ANNUAL MEETING and 3rd INTERNATIONAL 27th NATIONAL CLINICAL EDUCATION SYMPOSIUM of PSYCHIATRIC ASSOCIATION of TÜRKİYE

27-30 April 2025

Xanadu Resort Hotel, Antalya

BOOK OF SPEECH SUMMARIES

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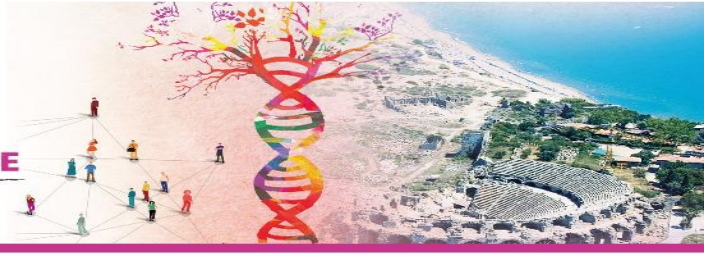


TREATMENT ADHERENCE İN CL PSYCHİATRY: MULTİDİSCİPLİNARY COLLABORATİON, DİGİTAL TOOLS AND LONG-TERM MONİTORİNG

Ali Gökhan Eşim

Alsancak Nevvar Salih Isgoren State Hospital, İzmir

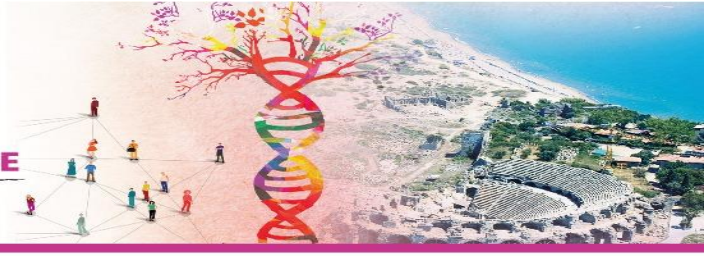
In the management of systemic diseases, treatment adherence is a critical determinant of therapeutic success and the predictability of disease progression. In Consultation-Liaison Psychiatry (CLP) practice, treatment adherence must be evaluated not only at the level of individual psychopathology but also within the broader context of patient-physician relationships, interdisciplinary coordination, healthcare accessibility, and technological support. Within this framework, the psychiatrist's role in CLP is evolving toward a more active and guiding position within the multidisciplinary team.

In such teams, the psychiatrist serves as a bridge between the patient and medical staff by identifying insight, motivational levels, and psychosocial risk factors. Particularly in patients with non-adherence issues, supportive and structured psychiatric interventions can significantly impact the treatment process (Katon et al., 2005). This approach reflects a model that seeks solutions not solely at the patient level, but also within systemic and institutional structures.

In recent years, the advancement of digital health technologies has offered new opportunities to support adherence. Reminder applications, digital monitoring systems, patient-provider communication platforms, and telepsychiatry services have been associated with improved treatment participation, particularly among patients with chronic illnesses (Torous et al., 2020). In CLP settings, remote consultation capabilities not only facilitate outpatient follow-up but also enable access to patients who cannot be hospitalized easily.

For long-term sustainability of adherence, regular psychiatric monitoring and feedback mechanisms within healthcare teams are essential. Rather than viewing the psychiatrist's role as a one-time consultant, maintaining a longitudinal perspective allows for early intervention in response to motivational decline, medication side effects, or denial of illness (Zolnierek & DiMatteo, 2009). Furthermore, the integration of psychiatric follow-up protocols into hospital information systems supports a systematic and data-driven monitoring process.

In conclusion, the psychiatrist's role in enhancing treatment adherence within CLP practice is becoming increasingly central—not only through individual-level interventions but also through leadership in team dynamics, integration of digital tools, and the establishment of sustainable follow-up systems.



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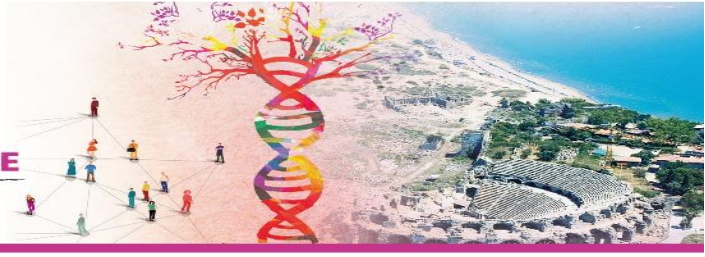


AUTISM SPECTRUM DISORDER IN DIFFICULT AREAS: GENDER DIVERSITY

Ali Gökhan Eşim

Alsancak Nevvar Salih Isgoren State Hospital, İzmir

Autism Spectrum Disorder (ASD) is a neurodevelopmental condition characterized by significant challenges in social interaction, communication skills, and behavioral patterns. These challenges typically manifest as restricted and intense interests, repetitive behaviors, and difficulties in interpreting social cues. In recent years, the intersection between ASD and Gender Dysphoria (GD) has garnered increasing attention in both clinical practice and scientific research.

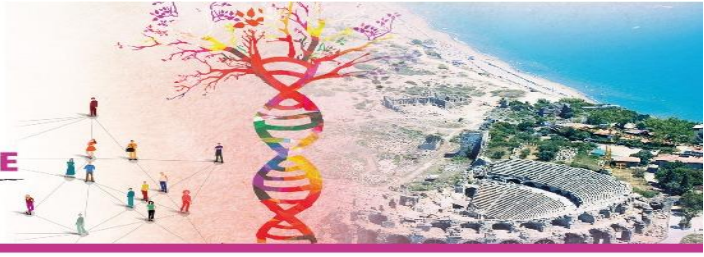
Recent studies have reported a higher prevalence of ASD among gender diverse adolescents than observed in the general population, highlighting the unique challenges this demographic faces in terms of adolescent development and support systems.

Research conducted by Cooper and colleagues further elaborates on the phenomenology of GD in individuals with autism, revealing that autistic traits may complicate the experience and expression of gender incongruence. Individuals on the autism spectrum often describe their experiences of gender dysphoria from various perspectives, emphasizing the intricate relationship between neurodevelopmental traits and gender identity (Cooper et al. 2022).

Coleman-Smith and colleagues explored the lived experiences of gender dysphoria among autistic individuals, showing how the process of identifying with specific gender groups is frequently shaped—and at times hindered—by autism-related challenges in social cognition (Coleman-Smith et al., 2020). Similarly, Miesen et al. demonstrated that the understanding of gender identity in autistic youth is shaped by unique socialization experiences, and that these deviations from normative expectations may contribute to feelings of isolation and dysphoria (Miesen et al., 2017).

In conclusion, the co-occurrence of ASD and gender diversity involves a complex and intertwined set of dynamics that requires a multidisciplinary approach to ensure a comprehensive understanding of each individual's experience. The social difficulties faced by individuals on the autism spectrum and those navigating gender identity issues necessitate more nuanced assessments and tailored support systems.

In this presentation, we will discuss the psychiatric assessment and follow-up process of an individual diagnosed with autism who is also undergoing a gender transition process due to gender dysphoria. The case study will be used to explore diagnostic complexities and supportive intervention strategies in depth.



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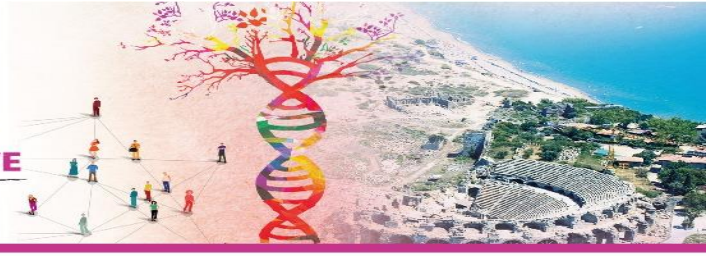

MANAGING INDEPENDENCE AND CONFRONTING NEW ADDICTIONS IN LATE ADOLESCENCE AND EMERGING ADULTHOOD (AGES 18-25)

Ali Gökhan Eşim

Alsancak Nevvar Salih Isgoren State Hospital, İzmir

Late adolescence and emerging adulthood, typically defined as ages 18 to 25, represent a critical period of psychological, neurological, and social development. During this transitional stage, young people experience increasing autonomy, identity exploration, and shifting social roles, all of which intersect with heightened vulnerability to behavioral addictions. These may include problematic internet use, gaming disorder, online gambling, and compulsive social media engagement.

The rapid maturation of cognitive control systems during this period is often outpaced by reward-related neural mechanisms, creating a developmental imbalance that predisposes individuals to risk-taking behaviors and impulsivity (Casey, Jones, & Somerville, 2011). When coupled with psychosocial stressors—such as academic pressure, economic uncertainty, or relational instability—this imbalance can facilitate maladaptive coping mechanisms and foster addiction-prone behaviors.

Digital platforms are particularly appealing in this age group due to their capacity to fulfill developmental tasks like identity exploration and social connection. However, excessive engagement can interfere with real-world functioning and mental health. For example, emerging adults who exhibit compulsive internet use often report heightened levels of anxiety, depression, and sleep disturbances (Kuss & Lopez-Fernandez, 2016). Preventive interventions should therefore focus not only on reducing risk exposure but also on enhancing digital literacy, emotional regulation, and autonomy-supportive environments.

In addressing these behavioral addictions, a developmental psychopathology framework is essential. Interventions tailored to this age group must recognize their quest for independence while promoting adaptive coping strategies and intrinsic motivation. Prevention efforts are most effective when they integrate psychoeducation, peer support, and policy-level strategies, such as restricting access to high-risk digital content and promoting campus-based mental health resources.

In the end, providing comprehensive support to young individuals as they navigate and take ownership of their newfound independence—while simultaneously nurturing emotional resilience, critical thinking, and responsible digital habits—plays a vital role in reducing the

likelihood of developing new forms of behavioral addictions. Given the ever-expanding digital landscape and its profound impact on daily life, it is imperative for clinicians, educators, and policymakers to stay alert, informed, and responsive to the shifting patterns and complexities of these emerging dependencies, ensuring timely interventions and sustainable strategies for prevention and support.

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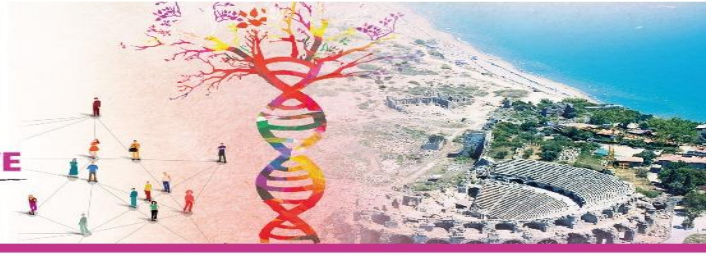


WORKING WITH FAMILIES DESPITE RESISTANCE: A CASE OF A TRANS WOMAN WITH AUTISM SPECTRUM DISORDER

Ali Gökhan Eşim

Alsancak Nevvar Salih Isgoren State Hospital, İzmir

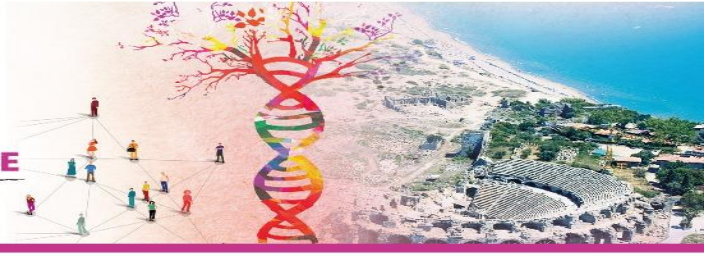
This presentation explores psychiatric interventions in the context of family resistance, focusing on the clinical work conducted with the family of a trans woman diagnosed with both gender dysphoria and autism spectrum disorder (ASD). Even in cases where the individual clearly and consistently articulates their gender identity, the presence of neurodevelopmental conditions such as ASD can significantly complicate the family's understanding and acceptance of that identity.

de Vries et al. (2010) demonstrated that individuals with ASD often perceive and express gender in ways that are more abstract and individualized. As a result, the expression of gender dysphoria may diverge from typical patterns, further fueling family skepticism and intensifying resistance to the individual's identity. In the presented case, conventional family sessions did not produce sufficient progress in reducing resistance. Therefore, the clinical strategy shifted to structured family group sessions.

These group sessions provided an opportunity for family members to recognize that they were not alone in their struggles, to learn from others' experiences, and to regulate their emotional responses in a shared, reflective space. According to Coleman et al. (2012), such group-based psychoeducational interventions play a critical role in helping families manage emotional distress and more effectively support their loved one through the gender transition process.

Throughout the intervention, the psychiatrist's role was not limited to affirming the individual's identity but also included understanding the emotional resistance of the family and working toward its transformation within a reparative relational framework. Bockting (2009) refers to this as "contextual reconfiguration," a therapeutic approach that invites families to reconstruct the place of the trans individual within their relational system.

This presentation will discuss the transformative potential of psychiatric care when family opposition is present, with a specific focus on the intersection of gender dysphoria and ASD. Through this case, it will highlight how targeted family work—particularly group-based interventions—can foster acceptance, reduce conflict, and support both individual and relational well-being.



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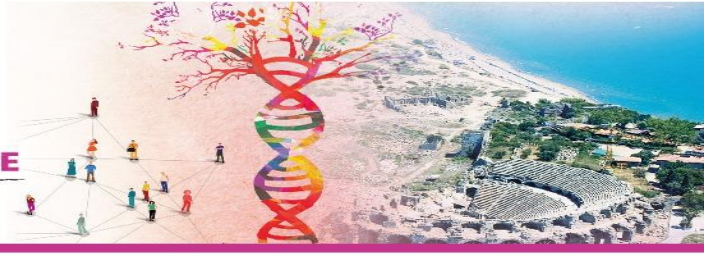


PHARMACOLOGICAL TREATMENT OF ADHD IN ADULTHOOD

Ali Kandeğer

Department of Psychiatry, Faculty of Medicine, Selçuk University

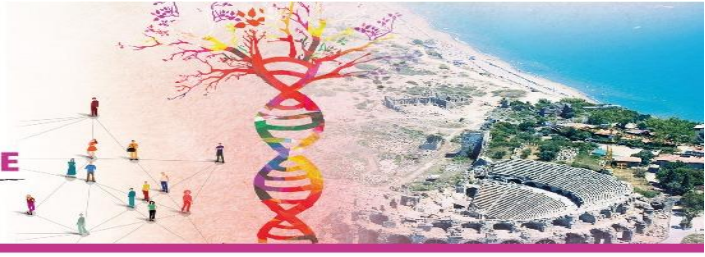
Attention-Deficit/Hyperactivity Disorder (ADHD) is a neurodevelopmental disorder that is not limited to childhood and may lead to persistent symptoms and functional impairments in adulthood. In adults, treatment of ADHD predominantly involves pharmacological interventions, which are considered the first-line approach for symptom management. However, treatment tends to be more effective when planned within a personalized and holistic framework.

Pharmacological treatment options are generally divided into two categories: stimulant and non-stimulant medications. Stimulant medications—particularly methylphenidate and amphetamine derivatives—act by increasing dopamine and norepinephrine levels, leading to significant improvements in core ADHD symptoms. These agents are the most commonly preferred and most effective options in the pharmacological treatment of adult ADHD. Nonetheless, it is important to note that stimulants may lead to tolerability issues, side effects, or the risk of misuse in certain cases.

Non-stimulant medications may be preferred in cases where these risks need to be minimized or when there is insufficient response to stimulants. Atomoxetine, a selective norepinephrine reuptake inhibitor, is the first non-stimulant agent approved for ADHD treatment. In addition, alpha-2 adrenergic agonists such as guanfacine and clonidine can be beneficial, particularly in the presence of comorbid anxiety, sleep disturbances, or tic disorders.

This presentation will summarize the mechanisms of action, dosing strategies, side effect profiles, and monitoring recommendations of medications used in the treatment of adult ADHD. It will also address the role of psychiatric comorbidities, individual factors influencing medication selection, and clinical strategies to improve treatment adherence.

While pharmacological treatment is a fundamental tool for improving functioning in adults with ADHD, the best outcomes are achieved when combined with psychoeducation, psychosocial support, and psychotherapy when indicated.



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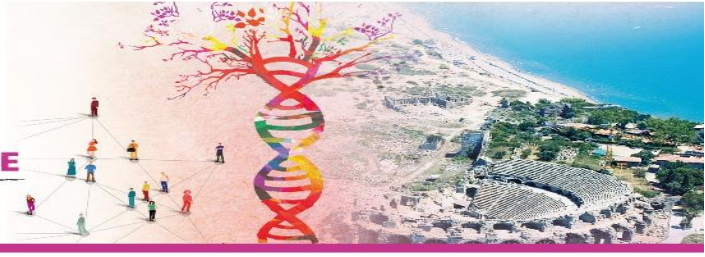


BRAİN EXCİTABİLİTY: NEUROBİOLOGY, MEASUREMENT AND MODULATİON

NEUROBİOLOGİCAL PRİNCİPLES AND MEASUREMENT TECHNİQUES

Ardıl Bayram Şahin

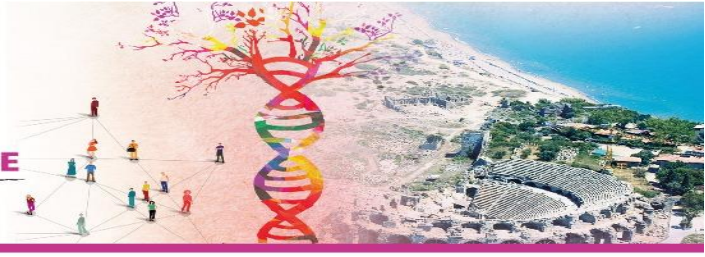
Koç University, Graduate School of Health Sciences, Neuroscience PhD Programme

Cortical excitability refers to the brain's capacity to respond to external stimuli and reflects the ease with which neurons are activated. It plays a fundamental role in regulating cognitive and emotional processes in healthy individuals and is also critically involved in the pathophysiology of numerous neuropsychiatric disorders. This excitability is shaped by the dynamic balance between excitatory and inhibitory neurotransmission—primarily glutamatergic excitation and GABAergic inhibition. Additionally, neuromodulatory systems, including dopaminergic, serotonergic, and cholinergic pathways, contribute to region-specific excitability patterns, influencing functions such as emotional regulation and executive functioning (Ziemann et al., 2015).

Cortical excitability is also sensitive to individual factors and psychological states such as stress and depression. These conditions can alter inhibitory-excitatory balances and, in turn, affect synaptic plasticity and cortical network activity. As such, investigating excitability provides valuable insights into the neurobiological mechanisms underlying psychiatric symptoms and may guide the development of targeted interventions.

In recent years, neurophysiological techniques such as transcranial magnetic stimulation (TMS) have become essential tools for assessing cortical excitability non-invasively. TMS induces motor-evoked potentials (MEPs) by stimulating the motor cortex, which are recorded from peripheral muscles via electromyography (EMG). The resting motor threshold (RMT), defined as the minimum stimulus intensity required to produce a detectable MEP, serves as a key indicator of corticospinal excitability. Lower RMTs and larger MEP amplitudes suggest increased excitability. Other TMS-derived measures—such as short-interval intracortical inhibition (SICI), long-interval intracortical inhibition (LICI), and the cortical silent period (CSP)—provide detailed indices of intracortical inhibitory and excitatory function (Rossini et al., 2015; Hupfeld et al., 2020).

This workshop aims to integrate theoretical knowledge with clinical application by emphasizing the relevance of brain excitability in psychiatric research. Participants will gain practical insight into current assessment methods and explore the clinical utility of neuromodulation techniques in psychiatric treatment, with a particular focus on how individual variability and affective states influence cortical excitability.



