkably, mourning can catalyze acts of creative expression, wherein the bereaved individual reimagines and reconstructs the essence of the departed entity. By engaging in this transformative process, the artist not only grapples with the reality of loss but also imbues newfound vitality into their own sense of self. It is intriguing to note that some of the most poignant artistic endeavors emerged from the depths of suffering, notably amidst the harrowing conditions of the Holocaust, defying expectations of creativity's demise in the face of adversity (Ogden, 2000).

Creativity, therefore, emerges as a potent tool for navigating the labyrinth of grief. Through creative endeavors, individuals confront the void left by loss, endeavoring to encapsulate its essence in symbolic form. As American psychoanalyst Judith Lingle Ryan profoundly observed following the tragic loss of her son, creative expression became a conduit for engaging with the intricacies of grief, allowing her to partake in the narrative of his untimely passing (Ryan, 2009).

Ultimately, artistic endeavors serve as conduits for collective remembrance, fostering emotional resonance and communion among audiences. Whether through tangible memorials or evocative works of art, these spaces transcend mere recollection, actively engaging with the present moment to facilitate the mourning process. Thus, the act of creative production becomes a testament to the enduring legacy of the departed, preserving their memory in perpetuity.

Such creative expressions, whether manifested physically or through emotional landscapes, serve as cathartic avenues for individuals to articulate the ineffable depths of their grief. In the act of remembrance, the pain of loss is transmuted into a palpable state, enabling mourners to navigate the labyrinth of grief with grace and resilience. For mourning is not a journey of forgetting, but rather a testament to the enduring power of memory—a process that unfolds over a lifetime.

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Sould We Ban or Hide Mourning?

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In Sophocles' 'Antigone', King Creon orders Eteocles' body to be buried with a magnificent ceremony, but Polyneices' body to be fed to the birds and left in pieces. Polyneices was a traitor and his mourning was forbidden by Creon for this reason. However, her sister Antigone buries her brother despite the ban and confronts Creon at his grave. With countless uncontrollable and forbidden mournings that do not only end in Sophocles' Antigone, but continue in Trojan Women and Eumenides, and extend in our country from the Marmara Earthquake to the Sivas Massacre, from the Saturday Mothers to the Soma Mine Disaster and the February 6 Earthquakes. history is full. For this reason, a society that cannot confront and come to terms with its perpetrator, that is, the state, cannot find its spiritual reality and cannot symbolize this reality in its mind. Mourning is not only prohibited, but also subject to a hierarchy. Just as King Creon decreed, some groups are worth mourning and others should be ignored. Judith Butler examined this situation and asked some questions. Who counts as human? Whose life counts as life? What makes a life grievable? Butler examined the answers to these questions in a political context and focused on the groups ghosted by the state. Walter Benjamin, on the other hand, mentions that unkept mourning causes a transfer crisis in societies, because one of the most important factors that form social identity is the experiences transferred from generation to generation. So, how can a society in mourning that is hierarchical, even banned, rebuild itself and what kind of a place can art find for itself in this context? If we focus on the problem of testimony in society's inability to mourn, art will open a new door for us here. Unless the society can witness the events, it cannot mourn, come to terms with it, and pass it on to the next generation. Witnessing through art makes it possible to take a step towards reckoning and then heal the wounds. Just as we were able to share the pain of the Saturday Mothers to some extent in Özcan Alper's Karanlık Gece movie.. We hope that we will never end our belief that it is possible to mourn, settle accounts and rebuild our social identity without any prohibitions...

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Mourning is Heavy in Its Place

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In a world where wars, terrorist acts and disasters occur, and where losses can reach thousands or even millions, the difference between mourning after multiple traumatic losses and mourning after the loss of a single individual under usual civilized conditions should be considered. In such losses, spaces, 'memorial areas' are needed to build a bridge between external reality and internal reality and to provide an opportunity for a reality experience (Ornstein 2010). After the February 6 Kahramanmaraş and Hatay earthquakes, the survivors experienced being caught in the middle like piles of debris representing the collapse of reality. In democratic times where there was cooperation between institutions, as in the example of the 2011 Van earthquake, these spaces of reality were created by institutional frameworks. Big tents would be set up, soup would boil, and everyone would wrap themselves in blankets. Thus, in secure base, our feeling of terror, similar to that in The Scream, could only be transformed into an experience of having loss. On the anniversary of the earthquake, in the prolonged being in limbo of those who cannot find a safe and real external space, cities turned into giant funeral homes with repeated walks on the road passing through the ruins, candles and incense burned over the rubble. Thanks to collective rituals, an internal space for mourning was created. On the other hand, it is obvious that mourning is not encouraged with the ban on commemorations in some provinces - whether it prevents mourning or not. However, the sincere sadness and introspection that mourning would also create an opportunity to pause and re-evaluate. Collective rituals such as marching, burning incense, chanting slogans are effective in expressing the unspeakable and making the unseen public. Thus, the unspeakable and formless acquires a physical form. Pain turns into strength (Daniel 2021). Since the February 6 earthquakes, there has been a struggle to mourn-not to mourn between those affected and those not directly affected. Assuming that struggle indicates turning away from loss, let's ask from a photographer's perspective, could the mourning in which we turn away point to a chronic disappointment with the normal we have lost and the possible good and fair times (Şermet 2021)? Our need for this panel must have arisen out of frustration. The solidarity with the effort to mourn brings those good and fair times we dream of into existence.