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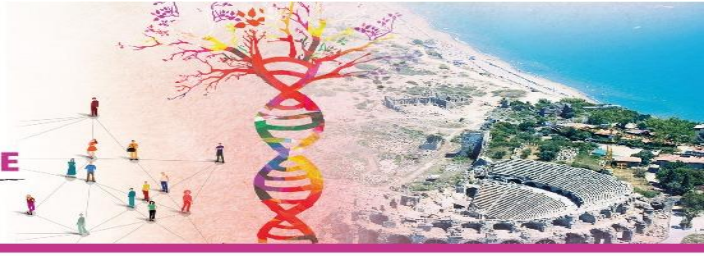


PSYCHODYNAMİC THERAPY APPROACH İN BİNGE EATİNG DİSORDER

Armağan Özdemir Ceylan

İstinye Üniversitesi İnsan ve Toplum Bilimleri Fakültesi, Psikoloji Bölümü

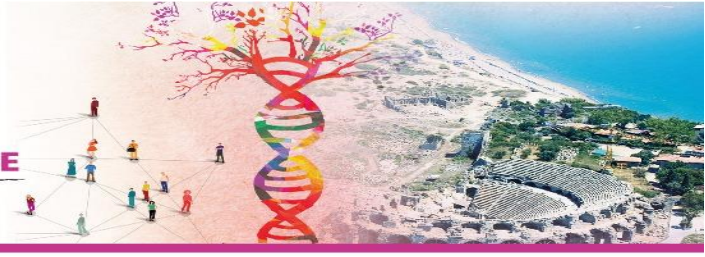
Binge Eating Disorder (BED), characterized by recurrent episodes of consuming large amounts of food accompanied by a sense of loss of control, has been increasingly explored through psychodynamic frameworks. Rather than viewing BED solely as a behavioral issue, psychodynamic theory conceptualizes it as a manifestation of unconscious conflicts rooted in early developmental experiences and relational patterns.

From the classical Freudian perspective, BED reflects a fixation at the oral stage of psychosexual development. Inadequate gratification during this phase—often due to an unresponsive or inconsistent caregiving figure—may lead to unresolved oral dependency needs. In adulthood, binge eating serves as a symbolic attempt to fulfill these unmet needs, offering temporary relief from unconscious anxiety and emotional deprivation (Abraham, 1996).

Heinz Kohut's self psychology deepens this view by focusing on the development of the self in relation to empathic attunement from caregivers. When caregivers fail to provide sufficient "mirroring" or validation, the child develops a fragmented sense of self. In such cases, binge eating functions as a self-object substitute, offering a transient sense of cohesion and emotional regulation in the absence of internal stability (Kohut, 1971).

Object relations theorists, such as Melanie Klein, emphasize the internal world of the individual, especially the dynamics of internalized "good" and "bad" objects. In BED, food can be used defensively to manage overwhelming affect linked to persecutory anxieties or unresolved rage toward internalized objects. Primitive defense mechanisms such as splitting and projective identification may dominate the psychic functioning of individuals with BED. Eating excessively thus becomes a way to "fill" psychic emptiness and defend against depressive or annihilatory anxieties (Steiner, 1993).

Psychodynamic therapy aims to uncover and work through the unconscious meanings of the bingeing behavior. It emphasizes the development of insight into early relational trauma, affect regulation patterns, and defensive structures. Rather than symptom suppression, the goal is structural change and the capacity to tolerate and integrate painful affect states more adaptively.



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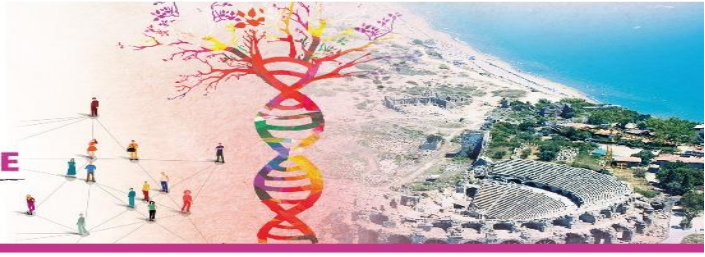


NICOTINAMIDE RIBOSIDE ATTENUATES MEMORY IMPAIRMENT AND DEPRESSIVE-LIKE BEHAVIOR IN AN ALZHEIMER'S DISEASE ANIMAL MODEL

Aslı Aytulun

Bakırköy Mazhar Osman Training and Research Hospital for Psychiatry, Neurology and Neurosurgery, Psychiatry Department

Alzheimer's disease is a neurodegenerative disorder that presents not only with cognitive impairments but also with neuropsychiatric symptoms such as depression, anxiety, and behavioral changes. These symptoms pose a significant burden on patients and caregivers. Depression accompanying Alzheimer's disease differs from major depression in terms of both clinical course and treatment response. Previous studies have shown that antidepressants provide limited benefit in Alzheimer's patients, suggesting that the underlying biological mechanisms of depressive symptoms in this population may differ from those in other depressive syndromes.

In recent years, mitochondrial dysfunction has gained prominence in Alzheimer's disease. Neurons, due to their high energy demands, are highly dependent on mitochondria. However, the process of removing damaged mitochondria (mitophagy) declines with aging, thereby threatening neuronal survival. It has been demonstrated that increasing nicotinamide adenine dinucleotide (NAD^+) levels can increase mitophagy, reduce Aβ accumulation, and improve both cognitive and behavioral symptoms. However, to date, no systematic study has investigated the use of NAD^+-boosting strategies to alleviate depression-like symptoms in Alzheimer's disease models.

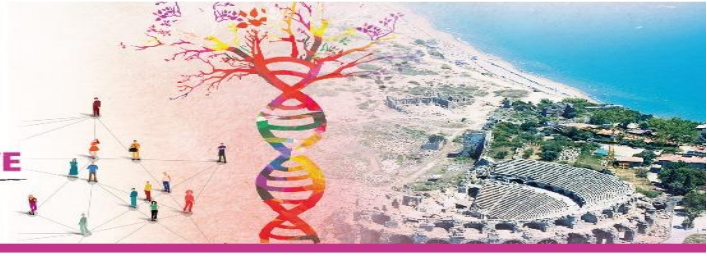
In our study, we aimed to evaluate the effects of nicotinamide riboside (NR), a precursor of NAD^+, on both cognitive and neuropsychiatric symptoms in a rat model of Alzheimer's disease induced by Aβ 1-42 injection and further exacerbated by REM sleep deprivation.

In our model:

- A single dose of Aβ 1-42 was injected intracerebroventricularly.
- This was followed by 96 hours of sleep deprivation.
- After sleep deprivation, rats were administered NR (700 mg/kg) or saline via oral gavage for 23 days.
- Six behavioral tests were conducted to assess memory, depression, anxiety, and aggression levels.

Our main findings were as follows:

- **Memory functions:** The Aβ group showed significant impairments in passive avoidance and T-maze tests. These impairments were ameliorated in the NR-treated group.



- **Depression-like behavior:** Increased immobility time in the forced swim test and reduced sucrose preference were significantly improved with NR treatment.

- **Aggression:** Although no significant increase was observed in the Aβ group, NR treatment significantly reduced aggressive responses, as assessed by the handling test.
- **Weight gain:** Rats treated with NR exhibited slower weight gain, which is consistent with NR's known metabolic effects that mimic caloric restriction.

No significant differences were observed in anxiety-like behaviors. However, increased time spent in the center during the open field test in the Aβ group was interpreted as a potential sign of behavioral disinhibition.

In conclusion: This study is the first to demonstrate that NR improves both cognitive functions and depression-like symptoms in an Alzheimer's disease model. Additionally, NR's effects on weight gain and its potential to regulate mitochondrial function were observed in this specific model.

These findings suggest that NAD^+ precursors like NR may offer a promising therapeutic approach for treating neuropsychiatric symptoms accompanying Alzheimer's disease. Future research should focus on delineating the precise biochemical pathways involved, with particular emphasis on NR's role in mitophagy. Such studies will be crucial in clarifying its translational potential and guiding clinical applications in the treatment of Alzheimer's-related behavioral symptoms.

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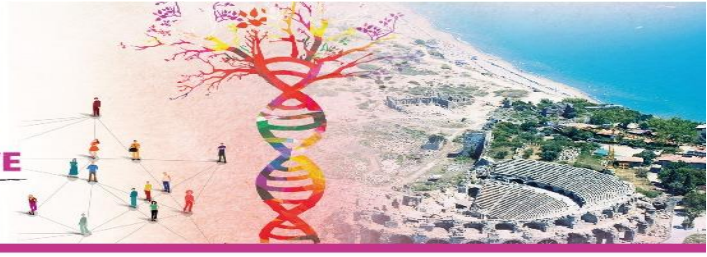


THE DİFFERENT FACES OF ADULT AUTİSM: COMORBİDİTY OF AUTİSM AND EATİNG DİSORDERS

Aslı Ceren Hınç

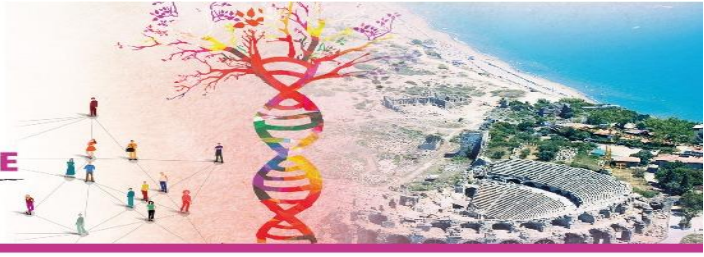
İzmir City Hospital, Psychiatry Department

The comorbidity of autism spectrum disorder (ASD) and eating disorders (EDs) has become an increasingly recognized concern in recent years, particularly among adults. Although historically studied as distinct clinical entities, emerging evidence suggests a significant overlap between ASD and various subtypes of EDs, most notably anorexia nervosa (AN). Numerous studies have reported that individuals with ASD, especially adult females, are at higher risk of developing EDs. The cognitive and behavioural traits associated with ASD, such as cognitive rigidity, sensory sensitivities, and difficulties in social communication, may contribute to the development and maintenance of disordered eating patterns. Among ED subtypes, AN appears to show the strongest association with ASD traits, although other forms such as Avoidant/Restrictive ood Intake Disorder (ARFID) and Bulimia Nervosa have also been observed.

In terms of intervention, treatment remains complex and often requires tailored approaches. Cognitive Behavioural Therapy (CBT), the first-line treatment for many EDs, may need to be adapted for individuals with ASD to accommodate their unique cognitive profiles. Recent studies suggest that modified CBT, family-based therapy, and skills-based interventions focusing on social cognition and emotional regulation show promise. Pharmacological treatments, while not specific to this comorbid population, may support symptom management when used judiciously. Selective serotonin reuptake inhibitors and atypical antipsychotics are among the most prescribed medications.

This review underscores the urgent need for increased clinical awareness and early screening for ED symptoms in adults diagnosed with ASD. Diagnostic overshadowing—where ED symptoms are misattributed to core ASD traits—remains a significant barrier to effective treatment. A better understanding of the overlapping features and the development of integrated treatment models are essential for improving outcomes in this population.

In conclusion, the intersection of ASD and EDs represents a complex clinical challenge that requires a multidisciplinary and individualized approach. Enhancing awareness among clinicians and caregivers is critical to ensuring timely diagnosis and appropriate intervention. Future research should focus on the development of evidence-based, ASD-sensitive treatment protocols that address the unique needs of this dual-diagnosed group.



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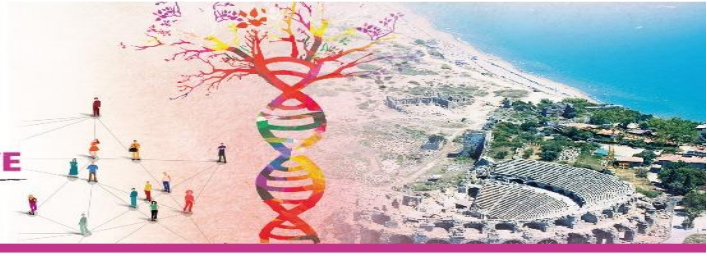


USE OF PSYCHOTROPİCS İN PATİENTS WİTH LİVER AND KİDNEY DİSEASE

Aslı Ceren Hınç

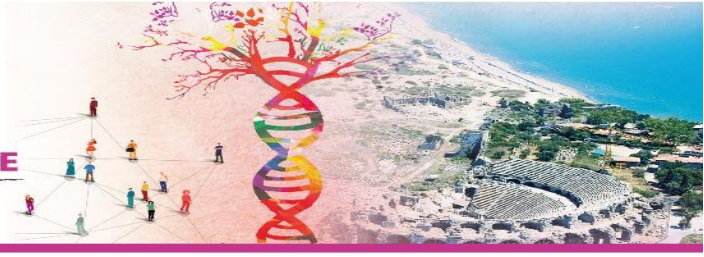
İzmir City Hospital, Psychiatry Department

Psychiatric disorders often co-occur with general medical conditions, requiring tailored use of psychotropic medications in the context of organ dysfunction. In patients with hepatic and renal disease, the selection and dosage of psychotropic medications must be carefully adjusted because of the altered pharmacokinetic and pharmacodynamic properties resulting from organ dysfunction.

The liver is the primary site of metabolism for most drugs. Drug metabolism generally occurs in two phases: Phase I (oxidation, reduction by cytochrome P450 enzymes) and Phase II (conjugation). In hepatic insufficiency, these pathways are slowed, leading to increased plasma concentrations and increased risk of toxicity. In addition, decreased albumin levels may result in a higher free drug fraction, potentially increasing pharmacological effects and adverse reactions. Psychotropic drugs that undergo phase II metabolism are generally considered to be safer in patients with hepatic impairment. Clinically, a "start low, go slow" approach is recommended. Liver function tests and mental status should be closely monitored throughout treatment. Sedatives should be avoided in patients at risk of hepatic encephalopathy.

The kidneys play a crucial role in the elimination of drugs and their metabolites. In the presence of renal impairment, accumulation of renally excreted active metabolites may lead to toxicity. It is therefore essential to estimate the glomerular filtration rate (GFR) before starting psychotropic therapy and to adjust the dose accordingly. Agents such as lithium that are eliminated exclusively by the kidneys carry a high risk of toxicity. If their use is necessary, regular monitoring of serum levels, GFR and fluid balance is required. In patients on dialysis, decisions about psychotropic treatment should be made by a multidisciplinary team. International guidelines also emphasise the importance of considering organ function. The American Psychiatric Association recommends a thorough medical evaluation before initiating psychotropic treatment. The Maudsley Prescribing Guidelines suggest that preference should be given to agents metabolised via phase II pathways, while NICE guidelines warn against masking or misinterpreting psychiatric symptoms in patients with underlying medical conditions.

In conclusion, the use of psychotropic medications in patients with hepatic and renal disease requires careful assessment based on pharmacological principles, individual patient characteristics, and evidence-based guideline recommendations. Appropriate drug selection and dose titration help to minimise adverse effects and facilitate safe and effective treatment. A multidisciplinary approach is essential to optimise clinical outcomes.



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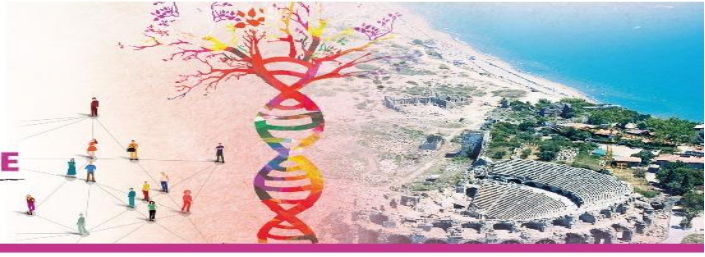

DEPRESSİON WİTH MİXED FEATURES: CLİNİCAL DİAGNOSİS AND TREATMENT

Aslı Ceren Hınç

İzmir City Hospital, Psychiatry Department

In bipolar disorder, a mixed episode is a clinical condition in which both manic and depressive symptoms occur simultaneously. This situation poses significant challenges for the diagnosis and treatment of patients with bipolar disorder. In a mixed episode, patients experience depressive symptoms (such as feelings of worthlessness, hopelessness, and loss of energy) along with the characteristic features of mania or hypomania (such as excessive energy, agitation, pressured speech, and decreased need for sleep). This combination of symptoms may lead to inappropriate interventions and worsen the patient's condition. Mixed episodes can be triggered by factors such as rapid-cycling bipolar disorder, substance use, traumatic life events, inappropriate use of antidepressants, the peripartum period, sleep cycle disorders, and uncontrolled discontinuation of medication. In particular, the use of antidepressants in mixed episodes is often avoided, as it can exacerbate manic symptoms and worsen the patient's condition.

Failure to recognise and treat a mixed episode promptly can lead to an increased risk of suicide. Early intervention can help to rapidly control both manic and depressive symptoms, speeding the patient's psychological and physical recovery. This can reduce the need for hospitalisation and help maintain psychosocial functioning.

The treatment of mixed episodes benefits from the combined use of psychotherapy and pharmacological interventions, which increases the effectiveness of the treatment process. Pharmacological treatment typically includes mood stabilisers (such as lithium, valproate) and atypical antipsychotics (such as quetiapine, olanzapine), while avoiding the use of antidepressants. Psychotherapy helps patients understand their emotional fluctuations, develop coping skills and adhere to treatment. Cognitive behavioural therapy (CBT) and similar approaches help patients change negative thought patterns and manage stress. Psychotherapy also enables patients to strengthen their social support networks and manage their disease more effectively. An integrated approach combining pharmacological treatment and psychotherapy contributes significantly to a patient's long-term recovery and improved quality of life.

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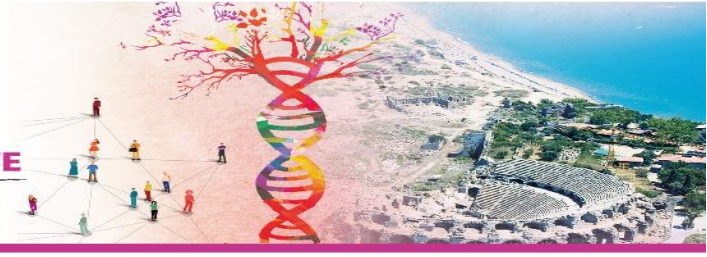


PAİN İN PSYCHOTİC DİSORDERS

Aslıhan Bilge Bektaş

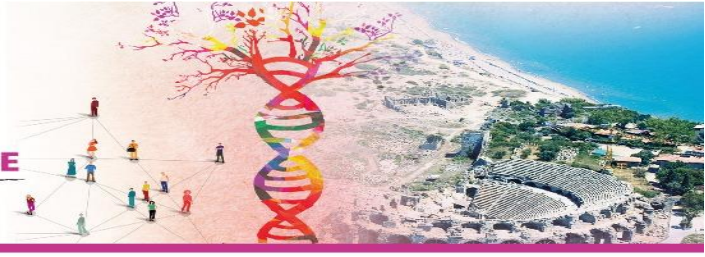
Sağlık Bilimleri Üniversitesi Tıp Fakültesi, İzmir Şehir Hastanesi Psikiyatri Anabilim Dalı

Psychotic disorders are characterized by profound disturbances in perception, cognition, and affect. Pain perception can vary significantly across different phases of psychosis. Pain is a complex experience comprising both sensory and emotional components, regulated by the peripheral nervous system, spinal cord, and central brain structures. The somatosensory cortex, anterior cingulate cortex (ACC), prefrontal cortex (PFC), amygdala, and hypothalamus play key roles in the perception and evaluation of pain (Tracey & Mantyh 2007).

It is well established that individuals with schizophrenia often exhibit elevated pain thresholds and diminished sensitivity to painful stimuli. These alterations have been linked to dysregulations in dopaminergic, serotonergic, and glutamatergic neurotransmission. Historical and contemporary literature suggest that dopaminergic hyperactivity and hypofrontality, both common in schizophrenia, may contribute to reduced pain perception. Furthermore, antipsychotic medications, which exert their therapeutic effects primarily through dopamine receptor antagonism, may paradoxically increase pain sensitivity in some cases (Engels G et al. 2014)

Changes in serotonergic transmission are also proposed to modulate pain sensitivity in psychotic populations, while hypofunction of NMDA receptors—another hallmark of schizophrenia—may further impact nociceptive processing. As a result, individuals with schizophrenia may display blunted behavioral responses to painful conditions, leading to delayed diagnosis and treatment of comorbid somatic illnesses such as diabetic neuropathy or cardiovascular disease. Interestingly, studies indicate that abnormalities in nociceptive pathways may not fully account for the altered pain perception in schizophrenia. Additionally, the content of hallucinations and delusions may include somatic themes or painful bodily sensations, further complicating clinical assessment (Wojakiewicz A et al. (2013), Urban-Kowalczyk et al. 2015).

In summary, pain perception in psychotic disorders is modulated by neurobiological alterations, primarily involving dopaminergic, serotonergic, and glutamatergic systems. Understanding these mechanisms has important clinical implications for the recognition, assessment, and management of pain in individuals with psychosis. A deeper exploration of the neurobiology of pain in psychotic disorders is essential for improving diagnostic accuracy and optimizing treatment strategies.



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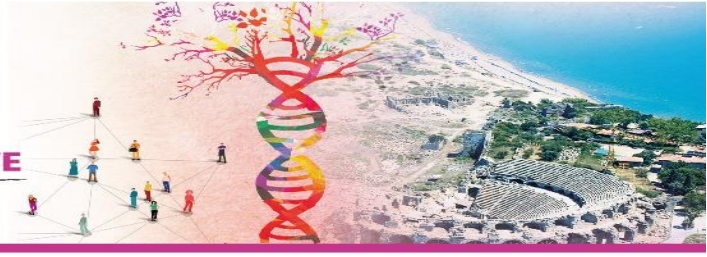

USE OF PSYCHOTROPİC MEDİCATİONS İN INDİVİDUALS WİTH CARDİOVASCULAR DİSEASE

Aslıhan Bilge Bektaş

Sağlık Bilimleri Üniversitesi Tıp Fakültesi, İzmir Şehir Hastanesi Psikiyatri Anabilim Dalı

Comorbid depression and cardiovascular disease (CVD) represent a clinically significant overlap, with depressive disorders identified in up to 31% of patients with CVD, particularly following myocardial infarction and in heart failure populations. The relationship is bidirectional: depression serves not only as a consequence but also as a potential risk factor for adverse cardiovascular outcomes. Shared pathophysiological mechanisms include hypothalamic-pituitary-adrenal axis dysregulation, autonomic imbalance manifested by reduced heart rate variability, systemic inflammation (e.g., elevated IL-6, CRP), serotonergic dysfunction and microbiota alterations. Clinical management requires integration of antidepressants with standard cardiovascular therapies. Selective serotonin reuptake inhibitors particularly sertraline and escitalopram, are considered first-line pharmacologic options due to their favorable cardiovascular safety profiles. Adjunctive strategies such as cognitive behavioral therapy, internet-based interventions and cardiac rehabilitation are essential components of a holistic treatment plan (Shatri H et al, 2024).

In schizophrenia, antipsychotic-related QT interval prolongation presents a critical safety consideration, especially given the increased baseline cardiovascular risk in this population. QTc prolongation may predispose patients to torsades de pointes and sudden cardiac death. Risk is heightened with specific antipsychotics (e.g., ziprasidone, iloperidone), polypharmacy, electrolyte disturbances, and underlying cardiac pathology. Clinical approach involves baseline and periodic ECG monitoring, correction of modifiable risk factors, and careful antipsychotic selection favoring agents with lower arrhythmogenic potential. Shared decision-making and interdisciplinary collaboration between psychiatry and cardiology are imperative for risk mitigation (Melo L et al. 2024).

In elderly patients with bipolar disorder, antihypertensive management must account for age-related pharmacokinetic changes, comorbidities and potential drug interactions. Lithium, while effective, requires vigilant monitoring due to reduced renal clearance and narrow therapeutic index. Valproate may carry hepatotoxic risk in those with diminished hepatic reserve. Lamotrigine offers a favorable profile with minimal cardiovascular impact. Antihypertensive regimens should avoid agents with depressive potential (e.g., central alpha agonists) and aim for optimal blood pressure control without exacerbating mood symptoms.

In conclusion, managing psychiatric and cardiovascular comorbidities in complex populations necessitates a nuanced, multidisciplinary approach. Tailored pharmacologic strategies, vigilant

monitoring and integration of psychosocial interventions are key to improving both mental and cardiovascular health outcomes.

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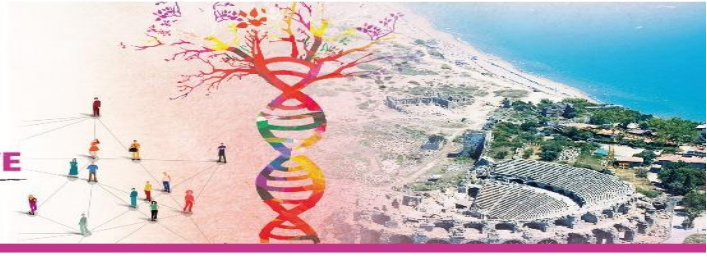


WORKİNG WİTH PSYCHOEDUCATİON AND THE REAL-LİFE REFLECTİONS OF ADULT ADHD

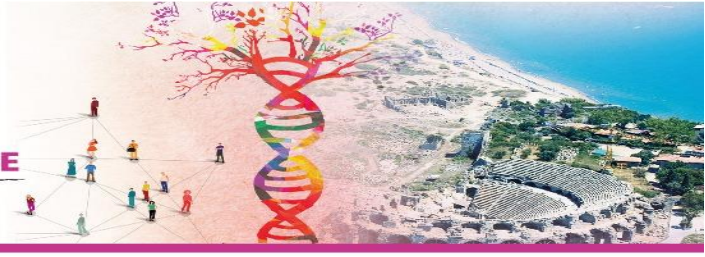
Bedia Kalemzer Karaca

Klinik Psikolog

Pharmacological treatment is widely accepted as the primary intervention for managing symptoms of Attention-Deficit/Hyperactivity Disorder (ADHD) in adults. However, medication alone may often fail to provide sufficient functional improvement for many individuals (Ramsay and Rostain 2011). Even with pharmacological support, adults with ADHD may struggle with executive functions such as planning, organization, time management, task tracking, and other difficulties stemming from ADHD symptoms, revealing the need for additional interventions (Wilens et al. 2000). At this point, individuals frequently turn to psychosocial interventions to cope with the residual symptoms of ADHD, highlighting their importance.

If an individual is not willing or able to access psychotherapy services, psychoeducation often appears to be the first—and possibly the most crucial—step in treatment following a diagnosis of ADHD. Adults with ADHD, who have spent years labeled as “lazy,” “irresponsible,” or “disruptive,” may perceive their difficulties as personality traits rather than symptoms. Through comprehensive psychoeducation, individuals can gain scientifically grounded awareness to differentiate whether the challenges stem from ADHD symptoms or character traits. A fundamental component of ADHD treatment, psychoeducation aims to provide accurate, reliable, and evidence-based information about ADHD to enhance awareness, and guide the selection of appropriate treatment strategies. Not only the individuals diagnosed with ADHD but also their immediate and extended social circles may benefit from such education. Considering that psychiatric interventions must be tailored to the individual, psychoeducation based on scientific knowledge should likewise be personalized according to the individual’s symptom profile.

Psychotherapy, on the other hand, offers individuals a variety of techniques and approaches to recognize and manage ADHD symptoms, enhance functionality, and improve quality of life by addressing the negative life experiences caused by the disorder. Psychotherapeutic interventions include individualized psychoeducation focused on the impact of symptoms on functional domains, patient-centered conceptualizations of associated difficulties, identification and implementation of coping strategies, cognitive and behavioral restructuring of maladaptive patterns and recognition and effective use of personal strengths and support systems (Ramsay and Rostain 2008). The goal of psychotherapy for ADHD is not to eliminate the disorder, but bring awareness regarding long-held beliefs, automatic thoughts, cognitive distortions and schemas developed over time as a result of ADHD and help individuals build a functional skill set for managing these challenges.



This presentation will highlight the significance of psychosocial interventions in the treatment of ADHD and explore clinical situations that may arise while working with the real-life reflections of the disorder, as well as potential strategies for addressing such.

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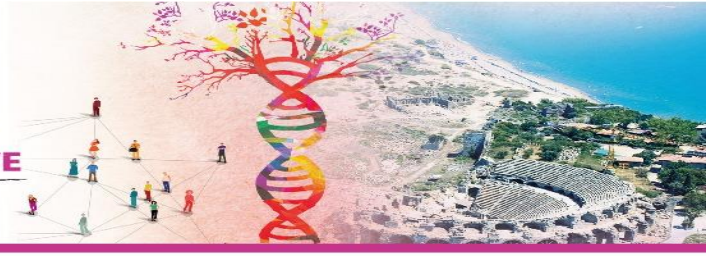


THE DİGİTALİZED MİND: COGNİTİON, BEHAVİOR AND MENTAL HEALTH İN THE AGE OF TECHNOLOGY

Begüm Marşap

Gazi University Faculty of Medicine, Department of Psychiatry

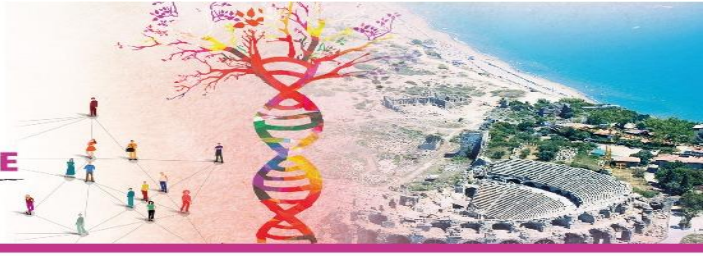
Digital technology has become an inseparable part of modern life, fundamentally transforming our understanding of communication, work and entertainment. However, the widespread use of digital devices has raised concerns due to their potential negative effects on mental health (Chase et al., 2022).

Understanding these emerging phenomena of the digital age is essential, as it enables us to better grasp our environment and the evolving social landscape—an increasingly important task for psychiatrists aiming to stay attuned to the changing dynamics of mental well-being.

Digital dementia is a concept that describes the cognitive impairments caused by excessive use of digital technology. This condition may adversely affect memory, attention, and executive functions. German neuropsychiatrist Manfred Spitzer emphasized the potential harm of technological overdependence on the brain by proposing the concept of “digital dementia” in 2012 (Spitzer, 2014). The term “brain rot”, on the other hand, refers to the cognitive fuzziness caused by the consumption of low-quality content on social media. This term was selected as the Word of the Year by the Oxford Dictionary in 2024.

Another significant phenomenon brought about by digitalization is parasocial relationships. These are one-sided emotional bonds that individuals form with media figures or online content creators. While they may provide a sense of social support, excessive involvement in such relationships can replace real-life interactions and increase social isolation. In the age of social media, it is known that parasocial relationships can shape identity development, attachment styles, and social interaction patterns. Moreover, the concept of parasocial grief has emerged as a noteworthy phenomenon affecting individuals’ mental health.

Lastly, another impact of the digital age on mental health is nomophobia. Nomophobia (short for “No Mobile Phone Phobia”) refers to the intense fear and anxiety experienced when individuals are separated from their mobile phones. This condition negatively affects social relationships and daily functioning and is particularly associated with psychological issues such as anxiety, depression and low self-control in young individuals (IJIP, 2016).



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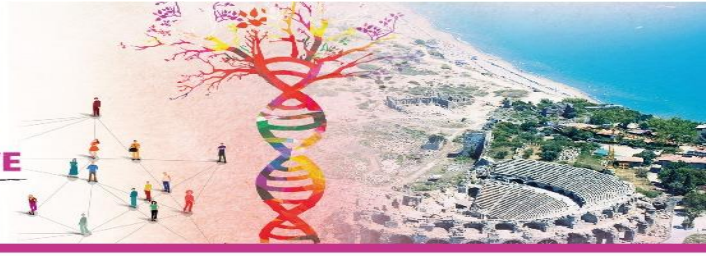


THE RELATİONSHİP BETWEEN NON-SUİCİDAL SELF-INJURY AND PSYCHİATRİC DİSORDERS

Burcu Bakar Kahraman

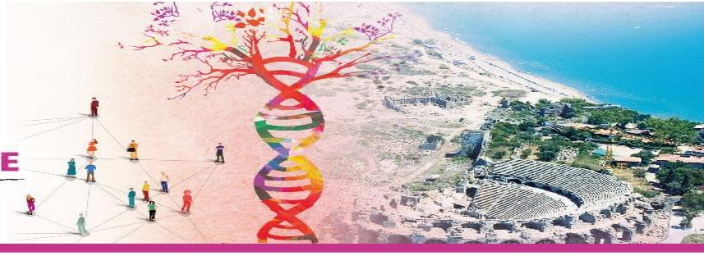
Sultan 2. Abdulhamid Khan Research and Training Hospital, Department of Psychiatry, Istanbul, Turkey

Non-suicidal self-injury (NSSI) is defined as the repetitive and intentional infliction of harm to one's own body without suicidal intent. This definition excludes stereotypic self-injurious behaviors observed in individuals with intellectual disabilities or autism spectrum disorders, as well as severe self-mutilation involving organ loss seen in psychotic disorders. NSSI may serve various functions, including alleviating negative affect, expressing self-directed anger, preventing suicide, self-punishment, generating excitement or arousal, ending dissociation or manipulating interpersonal relationships.

Several factors have been associated with NSSI, such as adolescence, a history of childhood sexual and physical abuse, substance and alcohol use, difficulties in emotion regulation, low self-esteem, and impulsivity. Beyond psychological factors, individuals with NSSI have demonstrated neurobiological irregularities; including imbalances in the serotonin, dopamine and endogenous opioid systems, increased amygdala activity, hypoactivity in the dorsolateral prefrontal cortex, impaired functioning of the anterior cingulate cortex, and reduced connectivity between frontal and limbic brain regions.

Psychiatric comorbidity is present in approximately 80–90% of individuals with NSSI and may occur across nearly all psychiatric conditions. The presence of comorbid psychiatric disorders is also associated with an increased risk of NSSI repetition. Among adults with NSSI, mood disorders (particularly depression) are the most frequently diagnosed, followed by alcohol and substance use disorders. Among adolescents, 20% report being under the influence of alcohol and 13% under the influence of drugs at the time of self-injury. It is thought that intoxication increases impulsivity and facilitates violent behavior directed at oneself. In young women with repetitive NSSI, personality disorders are the most common diagnosis, with a particularly strong association observed between NSSI and borderline personality disorder. NSSI is observed in 70–75% of individuals with borderline personality disorder. Additionally, individuals with NSSI have significantly higher rates of eating disorders. NSSI is also more frequent in those with dissociative symptoms and has been linked to oppositional defiant disorder and conduct disorder.

NSSI can be observed in nearly all psychiatric disorders. Although the definition excludes suicidal intent, it can be difficult to distinguish the purpose of the behavior. Some individuals may be ambivalent about their desire to die and it has been noted that suicide risk increases particularly during the first six months following an NSSI episode.



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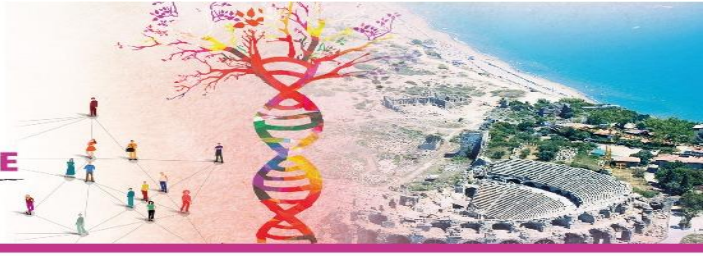

rTMS AS A MAINTENANCE TREATMENT FOR MAJOR DEPRESSIVE DISORDER

Cana Aksoy Poyraz

İstanbul Üniversitesi-Cerrahpaşa, Department of Psychiatry

Transcranial Magnetic Stimulation (TMS), a method discovered in the 1980s, involves stimulating cortical neurons with a rapidly changing and powerful magnetic current externally applied to the skull. This technique has been instrumental in studying neuronal functions. It has been found that repeated transcranial magnetic stimulation (rTMS) induces lasting effects on neuronal excitability by mediating neuroplastic changes, such as alterations in synaptic strength and quantity. Within the realm of treatment options for treatment-resistant depression (TRD), rTMS plays a significant role. Notably, rTMS has demonstrated efficacy in achieving complete remission in treatment-resistant depression. While rTMS is safe and has documented short-term efficacy, durability of antidepressant effects is poorly established. There is compelling evidence supporting the use of rTMS for treating acute episodes of major depression, with sustained responder rates of 50% up to 1 year after a successful induction course of treatment was reported. Moreover, it was found by these researchers that trials utilizing additional TMS post-acute treatment period showed higher sustained response rates at 3 and 6 months compared to trials that did not use TMS. The current body of literature on maintenance TMS for major depressive disorder and TRD is limited, primarily consisting of open-label studies, case reports, and case series. These preliminary research efforts provide initial insights into the potential long-term effectiveness of TMS as a maintenance treatment strategy, but more comprehensive and rigorous research is needed to establish definitive clinical guidelines and protocols. Maintenance repetitive rTMS applied to patients who initially demonstrate a positive response during induction rTMS appears to improve long-term treatment outcomes. The preliminary evidence suggests that targeted rTMS maintenance protocols could be an effective approach for managing treatment-resistant conditions by supporting sustained symptomatic recovery. This presentation will examine current research on the application of maintenance rTMS to prevent relapse in major depressive disorder.

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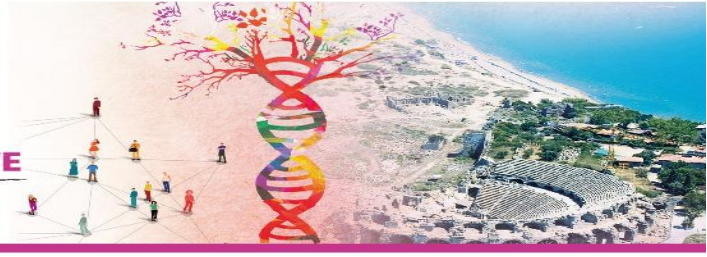

PHARMACHOTHERAPY FOR BINGE EATING DISORDER

Cana Aksoy Poyraz

İstanbul University-Cerrahpaşa, Department of Psychiatry

Binge-eating disorder (BED) is a psychiatric condition characterized by recurrent episodes of uncontrollable overeating (binges). Unlike anorexia nervosa (AN) or bulimia nervosa (BN), BED does not involve compensatory behaviors such as purging or excessive exercise. BED is a primary contributor to obesity and an independent risk factor for various metabolic, physical, and psychiatric disorders. The primary treatment for BED involves a combination of psychological and pharmacological approaches, with a focus on cognitive-behavioral therapy to target the emotional and behavioral components of the disorder.

The utilization of selective serotonin reuptake inhibitors is common in pharmacological interventions to diminish the frequency of binge-eating episodes and associated psychological symptoms, although they do not produce the desired outcomes in terms of weight reduction. Topiramate, an anti-epileptic medication, has demonstrated effectiveness in treating severe binge eating disorder when combined with cognitive-behavioral therapy. Randomized placebo-controlled trials showed that the drug helps reduce the frequency of binge eating and also decrease body weight.

Lisdexamfetamine, approved for treating BED in the USA and few other countries, is a central nervous system stimulant that boosts norepinephrine and dopamine release, linked to appetite suppression. It has demonstrated efficacy in curbing binge eating behaviors, alleviating associated symptoms, and facilitating weight loss in BED patients. BED and BN are debilitating conditions, underscoring the imperative for novel pharmacological strategies like glucagon-like peptide-1 receptor agonists (GLP-1RAs). GLP-1, a hormone and neuropeptide originating in the intestine and brainstem, suppresses appetite. Research indicates that GLP-1RAs (e.g., liraglutide and dulaglutide) diminish the frequency of binge eating and associated comorbidities, offering a more favorable psychiatric side effect profile compared to current interventions. Rigorous clinical trials are essential to definitively determine the drug's effectiveness, appropriate dosage levels, safety profile, and how it compares to existing treatment options before considering GLP-1RAs as a promising new therapeutic approach.

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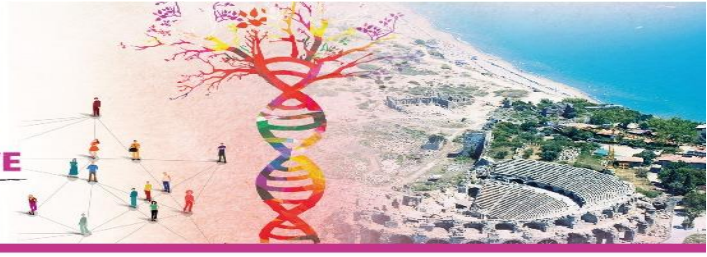

COUPLES THERAPY INTERVENTİONS AFTER INFİDELİTY USİNG CASE EXAMPLES

Canan Akkoyunlu

Serbest Hekim, Ankara

This speech explores the application of systemic therapy in couple counseling following infidelity, a complex issue that significantly disrupts relationship dynamics. Systemic therapy, with its emphasis on relational patterns and interactions, provides a valuable framework for understanding and addressing the multifaceted consequences of infidelity. We present case examples illustrating the implementation of key systemic therapy techniques, including crisis intervention, restructuring, circular questioning, reframing, in the context of couples navigating the aftermath of infidelity.

Infidelity often shatters the foundation of trust and intimacy within a relationship, leading to emotional distress, communication breakdowns, and uncertainty about the future. Systemic therapy approaches this relational crisis by examining the broader context in which infidelity occurred, considering factors such as family history, communication styles, and individual vulnerabilities. Case examples highlight how therapists utilize circular questioning to explore the couple's interactional patterns, uncovering the dynamics that contributed to and were affected by the infidelity and exploring intergenerational patterns and influences on their current relationship. Reframing techniques assist couples in shifting their perspectives, challenging negative attributions, and fostering a more constructive understanding of their situation.