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Why Can't We Sleep?

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Sleep appears to be a physiological and dynamic process, resembling a response formed by the interaction of circadian rhythm and homeostatic load(1). Insomnia disorder is a common condition in all societies, often caused by psychological factors. However, there are also clinical conditions where insomnia disorder is observed due to biological reasons. Nowadays, factors such as increased frequency of travel, variability in working hours, increased use of digital technology, and the rise in psychiatric disorders lead to changes in sleep habits and more frequent occurrences of insomnia. At this point, the question of why we sleep and why we cannot sleep gains significant importance. It should be questioned how individuals perceive sleep and define insomnia, as there are many variables that negatively affect the initiation and maintenance of sleep, hindering restful sleep. Many people experience insomnia at some point in their lives. However, it seems that later-established lifestyle habits and the meanings attributed to insomnia perpetuate this problem(2). Factors such as variability in sleep-wake hours, spending awake time in bed, daytime naps, sedentary lifestyle, dietary habits, and shift work contribute to the chronicity of insomnia disorder(2). Additionally, it is known that insomnia disorder reflects accompanying systemic diseases and psychiatric disorders, and despite appropriate treatments, it tends to persist stubbornly(2). Furthermore, neurobiological and genetic factors, along with phenotyping, play crucial roles in understanding insomnia and determining appropriate interventions(3). This session will involve a discussion on the causes of insomnia based on current literature data.
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How Will We Sleep?

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In order to explain the question of how we sleep, we need to understand why and why we sleep by defining sleep and its functions. Sleep; It is a temporary, periodic, psychophysiological state characterized by the decrease in consciousness, organic activities, sensory functions and voluntary muscle movements. Sleep; Active, complex and non-homogeneous, dynamic within itself, life-long changing features that cover 1/3 of life, occur within the endogenous circadian rhythm, activate many neuronal pathways in many localizations in the brain, affect mental and physical activities and are affected by changes in them. It is a different state of consciousness.

Sleep; It is a natural process that ensures energy conservation, development and repair of the nervous system in all mammals, and is associated with many components of the biological structure, especially the nervous system that controls arousal, automatic functions, behavior, cognitive functions and intracellular mechanisms. Initiation and maintenance of sleep occurs through the functions of many cortical and subcortical brain regions. It is accepted that the ventrolateral preoptic nucleus in the hypothalamus primarily plays a role in initiating sleep, in line with the cyclic inputs and endogenous chemical stimuli coming from the anterior hypothalamus. In the formation of wakefulness, orexinergic signals coming from the lateral hypothalamus; cholinergic, noradrenergic, serotonergic from the brain stem; It is accepted that histaminergic signals from the posterior hypothalamus play a role. Sleep consists of NREM (Non-Rapid Eye Movement) sleep periods, which are repeated at regular intervals and are not accompanied by rapid eye movements, and REM (Rapid Eye Movement) sleep periods, which are accompanied by rapid eye movements. The NREM-REM cycle that creates sleep is controlled by the mesopontine nuclei in the brainstem. is done.

The formation of sleep and wakefulness sleep-wake cycle; It is formed depending on biological rhythm, and its formation is determined by the circadian rhythm, which consists of the repetition of phases lasting 24 hours. Circadian rhythm is regulated by the suprachiasmatic nucleus located in the anterior hypothalamus. The strongest stimulus involved in the formation of this rhythm is sunlight. Light stimuli affect the suprachiasmatic nucleus through retinal photoreceptors. Another function that occurs due to these stimuli is melatonin synthesis. Melatonin is secreted depending on the rhythmic activity of the suprachiasmatic nucleus and reaches its highest level in the dark, regulating the activity of this nucleus through a feedback mechanism. With the absence of light, neuroendocrine regulations in the hypothalamus change, and the secretion or suppression of some hormones, especially melatonin, contributes to the induction of sleep. During wakefulness, serotonergic activity starting from the raphe nuclei spreads to the thalamus, hypothalamus and frontobasal region. This activity, especially reaching the ventrolateral part of the posterior hypothalamus, leads to the synthesis and accumulation of a series of hypnogenic substances in the peptide structure that enable sleep. In this way, the hemostatic process and circadian processes occur. This "Dual-Process Model of Sleep Regulation", proposed by Borbely in 1982, assumes that sleep and sleepiness tend to be governed by the interaction of Process S, a homeostatic pressure for sleep, and Process C, a circadian rhythm of arousal.

If there is insufficient or poor sleep hygiene in the symptoms of insomnia, no matter what treatment is applied, it will disrupt the treatment process and cause inadequate results or the picture will become more negative. In the treatment of insomnia disorder, first of all, life style should be changed with interventions specific to the individual, and initially the sleep-related dysfunctional cognitive structure should be intervened, as well as behavioral methods; Methods such as sleep hygiene training, stimulus control, sleep restriction, sleep compression, relaxation exercises, brief behavioral treatment, and paradoxical intention should also be used.

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