Systemic interventions aim to facilitate open communication, promote empathy, and rebuild trust. Therapists guide couples in exploring their emotional experiences, identifying their needs, and developing strategies for healing and reconnection. By focusing on the relational system as a whole, systemic therapy empowers couples to navigate the challenges of infidelity, fostering resilience and promoting the potential for growth. Ultimately, systemic therapy offers a hopeful approach for couples seeking to rebuild their relationship after infidelity, emphasizing the importance of understanding relational dynamics and fostering positive change within the couple system.

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PSYCHIATRIC-ONSET DIFFUSE LEWY BODY DISEASE

Burç Çağrı Poyraz

Cerrahpaşa Faculty of Medicine, Department of Geropsychiatry

Diffuse Lewy Body Disease (DLB) is the second most common cause of neurodegenerative dementia, yet it is often underrecognized in clinical practice. Early visual hallucinations are among the core diagnostic criteria of DLB. The prodromal phase of DLB includes (1) mild cognitive impairment (MCI), (2) delirium-onset, and (3) psychiatric-onset presentations. Late-onset major depressive disorder, late-onset psychosis, apathy, and anxiety are frequently observed early symptoms. Although mild cognitive impairment may be present in these patients, it can often be overlooked due to its subtle nature. Bradykinesia may be confused with psychomotor retardation, which is commonly seen in depressive disorders. Severe antipsychotic sensitivity reactions are observed in this patient group; patients may exhibit extreme sensitivity even at very low doses and may develop a severe, acute akinetic-rigid syndrome.

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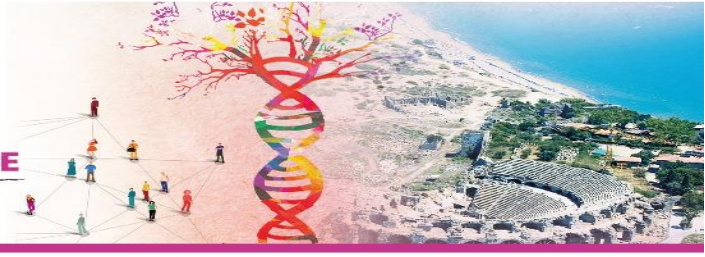

THE CONCEPT, NECESSİTY AND FEASİBİLİTY OF RESTORATİVE JUSTİCE

Diğdem Göverti

Kocaeli Üniversitesi Tıp Fakültesi Ruh Sağlığı ve Hastalıkları Ana Bilim Dalı

The theory of restorative justice is a justice approach rooted in the practices of ancient communal societies, emphasizing the voluntary participation of all parties involved in and affected by crime. Unlike traditional punitive justice systems that primarily focus on punishment, restorative justice aims to repair the harm caused by the offense, facilitate dialogue between the parties, and reestablish social harmony. In this respect, it is increasingly emerging as an alternative and significant path within modern legal frameworks.

Restorative justice methods particularly encourage more active involvement of those harmed by crime. This approach envisions victims not as passive observers but as active contributors to the process of justice. Victims are given the opportunity to express the impact of the crime and seek compensation or resolution, while offenders are expected to take responsibility for their actions and make meaningful efforts to amend their wrongdoings. This reciprocal interaction contributes significantly to societal healing and reconciliation.

Today, rising incidents of violence, perceptions of impunity, and growing mistrust in justice systems leave deep psychological scars in society. As psychiatrists, we frequently emphasize that psychological recovery cannot be achieved solely through punishment but requires the healing of trauma as well. In this context, especially in cases that leave profound effects—such as collective traumas, sexual offenses, and domestic violence—there is a pressing need to consider the applicability of restorative justice approaches that go beyond the limitations of conventional criminal justice systems.

This presentation will explore the core concepts, principles, and historical development of restorative justice theory in detail. Furthermore, it will examine how restorative justice can be integrated into modern legal systems, in which areas it may produce more effective outcomes, and its contribution to psychological recovery processes. The goal is to demonstrate that justice can be achieved not only through punishment but also through empathy, accountability, and dialogue.

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PEDİATRİC-ONSET BİPOLAR DİSORDER: CHALLENGES İN DİAGNOSİS AND TREATMENT TRANSİTİON

Uzm.Dr.Ece Özlem Öztürk

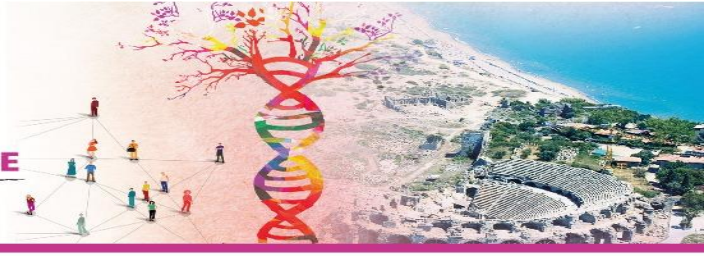
Department of Psychiatry, Kanuni Training and Research Hospital, Faculty of Medicine, Trabzon University, Trabzon, Türkiye

Bipolar disorder with onset in childhood or adolescence is characterized not only by complexities in diagnostic processes but also by uncertainties in treatment planning. Early-onset symptoms often overlap with other psychiatric conditions, complicating accurate diagnosis. However, in recent years, authoritative bodies such as AACAP, NICE, and CANMAT have emphasized the importance of considering clear clinical criteria—such as mood symptom continuity, episode duration, and functional impairment—in making a diagnosis. In this context, a systematic and criteria-based diagnostic approach is essential to mitigate the risks of both overdiagnosis and underdiagnosis.

The primary challenge, however, arises during the transition from diagnosis to treatment. In patients transferred from child and adolescent psychiatry to adult psychiatric services, treatment approaches often require reconfiguration. This is due to both age-related physiological changes and alterations in illness trajectory. Therefore, treatment adjustments should be guided by both evidence-based recommendations and the individual's clinical history (Cichoń et al., 2020).

When planning treatment for pediatric bipolar disorder, several factors must be considered, including the type of current episode (manic, depressive, or mixed), the presence of psychotic features, history of treatment response, and psychiatric comorbidities. The literature provides strong evidence supporting the efficacy of second-generation antipsychotics—such as risperidone, aripiprazole, olanzapine, quetiapine, and asenapine—and lithium, particularly in the management of acute manic and mixed episodes (Goldstein et al., 2017). Among these agents, risperidone has demonstrated the highest response rates, while the efficacy of lithium has been reaffirmed by recent randomized controlled trials.

On the other hand, anticonvulsants such as divalproex sodium and carbamazepine exhibit a comparatively lower efficacy profile than second-generation antipsychotics, with some studies reporting no significant superiority over placebo. For the treatment of depressive episodes, pharmacological options remain limited. Apart from the FDA-approved olanzapine-fluoxetine combination, lurasidone has shown promising results, whereas studies with quetiapine have yielded inconsistent and modest effects. The use of antidepressants as monotherapy is discouraged, as epidemiological data suggest an increased risk of manic episodes associated with this approach (Bhowmik et al., 2014).



Evidence for maintenance treatment in this population is still limited. Nevertheless, lithium has been shown in several studies to be effective in preventing relapse. Maintenance studies involving aripiprazole and lamotrigine have yielded variable results depending on age groups, underscoring the importance of individualized treatment planning.

In addition to pharmacological strategies, psychoeducation, family-based interventions, and lifestyle modifications are consistently recommended in clinical guidelines as adjunctive approaches that enhance treatment outcomes. Management of bipolar disorder should aim not only at symptom control but also at sustaining social functioning.

In conclusion, the process of reorganizing treatment in pediatric-onset bipolar patients transitioning to adult psychiatric care can only be successful through an integrated approach that balances clinical expertise, evidence-based guidelines, individualized treatment history, and institutional frameworks.

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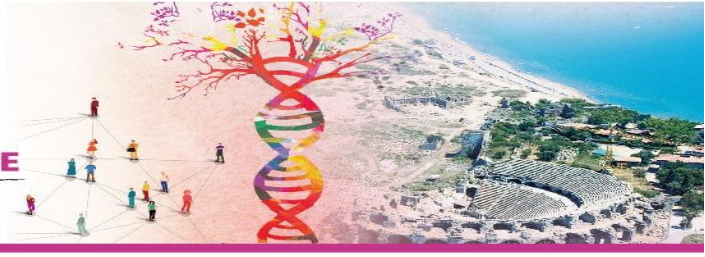

THROUGH THİCK AND THİN: FORENSİC PSYCHİATRİC CHALLENGES İN FAMİLY LAW

Eldem GÜVERCİN

İzmir Atatürk Training and Research Hospital

Legal competence to marry can be defined as the evaluation of whether an individual possesses the mental competence necessary to express the intention to marry. Assessing legal competence to marry in individuals with a current or past diagnosis of psychiatric illness is of great importance—not only in terms of protecting family and societal order, but also with respect to safeguarding the civil rights of individuals who express a desire to marry. Therefore, the psychological evaluation of individuals applying for marriage should be approached with diligence and professional sensitivity.

Within the framework of the Turkish Civil Code (TCC), Articles 124 to 148 regulate the conditions of legal competence to marry, impediments to marriage, the procedure and form of marriage applications, nullity and annulment of marriage, as well as various exceptional cases. The concept of legal competence to marry is particularly articulated in Articles 124, 125, and 133 of the TCC. According to these provisions, legal competence to marry requires that both parties be at least 17 years of age (with exceptional cases allowing marriage at age 16 upon court approval), possess the ability to exercise discernment, and—if the individual has a mental illness—a formal report from an official medical board must confirm that there is no impediment to marriage (1).

As part of routine procedure, individuals applying for marriage are required to provide a medical report indicating that they do not have any physical or mental illness that may constitute an impediment to marriage. This report is typically issued by a family physician, who may request consultations from relevant specialties if deemed necessary (2). Clinical conditions such as acute psychotic episodes, dementia or intellectual disability may impair one's capacity for reasoning and judgment, thereby eliminating the ability to exercise discernment (3). In such cases, as stated in Article 133 of the TCC, an official medical board report is required to document that the individual does not have a medical condition that legally prevents them from marrying.

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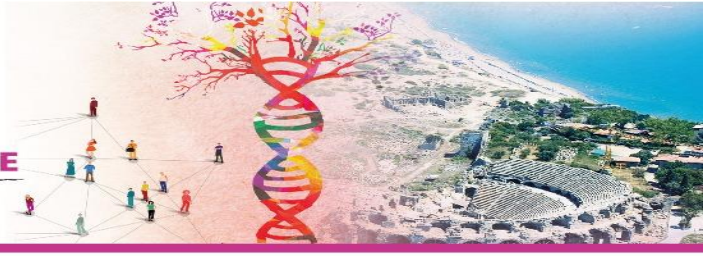

THE DİGİTAL REVOLUTİON OF SLEEP: NEW FRONTİERS İN DİAGNOSİS AND TREATMENT WİTH SMART TECHNOLOGİES INNOVATİVE APPROACHES THAT SHAPED SLEEP MEDİCİNE İN 2024

Elif Bolat

Ankara Etlik City Hospital

The year 2024 marked a pivotal point in the digital transformation of sleep medicine. Wearable technologies, artificial intelligence (AI) algorithms, and home-based monitoring systems have revolutionized both diagnostic workflows and treatment personalization. While traditional polysomnography remains the gold standard, wearable devices are increasingly accurate in screening for sleep apnea, insomnia, and circadian rhythm disorders.

Recently developed smartwatches and wristbands equipped with advanced sensors can algorithmically classify sleep stages by analyzing parameters such as heart rate variability (HRV), blood oxygen saturation, movement patterns and skin temperature. These data not only reflect sleep architecture but also reveal fragmented or poor-quality sleep episodes with high temporal resolution.

AI-powered applications are also playing an expanding role by processing sleep diaries and generating personalized behavioral recommendations. Cognitive behavioral therapy for insomnia (CBT-I) has been successfully adapted into digital platforms, with clinical studies showing outcomes comparable to in-person interventions.

Additionally, smart beds integrated into home environments are capable of detecting snoring and apnea events through respiratory sounds, with some models responding in real time by adjusting the bed's position to alleviate symptoms.

In summary, digital health technologies are ushering in a new era of accessible, cost-effective, and personalized care in the diagnosis and management of sleep disorders. These advancements underscore the emergence of AI-supported, data-driven and patient-centered paradigms as foundational to the future of sleep medicine.

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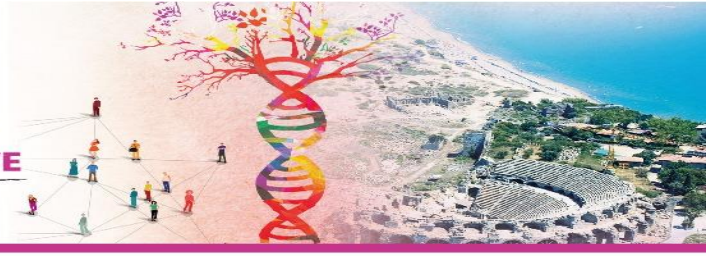


VANİLLA, KİNK AND BEYOND: RETHİNKİNG THE BOUNDARİES OF SEXUALİTY

Elif Poyraz

Erenköy Research and Training Hospital for Psychiatry and Neurological Diseases

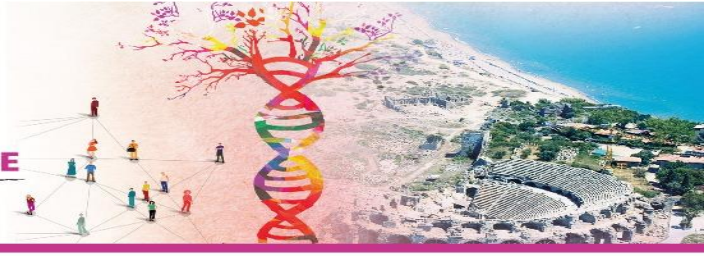
Sexual diversity is one of the many ways in which the complexity of human experience is expressed. This presentation explores the position of non-normative sexualities within psychiatric frameworks, with a particular focus on BDSM (Bondage and Discipline, Dominance and Submission, Sadism and Masochism). Far from being merely a form of sexual expression or fantasy, BDSM encompasses a broad range of consensual, negotiated, and emotionally meaningful interactions.

In the first part, the subcomponents of BDSM will be defined with clarity. “Bondage and Discipline” (B&D) refers to the use of physical or psychological restraint and structured behavioral agreements. “Dominance and Submission” (D&S) includes the consensual power dynamics between partners. “Sadism and Masochism” (S&M) involve deriving pleasure from giving or receiving controlled pain or sensation. The fundamental principles of BDSM, consent, trust, and negotiated boundaries, will be emphasized, alongside epidemiological data from both global and national sources. These findings indicate that interest in BDSM is not rare and may reflect a normative variation in sexual expression rather than pathology.

The second part will focus on neurobiological changes observed during BDSM-related activities. Functional MRI (fMRI) studies have demonstrated altered activity in regions such as the prefrontal cortex, anterior cingulate cortex, insula, and periaqueductal gray. These regions are associated with attention, pain modulation, emotional regulation and attachment. Of particular interest is the experience of submissive individuals who report entering a dissociative-like “subspace” state, which corresponds to measurable shifts in neural activity. Hormonal changes, including increased endorphins and oxytocin, also contribute to altered affective states and pair bonding.

In the final section, common myths regarding kink and BDSM will be addressed. These include assumptions that BDSM is inherently abusive, linked to trauma histories, or indicative of psychopathology. Based on current literature and DSM-5 criteria, consensual paraphilic interests are not considered mental disorders unless they cause distress or impairment. Studies have found that individuals who engage in BDSM do not show higher rates of psychiatric disorders than the general population, and may in some domains exhibit higher levels of psychological well-being and communication skills.

By deconstructing these myths and examining the biological and psychosocial underpinnings of BDSM, this presentation seeks to inform a stigma-free, evidence-based psychiatric perspective. Understanding non-normative sexualities is essential for creating therapeutic spaces where patients feel safe discussing their identities and experiences without fear of pathologization.



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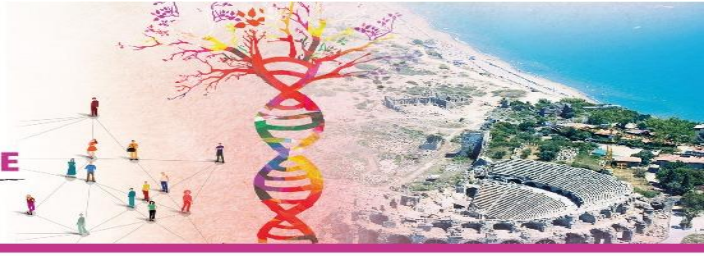


SELF-HARM AND SUİCİDAL BEHAVİOR FROM THE PERSPECTİVE OF COGNİTİVE EMOTİON REGULATİON

Emel Uysal

Karadeniz Technical University Faculty of Medicine, Department of Psychiatry

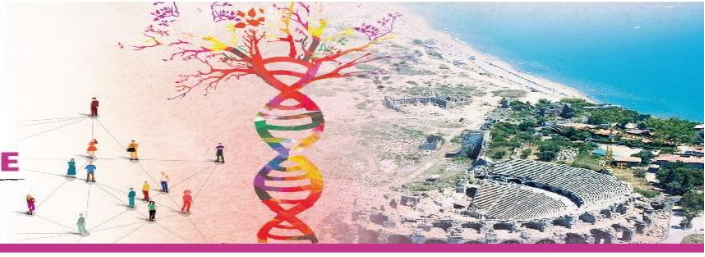
Emotion regulation is the ability to identify, understand, and modulate one's emotional experiences in adaptive ways. This process is critical for psychological well-being and social functioning. However, when individuals experience emotion regulation difficulties—defined as challenges in managing the intensity, duration, or expression of emotional states—they become more vulnerable to a range of mental health problems, including suicidal ideation and behaviors.

A comprehensive systematic review conducted by Turton and colleagues (2021) examined the relationship between emotion dysregulation and suicidality across 21 empirical studies. The review highlighted that higher scores on the Difficulties in Emotion Regulation Scale (DERS) were significantly associated with both suicidal ideation and suicide attempts. Importantly, though, the strength of these associations weakened when controlling for confounding psychological variables such as depression and anxiety. This finding suggests that while emotion dysregulation is a key factor in suicidality, it may interact with other vulnerabilities rather than function as an isolated predictor.

Building upon these findings, Mitchell et al. (2023) explored how cognitive emotion regulation strategies vary daily among emerging adults with different self-harm histories—specifically those with previous suicide attempts, non-suicidal self-injury (NSSI), or no history of self-harm. Their results showed that individuals with a history of NSSI tended to engage more frequently in maladaptive strategies such as rumination and catastrophizing over time. Interestingly, while acceptance is generally viewed as an adaptive strategy, its increased use in this group was associated with distress, possibly indicating a passive resignation rather than active coping. These findings underscore the importance of not only which strategies are used, but also how, when, and in what context they are employed.

Neacsiu et al. (2017) provided further nuance by incorporating both self-report and physiological measures. Their study revealed that depressed individuals with a history of suicide attempts displayed greater difficulties in emotional clarity and impulse control compared to both healthy and non-suicidal depressed individuals. Notably, these individuals also had a significantly delayed return to physiological baseline (e.g., heart rate) following emotionally stressful tasks. This suggests that suicide-related behaviors may be underpinned by both cognitive and physiological dimensions of emotion dysregulation.

In conclusion, a growing body of evidence points to maladaptive emotion regulation—particularly patterns of persistent rumination, catastrophic thinking, and poor emotional clarity—as central mechanisms in the development of suicidal ideation and behaviors. Therefore, clinical



interventions that target these specific regulatory deficits—such as Dialectical Behavior Therapy or Cognitive Emotion Regulation Training—may offer promising avenues for both prevention and treatment. By enhancing individuals' capacity to regulate emotional pain more effectively, we may ultimately reduce the likelihood of suicide attempts and promote long-term psychological resilience.

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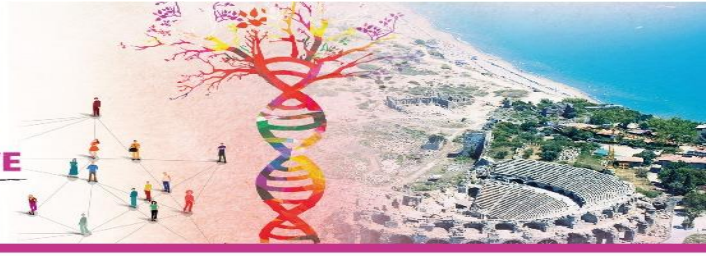

NEUROBIOLOGY OF PAIN AND PAIN IN VIRTUAL REALITY

Emre Cem Esen

Izmir University of Economics, Medicalpoint Hospital Psychiatry Department

While the Turkish Language Association defines "ağrı" as a discomforting sensation arising primarily from intense stimulation of nerve endings (thus emphasizing the physical aspect), it describes "acı" as psychological suffering resulting from events (consequently bringing attention to the psychological aspect). However, clinically and neurobiologically, while "ağrı" refers to slow and dull pain that is transmitted via non-myelinated C fibers, "acı" refers to fast and sharp pain sensations that are transmitted rapidly via lightly myelinated Aδ fibers. In English, the term "pain" encompasses all these meanings.

Neurobiologically, nociception, in its most basic form, involves the detection of mechanical, thermal, and chemical stimuli with the potential to cause tissue damage. These stimuli are perceived by non-adapting receptors located in free nerve endings in peripheral tissues, transmitted through dorsal roots to the spinal cord, and subsequently conveyed via the anterolateral afferent system to stimulate the reticular formation in the brainstem and the ventrobasal complex in the thalamus, ultimately activating the somatosensory cortex.

Pain, meanwhile, refers to the perception of irritating, painful, stabbing, aching, throbbing, distressing, or unbearable feelings originating within the body. The main input for the pain sensation comes from the nociceptive signal arising from the free nerve endings in the peripheral tissue. It can also be modulated in the peripheral tissues. For example, hyperalgesia is caused by increased sensitivity of free nerve endings due to inflammatory molecules released after tissue injury. However, distinct from other sensory systems, pain has a complex mechanism predominantly regulated by cognitive and sensory components in the central nervous system (CNS). For example, descending modulatory signals originating from periventricular and periaqueductal gray matter (PAG) activated by intense stress and emotional responses suppress pain perception even in the presence of significant nociceptive activity.

The endogenous opioid system also plays a crucial role in centrally regulating pain. Small injections of morphine or endorphins into the PAG, raphe nuclei, or dorsal root can produce analgesia. Neurons containing endorphins inhibit nociceptive signals in the dorsal horn, preventing their transmission to higher brain regions where pain perception occurs. Moreover, the endogenous opioid system is also thought to be accountable for a significant portion of the placebo effect, as naloxone has been shown to diminish the placebo analgesia.

As explained above, the pain sensation is not solely dependent on the nociceptive signal arising from the free nerve endings in the peripheral tissue. Recent studies have shown that the pain sensation comparable to actual physical impact can occur through visual, auditory, and tactile stimuli delivered via virtual reality, even without any activity stimulating free nerve endings.

Likewise, sensory stimuli experienced through virtual reality can divert an individual's attention from nociception. In particular, through sensory feedback, virtual reality has been shown to modify the behavior of pain modulation systems, enabling nociception to be perceived as non-painful stimuli. Experiments conducted using virtual reality have significantly broadened our understanding of how pain perception is regulated within the central nervous system.

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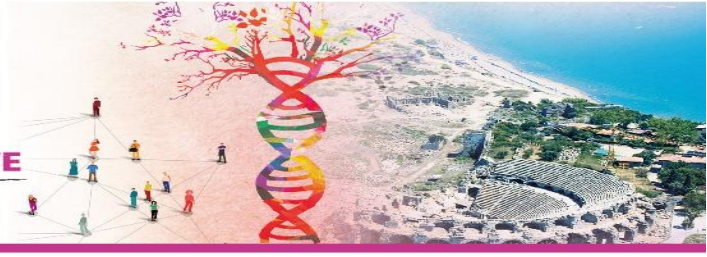


TREATMENT GUIDELINES FOR CHRONIC DEPRESSION

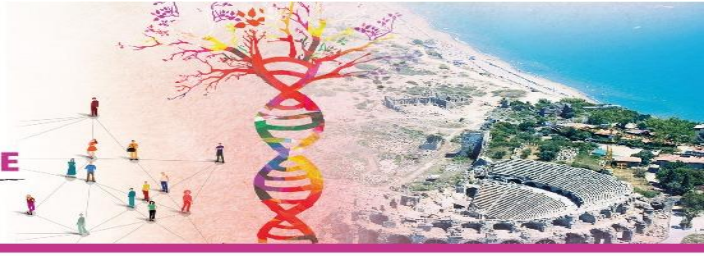
Emre Cem Esen

Izmir University of Economics, Medicalpoint Hospital Psychiatry Department

Even when pharmacotherapy is administered at appropriate doses and durations to individuals diagnosed with major depressive disorder, a significant proportion do not achieve an adequate treatment response, and approximately one in three cases follows a chronic course. A review of treatment guidelines from the National Institute for Health and Care Excellence (NICE), the American Psychiatric Association (APA), the Canadian Network for Mood and Anxiety Treatments (CANMAT), the Royal Australian and New Zealand College of Psychiatrists (RANZCP), as well as the "Depresyon Sağaltım Kitabı" published in 2021 by the Psychiatric Association of Turkey, reveals a lack of consensus regarding the definition of treatment-resistant depression. The widely used definition of treatment-resistant depression—failure to respond adequately to at least two antidepressant treatments at an adequate dose and duration—applies to nearly half of all cases diagnosed with major depressive disorder.

Current treatment guidelines recommend cognitive behavioral therapy (CBT), selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants (TCAs), or a combination of CBT and the aforementioned pharmacotherapies as first-line treatments for depression. In cases where these approaches prove insufficient, guidelines suggest either combining antidepressants from two different groups or augmenting treatment with another pharmacological agent, primarily lithium or atypical antipsychotics. Some guidelines also recommend the use of tricyclic antidepressants and monoamine oxidase inhibitors for treatment-resistant depression. Current NICE guidelines recommend esketamine nasal spray or implanted vagus nerve stimulation, which involves implanting an electrical stimulator under the skin of the chest and connecting it by wires to the vagus nerve for treatment-resistant depression. CANMAT, APA, and RANZCP also recommend neuromodulation treatments for treatment-resistant depression, such as electroconvulsive therapy, repetitive transcranial stimulation, vagus nerve stimulation, and deep brain stimulation.

Even though most guidelines define depression to be treatment-resistant when symptoms have not improved after at least two standard treatments, current approaches also include the concept of difficult-to-treat depression. Different from treatment-resistant depression, guidelines do not prioritize symptom remission via pharmacological and neuromodulatory interventions for difficult-to-treat depression but focus on the therapeutic goals to achieve the best possible improvement in patient-prioritized outcomes such as functioning and quality of life.



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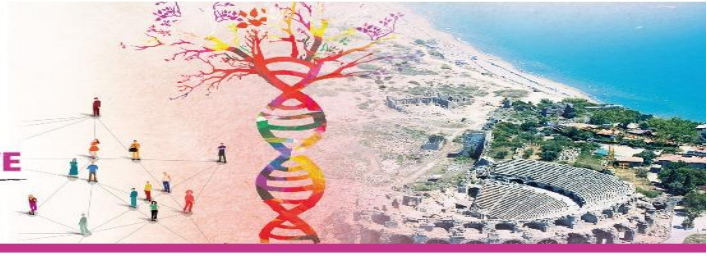


VIOLENCE IN OUTPATIENT CLINICS

Emre Cem Esen

Izmir University of Economics, Medicalpoint Hospital Psychiatry Department

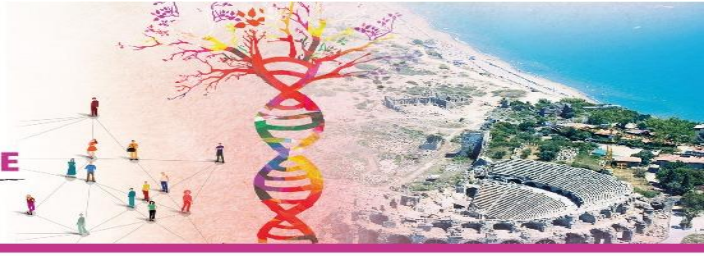
Unfortunately, the crises we face as young psychiatrists are not limited to the emergency cases and treatments for which our specialty training prepared us. Upon completing our residency training and beginning mandatory service, we leave behind the relative "protective shield" of our training clinics.

Violence against healthcare workers is one of the most pressing and long-standing unresolved problems in Turkey's healthcare system. This issue, which directly affects the quality and safety of healthcare services, poses an even greater threat in sensitive settings such as psychiatric outpatient clinics, where the patient-physician relationship is especially delicate. In recent years, the increasing frequency of violent incidents has come to threaten not only the professional satisfaction of physicians and healthcare workers but also their physical and psychological safety.

Observations and studies conducted by the Psychiatric Association of Turkey indicate that violence in healthcare is not merely an individual issue but has become a systemic problem. Violence in Psychiatric Outpatient Clinics report of the Task Force on Preventing Violence Against Physicians of The Psychiatric Association of Turkey shows that more than a quarter of the psychiatrists report experiencing verbal violence. This rate is even higher for psychiatrists who work at training and research hospitals and state hospitals. Psychiatrists working in public institutions are significantly more exposed to verbal violence compared to those working in private institutions.

Among the 663 psychiatrists who participated in the survey, a total of 3,661 incidents of violence were reported over the past year. While 22% of the participants stated that they had not encountered any violence in the past year, 15% reported being exposed to more than 10 incidents of violence in the past year, indicating that one in every seven physicians faces frequent and repeated acts of violence.

91% of participants believe that adequate measures are not being taken to prevent violence in the psychiatric outpatient clinics or private practices where they work. 70% of participants reported a lack of metal detectors in the psychiatric outpatient clinic or private practice building where they work. Only a quarter of the participants who reported a metal detector present at their place of work reported that the routine use of metal detectors is mandatory. Moreover, around one in every four psychiatrists reported no security presence at all, and they are completely unprotected in terms of security.



Improper prescription/health report requests stand out among the causes of violence, highlighting the risk of violating ethical and legal boundaries between the patient and the healthcare provider.

These figures reveal the challenging and unsafe conditions under which psychiatrists work daily, and many of our colleagues have been subjected to physical, verbal, and psychological violence. The widespread and intense prevalence of violence underscores the urgent need for serious protective measures to ensure the safety of healthcare professionals.

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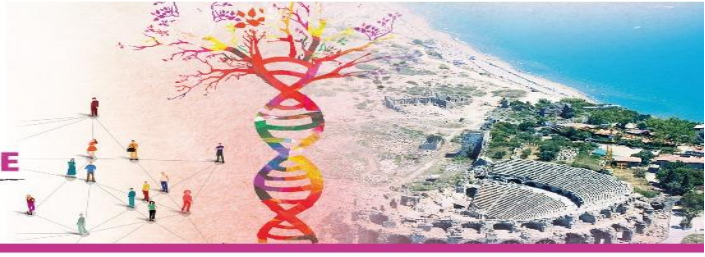

KEY DİFFERENCES BETWEEN INDİVİDUALS DİAGNOSED WİTH AUTİSM İN EARLY VS. LATE STAGES, AND COMORBİDİTİES AND TREATMENT OPTİONS İN THE LATE-DİAGNOSED GROUP

Emre Mısır

Başkent University Faculty of Medicine, Department of Psychiatry

Autism Spectrum Disorder (ASD) is a neurodevelopmental disorder characterized by impairments in social interaction and communication skills, repetitive behaviors, insistence on sameness, and perceptual abnormalities. The age at which the diagnosis is made can affect individuals' developmental processes, intervention opportunities, and quality of life. Although ASD is often noticed in early childhood, some individuals are diagnosed during school age, adolescence, or adulthood.

There is no universally defined age for a late diagnosis. The concept of late diagnosis in autism varies greatly depending on the research context. A recent meta-analysis (1989–2024, covering 420 studies) found that the average threshold defined for late diagnosis was 11.53 years (range: 2–55 years; median = 6.5 years). However, regardless of the threshold age, a diagnosis made after early childhood can result in missed opportunities for early intervention and may complicate individuals' developmental trajectories. Indeed, studies have shown that intensive and early intervention programs can improve cognitive and language skills as well as adaptive behaviors in children with ASD. Difficulties with social adaptation, academic problems, or emotional regulation often become more pronounced with delayed diagnosis. Individuals who do not receive early support may experience social isolation in peer relationships or develop secondary psychological issues.

Additionally, those diagnosed later often suffer the negative effects of masking, such as difficulty accessing healthcare services, psychological problems stemming from an inability to understand why they were excluded by peers in childhood, and emotional exhaustion. There are thought to be several reasons behind delayed diagnosis of ASD. Milder forms of autism (formerly referred to as high-functioning autism) may not be recognized at an early age. These individuals may exhibit subtle deficits in social skills rather than significant delays in language development, which can be misinterpreted by families or teachers. Secondly, cultural and socioeconomic factors influence the diagnostic process. In societies with low autism awareness or in regions with limited access to healthcare services, symptoms may go unnoticed. Thirdly, gender plays an important role; autism in girls is less frequently recognized compared to boys because girls tend to mask their social difficulties. Moreover, some individuals may compensate for their symptoms with their cognitive abilities, which can delay diagnosis until emotional crises in adolescence or functional difficulties in adulthood. Finally, insufficient training of healthcare professionals in autism and limited access to diagnostic tools can contribute to late diagnosis.

Comorbid conditions are frequently observed in individuals diagnosed later, further complicating the clinical picture. Treatment options should be tailored to the needs of individuals diagnosed later. Behavioral therapies can be supported with social skills training. Cognitive-behavioral therapy (CBT) is an effective method for comorbid conditions. Selective serotonin reuptake inhibitors (SSRIs) can be used for anxiety or depression, while psychostimulant treatments may be appropriate for ADHD. Short-term use of antipsychotics may be considered for accompanying psychotic symptoms. Family education, support groups, and occupational therapy can enhance environmental adaptation and independence. A multidisciplinary approach is essential to maximize the potential of individuals.

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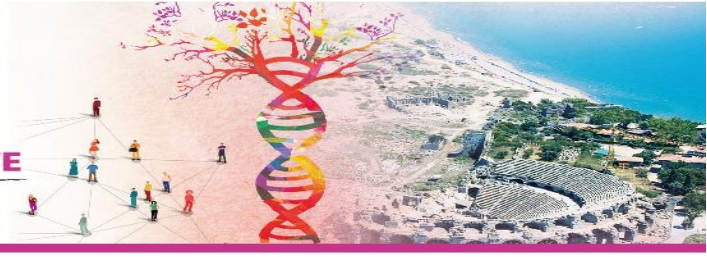


KETAMİNE TREATMENT FOR DEPRESSİON: PROS AND CONS

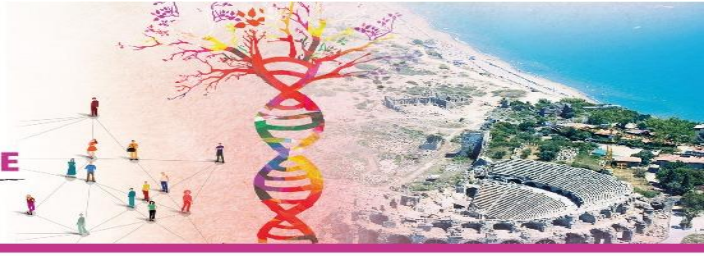
Emre Mutlu

Hacettepe University, Department of Psychiatry

Ketamine is considered a potentially “game-changing” therapeutic option for depression based on studies conducted in treatment-resistant and difficult-to-treat depression cases. Unlike the classical antidepressant mechanism of action involving the monoaminergic system, ketamine noncompetitively inhibits NMDA receptors. This distinct mechanism of action is considered being associated with a more potent and rapid antidepressant effect in treatment-resistant depression. It is administered intravenously in its racemic form and intranasally in its S-enantiomeric form (esketamine). Research is ongoing for oral and intramuscular administration.

Intranasal esketamine received approval from the U.S. Food and Drug Administration (FDA) and the European Medicines Agency (EMA) in 2019 as an adjunctive therapy to antidepressants. As of January 2025, the FDA has approved esketamine as monotherapy in treatment-resistant depression. Current guidelines recommend it as a second-line treatment for difficult-to-treat depression. In addition to its rapid antidepressant effect, there is evidence suggesting a potential anti-suicidal effect. However, limitations in ketamine and esketamine use arise from difficulties in 1) administering intravenous ketamine, 2) its potential for abuse, 3) acute side effects like sedation, dissociation, elevated blood pressure, and 4) inadequately studied long-term risks such as cognitive impairment and neurotoxicity. These side effects have led to specific administration conditions such as "at least two hours of clinical observation" and "administration only in registered and certified clinics." These conditions are included in the FDA's Risk Evaluation and Mitigation Strategy (REMS) requirements. In December 2024, additional specific risks and preventive measures related to respiratory depression were defined for clinics administering esketamine. With the increased use of ketamine, post-marketing reports have noted safety concerns such as hepatotoxicity and bladder toxicity. Furthermore, a recent meta-analysis indicated that ketamine does not significantly reduce suicidal thoughts.

Despite conflicting reports regarding efficacy and safe use, intravenous ketamine and intranasal esketamine are available in our country, and there are reports of its administration in private clinics or offices. In this panel section, the benefits and risks associated with ketamine therapy will be discussed, along with the FDA's latest report and methodological limitations of ketamine-related studies registered at clinicaltrials.gov.



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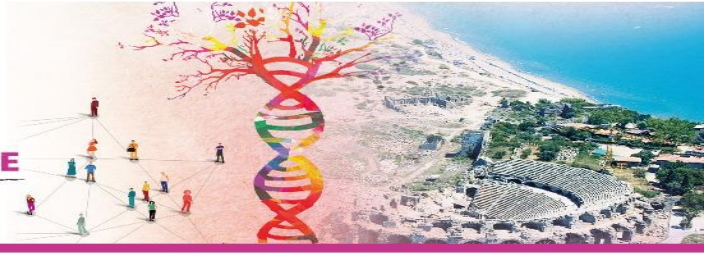

CLOZAPINE, THE EVERGREEN GAME-CHANGER DRUG

Emre Mutlu

Hacettepe University, Department of Psychiatry

Clozapine has a unique receptor profile with its distinctive response characteristics, dose titration, and diverse range of side effects. It was synthesized a few years after the discovery of the first antipsychotic, chlorpromazine. However, clozapine use was halted when it was linked to agranulocytosis. Due to its superiority in treatment-resistant schizophrenia, it was reintroduced for use in treatment resistance.

Clozapine is the gold standard for patients with treatment-resistant schizophrenia. The response to clozapine worsens as the time elapses until clozapine is initiated or the number of antipsychotic trials increases. Therefore, the initiation of clozapine should not be delayed in first-episode psychosis and in cases that are unresponsive to other treatments in the early stages of schizophrenia. With the increase in knowledge about agranulocytosis, the incidence of agranulocytosis has significantly decreased, and mortality rates related to agranulocytosis have markedly dropped. In recent years, myocarditis and pneumonia have emerged as life-threatening side effects of clozapine. However, these conditions can be prevented or managed with appropriate monitoring and interventions, making it possible to safely maintain clozapine. Half of the patients discontinue clozapine due to its side effects. Therefore, effective management of common side effects that affect clozapine use is essential. For patients to safely initiate and sustain long-term clozapine treatment, managing adverse events occurring during therapy such as pneumonia, as well as clozapine-specific side effects, is only possible through active psychiatrist monitoring and interventions, along with informing patients and their caregivers.

In this section, current discussions on the use of clozapine in the early stages of the illness are briefly discussed, followed by life-threatening side effects specifically related to agranulocytosis, myocarditis, and pneumonia. Additionally, current approaches to starting clozapine at the most appropriate time, ensuring its safe use, and optimizing long-term use by minimizing side effects will be covered.

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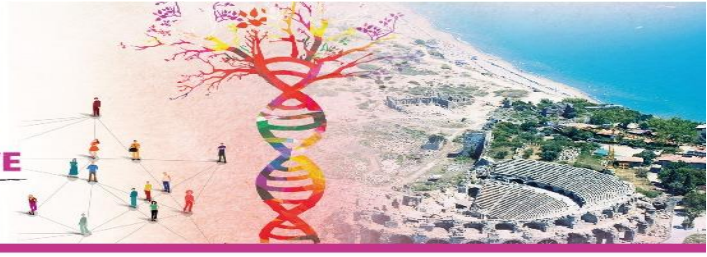

CHRONİC DEPRESSİON AND COGNİTİVE BEHAVİORAL ANALYSİS SYSTEM OF PSYCHOTHERAPY

Esengül Ekici

Yüksek Ihtisas University Faculty of Medicine, Psychiatry Department

Memorial Ankara Hospital

In depression, remission rates are higher in participants who are white, female, employed, and have a higher level of education or income; remission rates are lower in those with prolonged episodes, other comorbid psychiatric disorders (especially anxiety disorder and substance abuse), general medical illnesses, and those with previously low functionality and quality of life (Trivedi et al., 2006). Depression recurs in 80% of depressed patients treated for depression. Chronic depression may respond negatively to both drug therapy and psychotherapy. Cognitive Behavioral Analysis System of Psychotherapy (CBASP) was developed specifically to treat chronic depression. It is assumed that a stall or stagnation in cognitive development is the cause of chronic major depression. The goal of treatment is to strengthen the ability to solve social problems and respond empathically in social interactions per the Piagetian formal operating stage. The patient's transference reactions are conceptualized through significant people in the past. The patient's psychopathology is addressed with a technique called "situation analysis" (McCullough, 2006). New studies have also shown that CBASP is effective in chronic depression.

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EMOTIONS AND EMOTION REGULATION IN OBSESSIVE COMPULSIVE DISORDER

Esengül Ekici

Yüksek Ihtisas University Faculty of Medicine, Psychiatry Department

Memorial Ankara Hospital

Many emotions are experienced in obsessive compulsive disorder (OCD). In addition to anxiety, negative emotions related to anger, disgust, and guilt are also emphasized. These emotions are experienced frequently and significantly in OCD. Adaptive and maladaptive emotion regulation about emotions and related evaluations seem to be important for OCD. In studies conducted on OCD, anxiety itself can cause OCD symptoms, while avoiding anxiety can also be important in OCD symptoms. Although the feeling of disgust focuses on its specific relationship with OCD symptoms, especially contamination/contamination, it has been revealed in the literature that it is also related to other symptoms. When it comes to guilt, some studies show that the sense of guilt is related to contamination, mental contamination, unwanted thoughts, obsessions, and, as a result, cleaning or neutralization compulsions (1). Anger, when investigated together with other emotions experienced in OCD, has been stated as one of the most important emotions that predict OCD symptoms (2).

In anxiety disorders such as OCD, many maladaptive emotion regulation strategies can be used to regulate the experience and frequency of emotion. There is evidence that the interaction between emotions and emotion regulation can lead to and maintain OCD symptoms; for example, avoidance strategies for emotion regulation in OCD have a unique relationship with OCD symptoms. Compulsions in OCD are maladaptive emotion regulation strategies in which individuals attempt to change their negative emotional experiences. Adaptive emotion regulation strategies (reducing thought suppression and increasing acceptance of feelings and thoughts) have been shown to reduce OCD symptoms (3). It can be said that the benefits of treatment can be increased by using components aimed at improving emotion regulation skills in OCD treatments.

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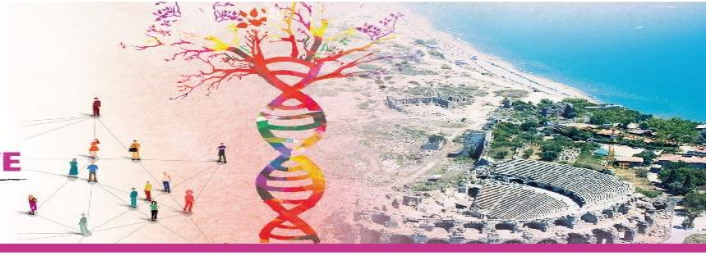


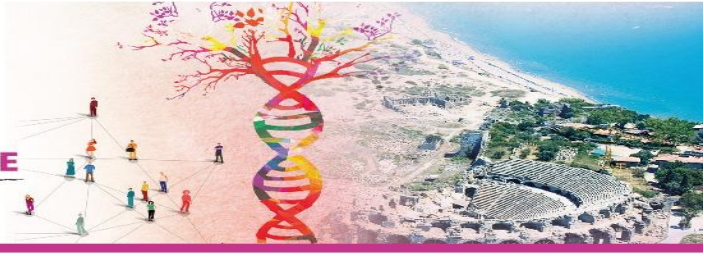
OBSESSİVE COMPULSİVE PERSONALİTY DİSORDER AND DEPRESSİON

Esengül Ekici

Yüksek Ihtisas University Faculty of Medicine, Psychiatry Department;

Memorial Ankara Hospital

Personality disorders and depression are psychiatric conditions that are frequently seen together. This association is clinically significant because the two disorders affect each other's course and bring their own problems in treatment. In addition, each personality trait reflects depression symptoms in its way. Having a comorbid personality disorder makes depression treatment difficult (Özdel & İlhan, 2007). Perfectionism, meticulousness, rule-abidingness, stubbornness, and emotional rigidity are prominent in people diagnosed with Obsessive Compulsive Personality Disorder (OCPD). They do not act spontaneously. They are often indecisive because they are terrified of making mistakes. Their mood is usually serious. They expect the other party to follow the rules and can be intolerant if this does not happen. Their interpersonal skills are limited. They have little sense of humor (Diedrich & Voderholzer, 2015). OCPD is a personality disorder that begins at a young age and continues throughout life, characterized by perfectionism, a need for control, and cognitive rigidity. Individuals with obsessive-compulsive personality traits try to achieve the best, the most complete, the most perfect, and the most perfect. They have strict rules that they cannot bend towards themselves and others. They are strictly committed to these rules and spend a lot of time on them. This meticulousness and the effort to act according to the regulations can be intensified, especially during stressful periods and when responsibility increases. Experiencing these personality traits intensely for a long time can cause psychological problems such as exhaustion, depression, and anxiety to emerge after a while, and the existing ones to continue and intensify. Although it has been shown that the treatment course can be positive in the additional diagnosis of obsessive-compulsive personality disorder in depression with proven therapy methods, studies have not sufficiently clarified why some individuals benefit more from the process and why some remain resistant or terminate therapy. Successful treatment of depression may play a role in the recovery of the personality disorder it is associated with. There are currently studies in the literature examining the effectiveness of various psychotherapy methods in OCPD, and it has been observed that these treatments significantly reduce OCPD and depression symptoms. Although it is known that OCPD can be resistant to change, it has been stated that a stable and collaborative approach will provide significant improvement, and psychotherapies have been conceptualized regarding OCPD. In addition, when it is considered that there are cases where the validity of the distinction between these concepts is questioned, it can be argued that a holistic approach may be more effective in addressing the situation.



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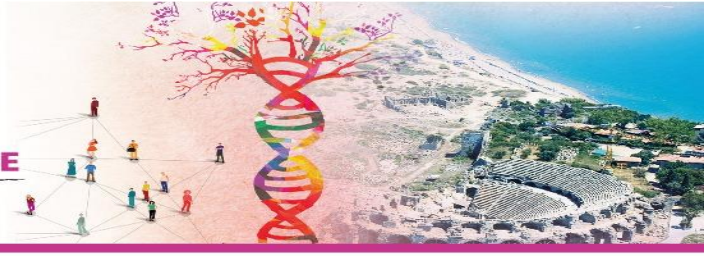

PSYCHOPHARMACOLOGİCAL TREATMENT SELECTİON İN PATİENTS WİTH SYSTEMİC DİSEASES USE OF PSYCHOTROPİCS İN PATİENTS WİTH ONCOLOGİCAL CONDİTİONS

Esin Erdoğan
University of Health Sciences, Izmir Faculty of Medicine, Izmir City Hospital, Department of Psychiatry, Turkiye

Psychiatric disorders such as depression, anxiety, delirium, and sleep disturbances are frequently observed in individuals with cancer and can negatively impact quality of life, treatment adherence, and prognosis. When choosing psychotropic medications, one must consider cancer pathophysiology, potential interactions with chemotherapy/radiotherapy, organ dysfunction, and the risk of polypharmacy. This presentation aims to summarize current psychopharmacological approaches in oncology patients in light of recent literature.

The prevalence of depression in cancer patients ranges from 15% to 25%. Selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs) are commonly preferred for treating depression and anxiety in oncology patients. Among SSRIs (citalopram, escitalopram, sertraline), those with minimal drug interaction and good tolerability are prioritized. Sertraline may also be favored due to its immunomodulatory effects. In breast cancer patients receiving tamoxifen, potent CYP2D6 inhibitors such as paroxetine and fluoxetine can reduce the levels of endoxifen, the active metabolite of tamoxifen, thereby decreasing treatment efficacy. Thus, antidepressants with lower CYP2D6 inhibition such as citalopram, escitalopram, and venlafaxine are preferred.

SNRIs (venlafaxine, duloxetine) are suitable options when neuropathic pain is present. However, venlafaxine may increase the risk of chemotherapy-induced neutropenia and should be used cautiously. Mirtazapine is advantageous in cases of anorexia, nausea, and insomnia, though sedation and weight gain should be monitored. Tricyclic antidepressants (TCAs) have risks of cardiotoxicity and anticholinergic side effects. Mirtazapine and TCAs may also carry a risk of myelosuppression (e.g., leukopenia).

For long-term anxiety symptoms, SSRIs and SNRIs are considered safe. For acute anxiety, benzodiazepines may be used short-term, and those with minimal hepatic metabolism (e.g., lorazepam, oxazepam) are preferred in hepatic dysfunction. Buspirone is non-addictive but has a delayed onset of action (2–4 weeks).

Antipsychotics are frequently used for delirium, chemotherapy-induced nausea, and terminal agitation. Haloperidol is an effective choice for managing delirium and nausea. Olanzapine is also effective and safe for controlling acute and delayed nausea and vomiting in patients receiving highly emetogenic chemotherapy. For cancer-related fatigue (CRF), methylphenidate has shown superiority over placebo. Sedative-hypnotics (zolpidem, zaleplon) are recommended for short-

term use in sleep disorders. If depression coexists, mirtazapine is a suitable option. Modafinil may benefit patients with severe fatigue, though its efficacy is limited in mild-to-moderate cases. In home care settings, psychotropic prescriptions are often based on symptom-oriented rather than diagnosis-based approaches.

Psychotropic selection in oncology patients should be personalized based on pharmacokinetic/pharmacodynamic properties, tumor type, and treatment regimen. A multidisciplinary approach involving oncologists, psychiatrists, and palliative care teams, along with periodic medication reviews, is crucial to minimizing side effects and drug interactions. While current guidelines highlight the use of SSRIs and atypical antipsychotics, individualized evaluation remains essential.

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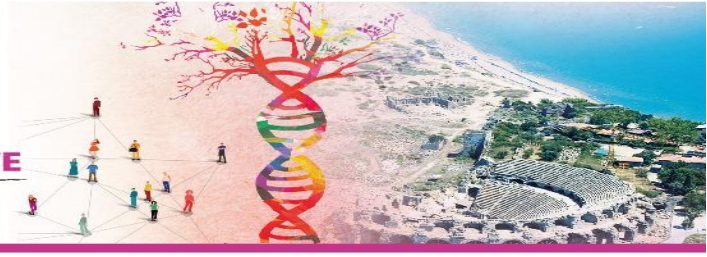


THE OVERVIEW OF SUICIDE

Esma Akpinar Aslan

Tokat Gaziosmanpasa University School of Medicine, Department of Psychiatry

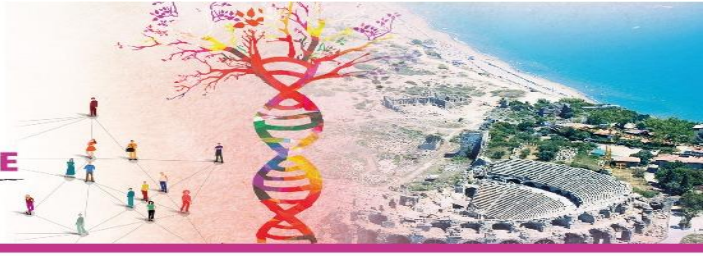
Suicide is a self-harming behavior undertaken by an individual with the knowledge and intention that the outcome will be death. According to the World Health Organization (WHO), more than 720,000 people die by suicide every year and many more attempt suicide. Suicide occurs throughout the lifespan and was the third leading cause of death among individuals aged 15–29 globally in 2021. According to the Turkish Statistical Institute, the crude suicide rate in Turkey for 2023 was 4,76. Suicide is a serious public health problem that requires a public health response. Efforts to prevent suicide and reduce suicidal thoughts and behaviors, which continue to have negative effects on large masses in both personal and social dimensions, are of great importance.

Suicidal thoughts and behaviors can be defined in different ways within a spectrum. At one end are suicidal thoughts and at the other are suicide and death. In between the two ends, suicide attempts are encountered. There are many different views to understand and explain why and how suicidal thoughts and behaviors occur. These include the biopsychosocial model, sociological theories, psychoanalytic theories, cognitive behavioral models, biologically based explanations (imbalances in neurotransmitter systems, hormonal disorders, genetic and familial predisposition, etc.), and the epidemiologically high-risk individual approach (Fazel and Runeson 2020).

Suicidal behavior is a multifactorial phenomenon influenced by genetic, biological, psychological, social, and environmental factors. Risk factors can be categorized into individual, relational, environmental, social, and healthcare system-related domains. One of the key objectives of suicide risk assessment is to identify individuals at high risk and determine the most appropriate setting for their treatment. For the clinical risk assessment interview, the American Psychiatric Association's (APA) guideline for the approach to suicide can be consulted (APA 2010).

Preventing the suicide is a global imperative. Early identification, assessment, management, and follow-up of anyone affected by suicidal behaviors are important steps in suicide prevention. Other important prevention steps include limiting access to suicide tools (e.g. pesticides, firearms, certain medications), interacting with the media for responsible reporting of suicide, and developing socio-emotional life skills in adolescents.

Efforts to prevent suicide must be comprehensive and integrated due to the complex nature of suicide. These efforts require coordination and collaboration across multiple sectors, including health, education, labor, agriculture, business, justice, law enforcement, defense, politics, and the media.



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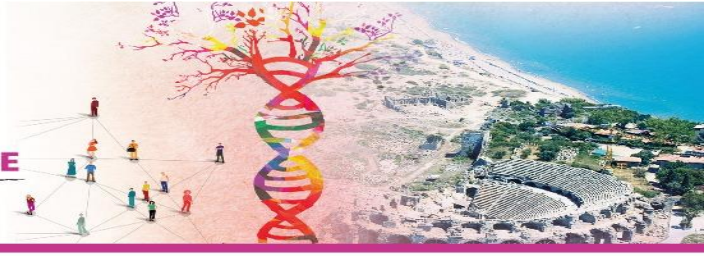


TİNY DREAMS: A JOURNEY İNTO THE SLEEP WORLD OF BABİES

Esra Ünverdi Bıçakcı

Gülhane Training and Research Hospital, Department of Psychiatry

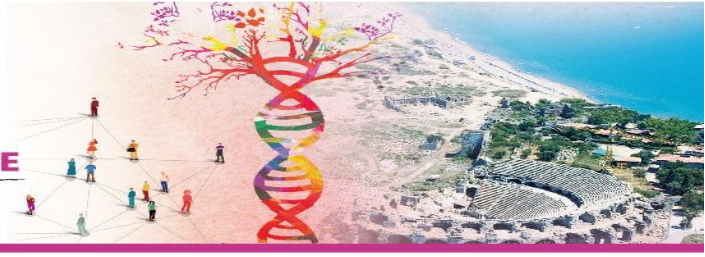
Sleep has a critical role in the physiological and neurological development of infants. Sleep is crucial for brain plasticity, learning, memory consolidation, physical growth and the immune system. In infants, the NREM (non-rapid eye movement) and REM (rapid eye movement) sleep phases differ from thıse in adults. Newborns usually sleep between 16 and 18 hours a day. Due to their high metabolism and frequent feeding needs, their sleep periods are distributed across short intervals. As infants grow older, their sleep duration and consolidation change (1).

In newborns, sleep is classified into active, quiet, and mixed sleep periods. The active sleep phase corresponds to the REM sleep. In this phase, infants experience rapid eye movements, rapid breathing and sometimes small twitches in the muscles. Newborns spend approximately 50% of their sleep during the active sleep phase. This is more than twice the amount of REM sleep observed in adults. This sleep phase is very important for brain development and learning. The brain is active during this phase, and dreaming occurs here, although it cannot be definitively stated that infants experience dreams as adults do. It is believed that dreaming requires the capacity to imagine and visualize. In other words, infants would need to be able to construct visual and spatial representations to experience dreams in the way adults do. o construct visually and spatially to experience dreams as we know them. Considering the high brain activity and ongoing developmental processes during REM sleep, it is possible that infants may dream, but there is no definitive information on the nature or content of these dreams. What is certain, however, is that REM sleep is important for brain development.

Quiet sleep corresponds to the NREM sleep phase. During this stage, the baby is in a deeper sleepwith minimal body movement. The brain is less active, but the body is focused on growth and repair processes. This is a critical period for physical regeneration. The mixed sleep period in babies is when both active (REM) sleep and quiet (NREM) sleep phases occur together, which is particularly observed in the first few months of life. As the baby grows older, active and quiet sleep periods begin to differentiate (2,3).

In the first year of life, the transition from wakefulness to sleep is usually accomplished by REM sleep (referred to as active sleep in newborns). The cyclic alternation of NREM-REM sleep is present from birth, but has a duration of about 50 to 60 minutes in the newborn, compared to around 90 minutes in adults. Infants also gradually acquire a consolidated nocturnal sleep cycle, and fully developed EEG patterns of NREM sleep stages are not present at birth, but appear in the first 2 to 6 months of life. When brain structure and function reach a level that can support high-voltage slow-wave EEG activity, NREM stage 3 comes to the fore (3).

Looking at the sleep duration for preschool-aged children, it is emphasized that infants aged 4-12 months need to sleep 12-16 hours in a 24-hour period (including naps) to support optimal health.



Children aged 1-2 years should sleep 11-14 hours, and children aged 3-5 years need 10-13 hours of sleep within a 24-hour period (including naps).

Knowing the nature of infants' sleep will help in predicting possible sleep disorders and parent education. This presentation will provide information about infant sleep organization and processes.

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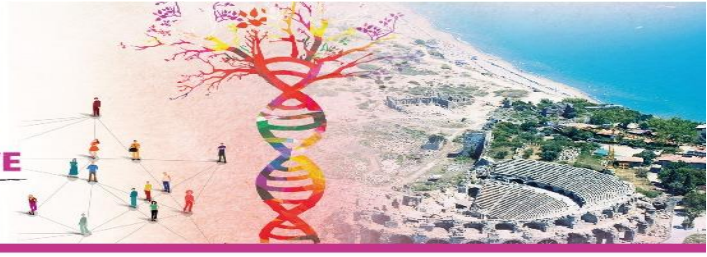


OVERLOOKED FEATURES İN ADULT ADHD CLİNİCAL PRACTİCE

Eylem Özten Özsoy

Private Practitioner

Adult Attention-Deficit/Hyperactivity Disorder (ADHD) is a neurodevelopmental psychiatric condition defined by persistent inattention, hyperactivity, and impulsivity that significantly impair functioning. In adults, ADHD can be detected within a broad range of symptoms, including distractibility, difficulty in focusing, procrastination, poor time management, forgetfulness, disorganization, and sexual impulsivity. These symptoms affect daily responsibilities, relationships, and occupational performance.

While these core features are widely recognized, there are other less commonly assessed characteristics that often remain underexplored in clinical settings such as emotional dysregulation. Individuals with ADHD may experience emotions rapidly and intensely, showing high sensitivity and difficulty controlling emotional responses. Mood swings, irritability, and emotional outbursts—particularly in response to frustration—are frequently observed (Soler-Gutiérrez et al. 2023). Emotional vulnerability is often tied to low emotional tolerance and impatience, which can intensify interpersonal difficulties.

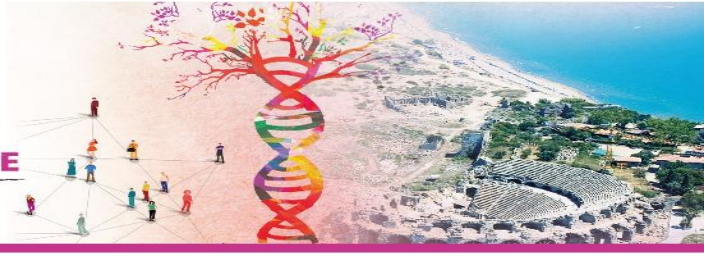
Sensory hypersensitivity and overload are also common but underrecognized. Environmental stimuli such as noise or light may be perceived as overwhelming, leading to concentration difficulties and increased emotional stress (Bijlenga et al. 2017). This can disrupt daily routines and social interactions.

Adults with ADHD showing signs of cognitive inflexibility may find it difficult to shift their mindset, adapt to new plans, or consider other perspectives. Such rigidity can affect decision-making and problem-solving and contribute to conflict in relationships or the workplace.

Many individuals report feeling emotionally disconnected or detached, particularly in low-stimulation environments. Alongside this, feelings of failure, inadequacy, low self-worth, shame, and guilt often develop—typically related to an enduring sense of low self-esteem. A prevailing feeling of being different or not belonging is also common.

Additionally, adults with criticism sensitivity may overreact to feedback, often rooted in a history of frequent correction or judgment throughout childhood. Lastly, difficulties in social cognition—such as misreading social cues or failing to interpret others' emotions—can lead to inappropriate reactions and misunderstandings, affecting social relationships (Morellini et al. 2022).

This presentation aims to draw attention to these overlooked dimensions of adult ADHD. Recognizing and addressing these features is essential for accurate diagnosis, personalized treatment, and improved therapeutic outcomes.



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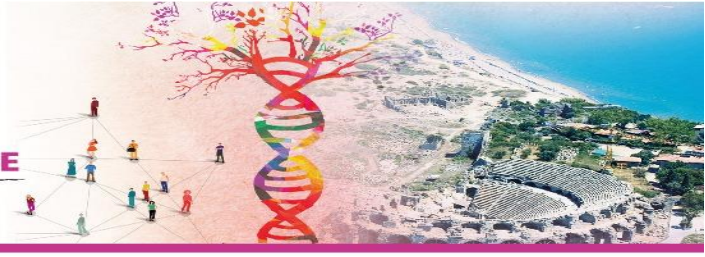

DIFFICULT TOPICS, DIFFICULT DECISIONS: CONFRONTING SEXUAL VIOLENCE AND GENDER INEQUALITY IN PSYCHIATRY

Ezgi Karakaya Hacır

Ankara University Faculty of Medicine, Department of Psychiatry

Sexual violence and gender inequality are important and challenging issues within the field of psychiatry. These phenomena can influence both the therapeutic relationship and the broader institutional environments in which mental health professionals operate. As a discipline grounded in the care of human experience, psychiatry is called upon to engage with such matters not only clinically, but also ethically and professionally.

While sexual violence is often understood as an individual experience, it is increasingly acknowledged that structural and institutional factors can shape how such cases emerge, are disclosed, and responded to. Mental health professionals may encounter difficult dilemmas—such as how to respond to a patient who discloses abuse, or how to act when concerns arise within their own professional settings. These situations often require balancing care, confidentiality, professional responsibility, and emotional sensitivity.

Gender inequality may also manifest in various ways within psychiatric settings, including disparities in leadership roles, gender-based assumptions in diagnosis and treatment, or experiences of discrimination in the workplace. Such issues, though sometimes subtle, can have a cumulative impact on the quality of care and the well-being of both patients and clinicians.

Promoting ethical awareness and inclusive professional environments is essential to ensuring that psychiatry lives up to its core values of empathy, safety, and respect. This involves creating safe spaces for dialogue, improving awareness around gender-based dynamics, and supporting professionals in navigating complex ethical situations related to harassment, discrimination, and power imbalances.

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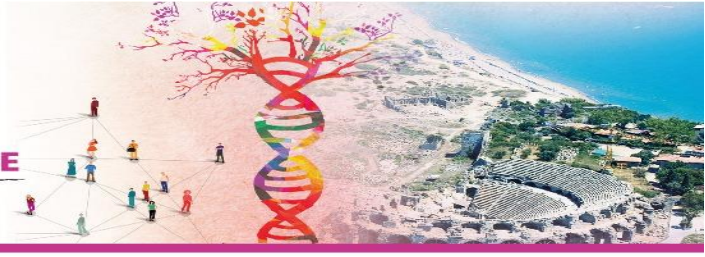

MOVING FROM POLICY TO PRACTICE IN ADDRESSING GENDER-BASED VIOLENCE

Ezgi Karakaya Hacır

Ankara University Faculty of Medicine, Department of Psychiatry

Gender-based violence and discrimination are not merely legal or disciplinary issues—they are ethical, structural, and cultural challenges. The Turkish Psychiatric Association's policy document titled *"Policy Against Gender Discrimination, Sexual Violence, and Harassment"* provides a roadmap for turning policy into meaningful practice (1).

This policy recognizes that gender equality must be actively promoted in clinical, academic, and institutional environments. It urges members to avoid gender-discriminatory language and behavior, and to approach issues like sexual harassment not as isolated incidents but as part of a broader culture of inequality. This shift in perspective allows institutions to focus on root causes—power imbalances, social norms, and silence—and take meaningful action.

The policy emphasizes awareness, education, and inclusivity. It calls for collaboration with the Women's Mental Health Working Group, a commitment to equal representation in leadership, and the development of safe mechanisms for reporting misconduct. Investigations are grounded in respect and the principle that a complainant's statement is sufficient to start a review. Importantly, it also highlights the need for legal and psychological support to survivors, helping them avoid further trauma during the process.

This approach aligns with international standards, including The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Istanbul Convention. But more than fulfilling legal obligations, it demonstrates a cultural shift—a move from passive acknowledgment to active prevention and empowerment (2).

Ultimately, the policy's strength lies in its ability to transform institutional spaces into communities of respect, equity, and care. It shows that when policy is rooted in ethical responsibility and supported by concrete mechanisms, it becomes a tool for long-term, systemic change.

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"CATATONİA" FROM PAST TO PRESENT

Ezgi Sıla Ahi Üstün

Mamak State Hospital, Psychiatry, Ankara

Catatonia was first described by Kahlbaum in 1874. It was observed in psychiatric patients with abnormal motor behaviour. It was later recognised by Kraepelin and Bleuler and associated with schizophrenia. As a result, clinicians have used neuroleptic drugs to treat these patients, but these trials have been unsuccessful. The link between catatonia and schizophrenia was completely severed in 2013 when the DSM-5 moved away from the concept of subtypes of schizophrenia and defined "catatonia secondary to a medical condition". Today, catatonia is no longer considered a primary psychiatric syndrome. It is now recognised as a systemic medical syndrome.

Some authors consider catatonia to be an adaptive behaviour inherited from our ancestors' encounters with predators; a terminal response of the whole body. Because of their historical importance, the concepts of schizophrenia and catatonia are linked; antipsychotic drugs may be given to patients with catatonia clinic and neuroleptic malignant syndrome, an acute neurotoxic condition that can be fatal, may develop in some of these patients. Contrary to popular belief, stopping antipsychotics is a critical part of this presentation. Therefore, it is no longer possible to define catatonia as schizophrenia or any other psychiatric disorder.

With the recognition of the symptoms of catatonia and the subsequent demonstration of the effectiveness of catatonia treatments, many syndromes with different names have been included under the umbrella of catatonia. Delirious mania, Gilles de la Tourette syndrome, anti-NMDAR encephalitis, serotonin syndrome are just some of them. In particular, the recognition of catatonia in neuroleptic malignant syndrome, the development of effective treatment with high-dose benzodiazepines and electroconvulsive therapy (ECT), and the development of a challenge test for catatonia (lorezepam challenge test) can be seen as important steps in the history of this subject.

It is now generally accepted that catatonia has many faces and deserves to be recognised beyond psychiatric disorders, especially schizophrenia.

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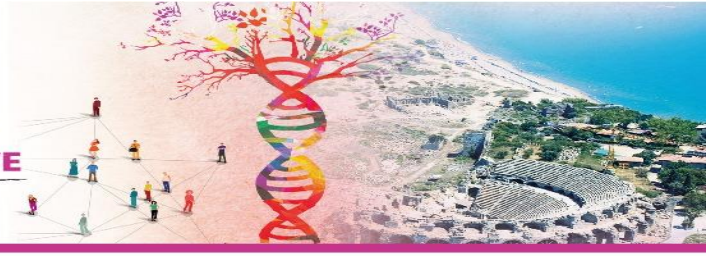


PSYCHODRAMA PERSPECTİVE ON PSYCHOTHERAPY METHODS APPLİED İN PSYCHİATRİC CLİNİCS.

Fatih Aygüneş

Konya Meram State Hospital

The emergence of psychodrama dates back to the early 20th century. Psychodrama is based on the components of action, spontaneity and creativity. These components of psychodrama also provide change and transformation in the individual. Psychodrama, which includes the concept of “sociometry” that develops as a result of interpersonal relationships and is performed through role theory, contributes to mental healing through action and observation.

Although group therapy has advantages over individual therapy, psychotherapy applications in our country are generally individual and couple/family applications. On the other hand, psychodrama can be used in individual therapy in the form of monodrama, but it is still generally applied as group psychotherapy.

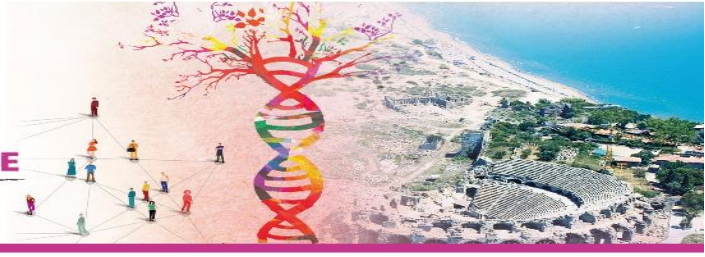
When evaluated from a psychodramatic perspective, it can be said that the psychotherapy application techniques commonly used in clinics today contain psychodramatic elements.

Individual psychotherapy methods frequently used in psychiatry clinics can be listed as psychodynamic therapies (transference-focused therapy and supportive psychotherapy), cognitive and behavioral therapy (CBT), eye movement desensitization and reprocessing (EMDR) therapy, schema therapy, acceptance and commitment therapy, metacognitive therapy, and interpersonal relationship psychotherapy.

The most frequently applied of these in psychiatry clinics is CBT. Applications such as metaphors, imagination, and behavioral experiments, which are frequently used during both psychoeducation and intervention methods of CBT, facilitate the patient's acquisition of different role skills by staging the process in question in a mental or real environment.

In the "safe place creation" process carried out in the preparation phase of EMDR therapy, the patient is provided with a scene in his mind where he feels good before the traumatic event is worked on, and the patient is asked to use this safe area in case of intense difficulty. This personalized area of the patient is also a mental formation of the psychodrama scene.

This presentation aims to explore psychodramatic elements in psychotherapy methods in clinical practice in general.



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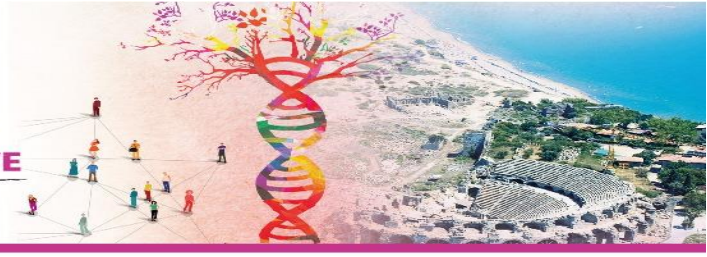
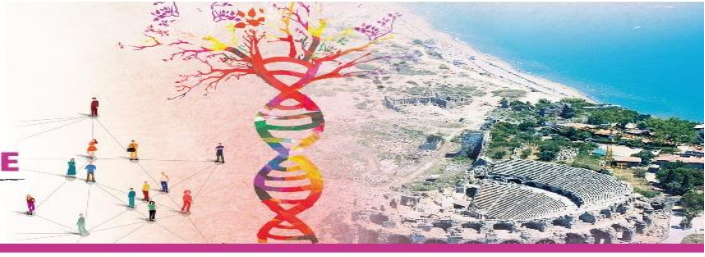


SCHİZOPHRENİA AND NEURODEVELOPMENTAL DİSORDERS

Fatma Kartal

Kırıkkale University Faculty of Medicine Department of Psychiatry

Schizophrenia is a neurodevelopmental disorder that involves complex aberrations in the structure, connectivity, and chemistry of multiple neuronal systems (Stachowiak et al. 2013). Behavioral symptoms generally follow a predictable timeline with cognitive deficits such as memory and attention deficits, typically emerging in childhood, and positive symptoms (psychotic episodes) and negative symptoms such as social and motivational deficits emerging in late adolescence or early adulthood (Stachowiak, 2013). There are studies suggesting that neurodevelopmental disorders and schizophrenia have a partially shared molecular etiology and thus possibly overlapping pathophysiology, or at least some types of schizophrenia are hypothesized to lie on a continuum of neurodevelopmental disorders (Rees et al. 2021). In addition, autism spectrum disorders and mental development disorders (mild mental retardation, borderline mental development) that are relatively mild and not diagnosed in childhood may begin with a wide range of psychiatric symptoms, including psychosis symptoms, in adolescence or early adulthood. (Turkish source) Therefore, in clinical practice, these diagnoses can often be confused or overlooked at the level of cognitive or behavioral symptoms. As a result, many patients may be misdiagnosed or underdiagnosed. In this context, it is important for mental health professionals to evaluate the common and different aspects of schizophrenia and neurodevelopmental diseases (Kokurcan and EC2015).



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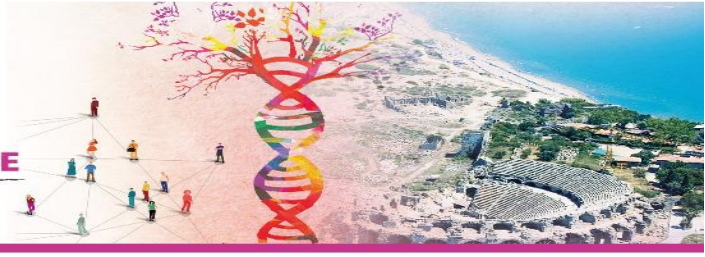


PSYCHİATRİC ONSET İN FRONTOTEMPORAL DEMENTİA

Fatma Cengiz Örengül

Haseki Training And Research Hospıtal, Psychiatry Department

Frontotemporal dementia (FTD) is most commonly diagnosed in the early stages of the sixth decade of life, although symptoms may begin to manifest as early as the third decade. FTD is primarily a sporadic disorder; however, approximately 13.4% of cases exhibit autosomal dominant inheritance, with frequent penetrance of *MAPT*, *GRN*, and *C9orf72* mutations. The average disease duration is approximately 7.5 years (1).

There are three clinically recognized variants of FTD: the behavioral variant (bvFTD), semantic dementia (SD), and primary progressive aphasia (PPA) (1). In semantic dementia, the initial symptom is impaired single-word comprehension, typically presenting as a confrontation naming deficit, and is associated with anterior temporal lobe atrophy. Primary progressive aphasia is characterized by articulation difficulties in polysyllabic words, disrupted prosody, and slowed speech. The Cookie Theft picture description test is commonly used for assessment, and left perisylvian cortical atrophy is typically observed.

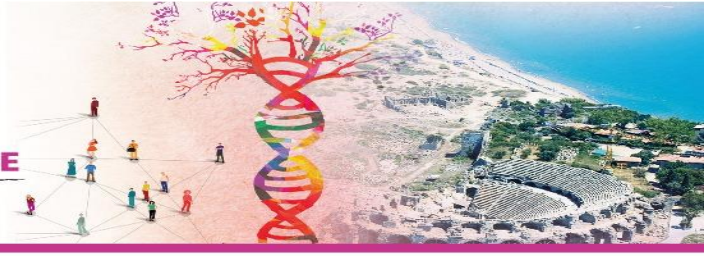
BvFTD is the most common form of early-onset dementia and is characterized by alterations in behavior, social conduct, and personality. Frontal lobe atrophy is a hallmark of this subtype. This paper will focus on bvFTD, particularly its prominent neuropsychiatric symptoms (NPS).

According to the diagnostic criteria developed by the International Behavioural Variant FTD Criteria Consortium (FTDC), the presence of at least one of the following symptoms—behavioral disinhibition or apathy (or inertia) is required for diagnosis. In addition, symptoms may include loss of sympathy or empathy, perseverative, stereotyped, or ritualistic behaviors, hyperorality, and changes in dietary habits. Neuropsychological assessments typically reveal executive dysfunction, including impairments in reasoning, planning, cognitive flexibility, decision-making, abstraction, and verbal fluency (2).

During the prodromal phase of FTD, progressive psychiatric symptoms often emerge as a result of underlying cognitive or neurological deficits. Since behavioral disturbances frequently precede memory impairments, symptoms such as obsessive-compulsive tendencies, irritability, paranoia, and apathy may be misdiagnosed as primary psychiatric disorders, leading to delays in the diagnosis of FTD (3).

In the diagnostic process of neurodegenerative diseases, structural and functional neuroimaging, neuropsychological assessments, and genetic testing are commonly utilized. Research into potential biomarkers is ongoing.

The use of acetylcholinesterase inhibitors and NMDA antagonists has not demonstrated benefit in the treatment of bvFTD. Selective serotonin reuptake inhibitors (SSRIs) are frequently



employed. Given the common occurrence of movement disorders in these patients, caution is advised in the use of antipsychotic medications.

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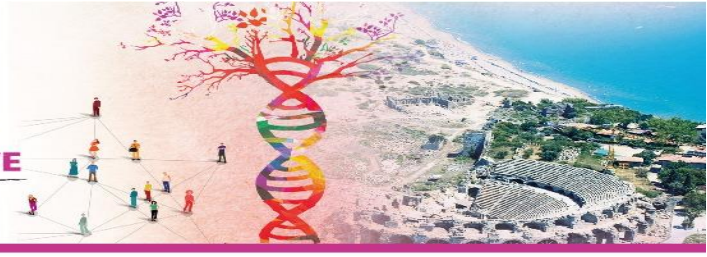


PHYSICIAN SUICIDE

Figen Ünal Demir

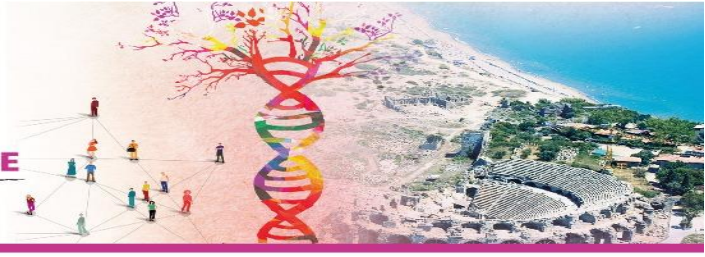
Tokat Gaziosmanpaşa Üniversitesi Tıp Fakültesi Psikiyatri Anabilim Dalı

Physician suicide is a public health issue with serious individual and societal consequences, yet it is often overlooked. Among all professions, medicine has one of the highest suicide rates, with numerous psychosocial risk factors such as intense stress, emotional burden, and occupational burnout. Studies in the literature have demonstrated that physicians have a significantly higher likelihood of attempting and dying by suicide compared to the general population. While some studies have indicated that suicide rates among physicians have remained stable in the US and have even declined in parts of Europe, the elevated suicide rates—particularly among female physicians—remain a concern (Dutheil, Aubert, & Pereira, 2019).

In recent years, a noticeable increase in physician suicides has been observed in Türkiye. This rise can be attributed to both individual factors and the increasing challenges of practicing medicine in the country. In a study by Ünler and Ertek, which examined 138 cases of physician and medical student suicides in Türkiye, between 2006 and 2021 (sourced from social media and news outlets), most cases involved specialist doctors. The most common methods were drug overdose and jumping from heights. Among medical specialties, anesthesiology (12.5%), obstetrics and gynecology (10.2%), and psychiatry (10.2%) had the highest representation. The most frequently reported reasons for suicide were family-related problems, followed by professional or academic issues (Unler & Ertek, 2023). In the post-pandemic period, the psychological burden on healthcare professionals has further increased, with depression, anxiety disorders, and burnout syndrome becoming widespread among physicians.

Burnout syndrome is a condition arising from chronic workplace stress, typically characterized by emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment. Studies have reported that the prevalence of burnout among physicians ranges from 30% to 66%. Similar to the general population, depression and anxiety disorders are the most common psychiatric conditions among doctors. Despite the high prevalence of psychological distress, physicians are less likely to seek psychiatric help. Barriers to this include fears of career damage, concerns over confidentiality, the discomfort of being evaluated by a colleague, difficulty accepting one's own mental illness, time constraints, and cost. As a result, self-treatment behaviors are frequently observed. However, untreated psychiatric disorders are strongly associated with an increased risk of attempting suicide. Furthermore, physicians who are at risk of attempting suicide often have easier access to lethal means due to their medical knowledge and the availability of medications. This increases the likelihood of fatal outcomes in suicide attempts.

Preventing physician suicide requires a multidimensional and systematic approach. Key strategies include eliminating workplace violence, restructuring workloads in accordance with humane and medical standards, strengthening peer support networks, combating stigma, and



ensuring psychiatric evaluations for at-risk physicians. In addition, raising awareness starting from the early stages of medical education, increasing the visibility of physician suicides, encouraging scientific research on this topic, and collecting national-level data are essential steps in addressing the problem.

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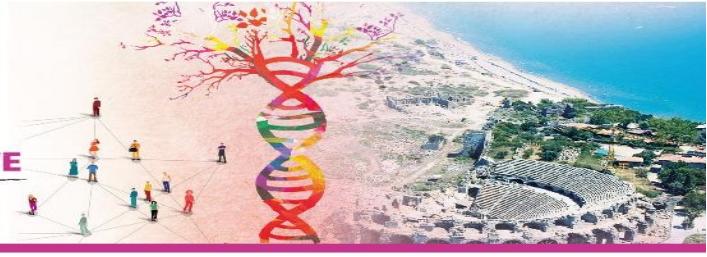

MİXED FEATURES DEPRESSİON: CLİNİCAL DİAGNOSİS AND TREATMENT

Furkan Yazıcı

Ege University Department of Psychiatry

Case TY, male, 25 years old, single, university student, living in Izmir. First psychiatric visit 4 years ago with anxiety, insomnia, thoughts of death, depressive symptoms, sertraline 100 mg was started, partial benefit with 2 years of use, ongoing suicide/death imagination. Irregular psychologist follow-up in the interim period -Personality Disorder Preliminary Diagnosis- is present. Approximately 2 years of school interruption, introversion, melancholic features, prominent depressive period are present. 1 year ago psychiatric visit with panic attack, anxiety, insomnia, anger, short-term fluoxetine use, no benefit. Applied to the clinic in October 2024 with itching, intense health (HPV) anxiety, increased poetry writing, melancholic features, increased thoughts of death and imagination, difficulty in maintaining human relationships for the last 3 months. Mental status examination: Depressed mood, normal affect (not depressed), anhedonia present, excessive amount of speech, depressive content, decreased sleep, no anergy, thought acceleration+, psychomotor restlessness+, anxiety+, irritability+, increased productivity (poem-song), decreased sexuality, suicidal imagination+, worthlessness+, no psychotic findings, suicidal thoughts always present.

The diagnosis was considered as "Mixed Features Depression". Treatment: Olanzapine was started at an evening dose of 5mg. In the 10-day follow-up, sleep improved (7-8 hours), thoughts of death decreased, productivity continued, anxiety decreased, social isolation decreased, Olanzapine was increased to 10mg. Approximately 25 days later, lithium was added due to continuing anhedonia and hopelessness, and decreased persistent death imagination. Depressive findings decreased, thoughts of death completely disappeared.

Koukopoulos Criteria

With Major Depression, at least three of the following symptoms must be present: 1. Internal tension/agitation, 2. Racing or crowded thoughts, 3. Irritability or unprovoked anger, 4. Absence of signs of retardation, 5. Talkativeness, 6. Dramatic descriptions of pain or frequent crying spells, 7. Mood swings and marked emotional reactivity, 8. Initiating insomnia

The most common symptoms in mixed depression have been shown to be absence of retardation (82%), talkativeness (70%), mood lability (55%), racing/crowded thoughts (54%), dramatic depiction of suffering (52%), irritability (48%), and early insomnia (35%).

The symptom of decreased need for sleep is differential for the diagnosis of bipolar disorder.

Lithium

In treatment-resistant depression, lithium addition showed a significant superiority over placebo OddsRatio=3.09 (95% CI 1.74–5.51). Long-term lithium (alone or in combination) OR=2.8 (95% CI: 1.59–4.92); superiority in treatment.

In a cohort of 123,712 patients with a mean follow-up of 7.9 years (SD 5.3), lithium use reduced the risk of hospital readmission for mental illness (hazard ratio [HR] 0.47).

The risk of hospital readmission was lower when lithium was used alone (HR 0.31) than when lithium was used in combination with antidepressants (HR 0.50).

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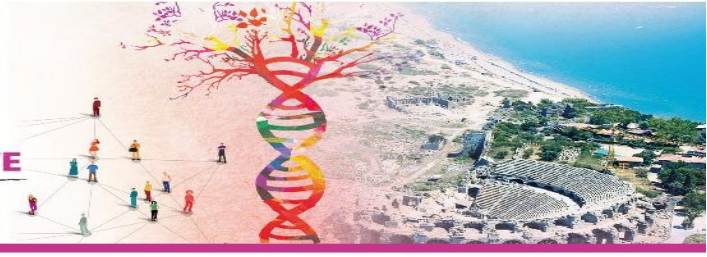


APPROACH TO GENDER DYSPHORİA

Furkan Yazıcı

Ege University Department of Psychiatry

The diagnostic approach to transgender individuals is made with a broad perspective. Endocrinology, genetics, gynecology and urology physicians examine the individual in terms of differential diagnosis. Family interview and compliance with the process are evaluated. Supervision is received from the faculty member in the relevant departments. After a certain monitoring period, hormone replacement therapy for the appropriate gender is started by the endocrinologist and monitored. The patient is monitored during the hormone replacement therapy and surgical operations. Finally, the judicial process is evaluated by the health board.

Fighting against Transphobia/Homophobia, foremost, attempts are made to build the individual's self that contradicts his/her own beliefs and values, and to ensure acceptance of his/her self. Family members are informed about the process. The patient, understanding, tolerant and supportive attitudes of health workers, especially psychiatrists, are very important.

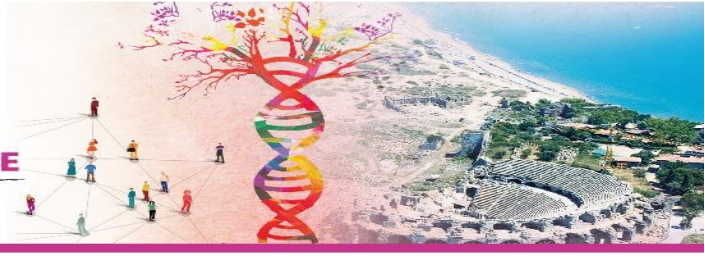
Approach to Gastrointestinal System Diseases

It has been shown that one third of the patients who apply to gastrointestinal system clinics have "Functional GIS Diseases" and it is highly related to psychiatry. The deterioration of the existing biological pathologies of the patients with psychiatric comorbidity and the evaluation of the processes leading to the operation are evaluated in multidisciplinary councils. Some patients continue to be monitored after the operation. Evaluation of the patients throughout the process increases the chance of success in the operation and treatment.

Psycho-oncology; When is a psychiatrist needed?

In oncology patients, oncology doctors may need psychiatric consultation in accepting the diagnosis, treatment and outcome of the disease. In the presence of accompanying psychiatric diseases in patients, treatment should be arranged, drug interactions with chemotherapy drugs should be checked, and caregivers should be assisted in necessary situations.

It is essential for the process that the patient is informed in detail about the diagnosis, treatment options, and side effects, that they are given the opportunity to ask questions and question, that the patient is allowed to express their emotions - as long as they are not too disruptive - and that unconditional support continues in all decisions and situations the patient will be in.



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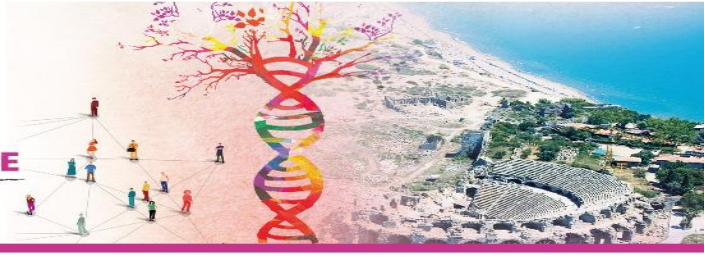


RECOGNIZING AND MANAGING CO-DIAGNOSIS IN SCHIZOPHRENIA: SCHIZOPHRENIA AND DEPRESSION

Furkan Yazıcı

Ege University Department of Psychiatry

It is important to recognize depression in patients with schizophrenia, because depression plays an important role in prognosis, increases suicidal tendencies in patients, increases weight gain, impairs the quality of life of patients and impairs daily functioning independently of psychotic symptoms.

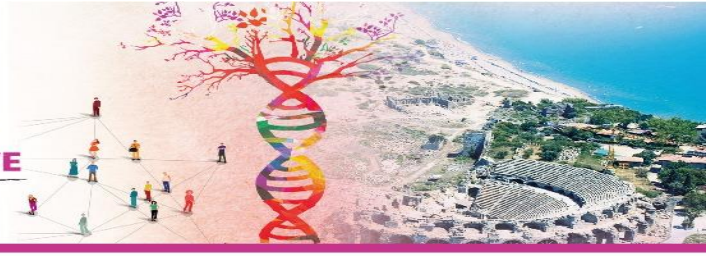
It has been shown that 30% of patients with schizophrenia have a diagnosis of major depression; less than half of depressed patients take antidepressants and almost half of patients treated with antidepressants do not improve. Depression was observed in 50% of patients in the premorbid period, 33% during the first episode, 38% during psychotic episodes and 27% in remission.

The negative symptoms of schizophrenia are often confused with depressive symptoms. Decreased interest, motivation and emotional expression, anhedonia, anergy and psychomotor retardation and cognitive impairment are overlapping features. Depression is primarily characterized by a markedly depressed or melancholic mood and certain cognitive impairments, such as depressive thoughts, feelings of helplessness, ideas of guilt, and a low value for life. According to a multivariate analysis of symptoms, hypothymic affect, pessimism, and suicidal thoughts are present in depression, while poverty of speech (alogia), blunted affect, and social isolation are common in negative symptoms.

The scale to be used to diagnose depression in patients with schizophrenia is the Calgary Schizophrenia Depression Rating Scale. (CDSS) It is the only depression scale designed to assess depression in individuals with schizophrenia spectrum disorders, including attenuated psychosis syndrome. It separates depressive symptoms from negative, positive, and extrapyramidal symptoms. The scale works in both relapsing and remitting patients and is sensitive to change. It is valid in adolescents and adults.

Prolonged dopamine receptor blockade can lead to the development of anhedonia and possibly depression. A typical manifestation of neuroleptic depression with psychomotor retardation and anhedonia is the presence of neuroleptic pseudoparkinsonism. The addition of akathisia in such patients can cause dysphoria and suicidal behavior. The risk of suicide in patients with schizophrenia is 20 times higher than in the general population; approximately 50% of patients with schizophrenia attempt suicide and approximately 10% die from suicide.

Most first-generation antipsychotics (FGAs) at therapeutic doses increase symptoms of depression primarily because of extrapyramidal side effects and hypersedation. It often occurs with the development of dysphoria, akathisia, or more pronounced neuroleptic depression.



Therefore, reducing the dose of the antipsychotic drug as a first step may reduce the severity of depressive symptoms. Prescribing anticholinergic drugs to correct extrapyramidal symptoms also reduces the severity of depression.

A meta-analysis of 32 antipsychotic agents, including nearly 90 RCTs enrolling 20,000 patients, showed that most antipsychotics were significantly superior to placebo in reducing depressive symptoms according to the PANSS scale. Sulpiride, clozapine, amisulpride, olanzapine, aripiprazole, cariprazine, and paliperidone had the most significant effect (in decreasing order).

In a pooled analysis of four RCTs, lurasidone was superior to placebo in its effect on depressive symptoms in the treatment of schizophrenia exacerbations within six weeks.

In schizophrenia patients with more severe depressive episodes, the SSRI group as a whole was significantly more effective than the placebo group.

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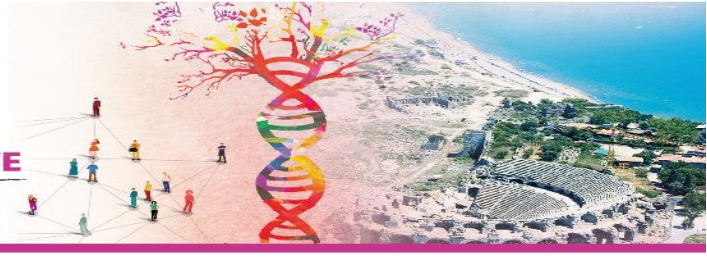
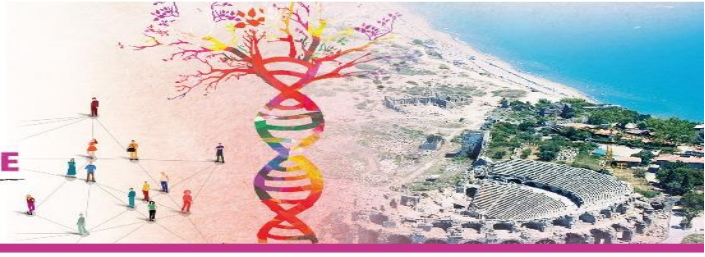


TREATMENT ADHERENCE İN SYSTEMİC DİSEASES: A PERSPECTİVE FROM CONSULTATİON-LİAİSON PSYCHİATRY PRACTİCE

Gamze Gürcan

TOBB University of Economics and Technology, Faculty of Medicine, Department of Psychiatry

Treatment adherence in systemic diseases represents a pivotal determinant of therapeutic success. The consistent implementation of prescribed pharmacological regimens and recommended lifestyle modifications is essential for the effective management of chronic conditions. Nevertheless, adherence is frequently compromised by a range of factors, particularly psychiatric comorbidities. Mental health disorders—including depression, anxiety, and cognitive impairments—have been extensively documented to adversely impact patients' ability to maintain adherence. These conditions often result in forgetfulness, diminished motivation, or an impaired understanding of the necessity of adhering to treatment protocols. Beyond psychiatric diagnoses, individual psychological and behavioral characteristics also significantly influence adherence. Personality traits, coping mechanisms, the degree of insight and interpretation of illness, and the presence of somatization may all affect treatment compliance. For instance, individuals exhibiting high levels of neuroticism may face greater challenges in managing their health, whereas those employing adaptive coping strategies are more likely to adhere to prescribed interventions. Similarly, patients with limited illness insight or those experiencing physical symptoms lacking a clear medical basis may demonstrate reduced motivation to engage in treatment. Substance use disorders further exacerbate non-adherence. Individuals with addiction often encounter additional barriers to consistent treatment engagement, such as heightened impulsivity, reduced motivation, and a prioritization of substance use over health-related concerns. To address these challenges, several evidence-based interventions have been shown to enhance adherence. Psychoeducation, cognitive-behavioral therapy (CBT), and motivational interviewing are among the most effective approaches for increasing patients' understanding of their condition and fostering greater commitment to treatment. Furthermore, technological advancements—such as telepsychiatry, digital health applications, and artificial intelligence-supported systems—are increasingly being employed as adjunctive tools to promote engagement and continuity of care. These innovations enable remote monitoring, support, and education, thereby improving the overall treatment experience. The presentation will highlight psychiatric factors affecting treatment adherence in systemic diseases and discuss the most current intervention strategies designed to improve treatment outcomes.



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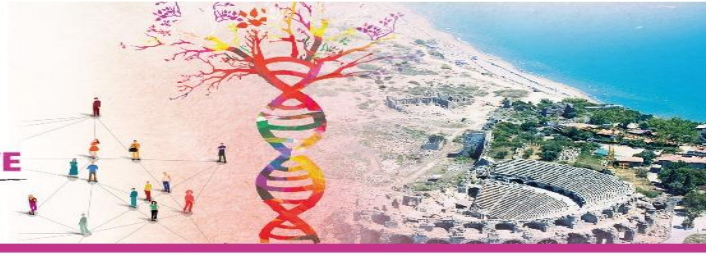

COGNITIVE BEHAVIORAL THERAPY FOR BINGE EATING DISORDER

Gamze Usta Sağlam

Istanbul University-Cerrahpaşa, Cerrahpaşa Faculty of Medicine, Department of Psychiatry

Binge Eating Disorder (BED) is a prevalent psychiatric condition characterized by recurrent episodes of consuming large quantities of food accompanied by a perceived loss of control, occurring without subsequent compensatory behaviors. This disorder is associated with significant psychological distress and various physical health complications, including obesity, type 2 diabetes, and cardiovascular diseases. The global prevalence of BED The is estimated to be 0.6–1.8% in adult women and 0.3–0.7% in adult men is, underscoring its public health significance (Giel et al. 2022).

Cognitive Behavioral Therapy (CBT) has emerged as the most empirically supported intervention for BED, with demonstrated efficacy across multiple clinical trials. This presentation will examine the enhanced CBT (CBT-E)- a transdiagnostic psychological treatment for eating disorders- framework for BED through the lens of an actual clinical case, illustrating both the theoretical principles and practical application of this treatment approach.

The CBT-E approach progresses through four distinct stages (Fairburn et al. 2003). The first stage, initial stabilization, focuses on establishing regular eating patterns, providing psychoeducation tailored to the individual's eating problem, and addressing weight-related concerns. This stage creates a foundation for change through collaborative formulation and behavioral modification. The second stage aims to review progress, evaluate treatment gains and develop a personalized plan for the core intervention stage. In the core intervention stage weekly sessions target the specific maintaining mechanisms of the individual's eating disorder, typically including overvaluation of body shape and weight, dietary restraint and its role in binge cycles, deficits in mood regulation and problem-solving. Final stage focuses on relapse prevention. The focus shifts to maintaining changes, developing strategies for managing setbacks, and preparing for long-term recovery.

This presentation will delve into the theoretical underpinnings and practical application of the CBT-E framework for BED through the lens of an actual clinical case. The case example will particularly highlight the implementation of core techniques, providing practical insights into the application of CBT-E in real-world settings.

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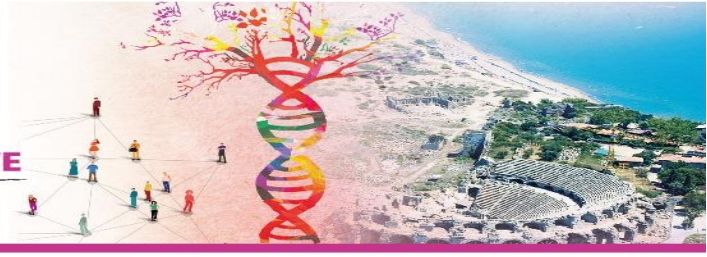


TRANSCRANIAL MAGNETIC STIMULATION (TMS) IN EATING DISORDERS: A PROMISING APPROACH?

Gamze Usta Sağlam

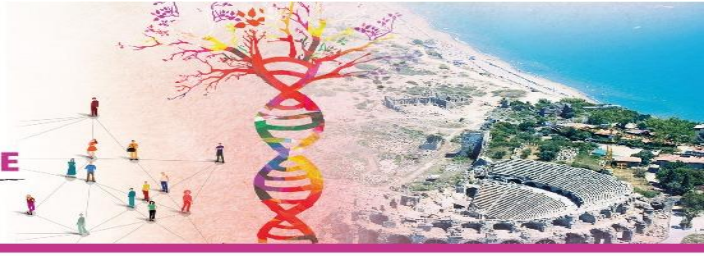
Istanbul University-Cerrahpaşa, Cerrahpaşa Faculty of Medicine, Department of Psychiatry

Eating disorders are serious conditions that can lead to long-term functional impairment and, in some cases, life-threatening consequences. Psychotherapeutic and psychopharmacological interventions are the primary approaches in the treatment of eating disorders, but their effectiveness is limited, and a significant proportion of individuals with eating disorders fail to achieve full or sustained recovery despite available treatments (Eddy et al. 2017). Given the increasingly understood neurobiological underpinnings of eating disorders, the use of repetitive Transcranial Magnetic Stimulation (rTMS) in treatment has come into consideration.

Research has identified disruptions in reward-related neurocircuitry—critical for regulating eating motivation—along with prefrontal cortex (PFC) hypoactivity in individuals with eating disorders (Rachid 2018). Specifically, the dorsolateral prefrontal cortex, which governs inhibitory control and cognitive flexibility, is often impaired in eating disorders. This dysfunction manifests behaviorally as poor impulse control (e.g., binge-purge cycles) and rigid, obsessive thoughts about food, weight, and body shape. Given the parallels between EDs and substance use disorders—where repetitive transcranial magnetic stimulation has shown efficacy in modulating cravings and addictive behaviors—the overlap in neural substrates (e.g., reward pathways and inhibitory systems) suggests rTMS may hold promise for ED treatment.

Results from rTMS studies in eating disorders have been mixed, though some evidence suggests beneficial effects on disordered eating behaviors and food cravings. Notably, rTMS has been associated with improved body mass index in individuals with obesity (Cavicchioli et al. 2022). Additionally, modest improvements in affective symptoms—including negative mood, depression, and anxiety—have been observed in eating disorder populations (Cavicchioli et al. 2022). The intervention appears to be well-tolerated and safe, supporting its potential therapeutic utility. While current findings are promising, particularly for binge eating disorder, the generalizability of these results remains limited due to small sample sizes and a lack of large-scale studies. Further research is needed to establish the efficacy of rTMS as a treatment for eating disorders.

In this presentation, we will address the following questions: What are the neurobiological mechanisms supporting the efficacy of rTMS in eating disorders? What do current data reveal about the effectiveness of rTMS for anorexia nervosa, bulimia nervosa, and binge-eating disorder? Which brain regions are targeted in rTMS applications for eating disorders, and what are the most commonly used protocols? In the light of these questions, we will discuss whether rTMS holds promise as a future treatment method for eating disorders.



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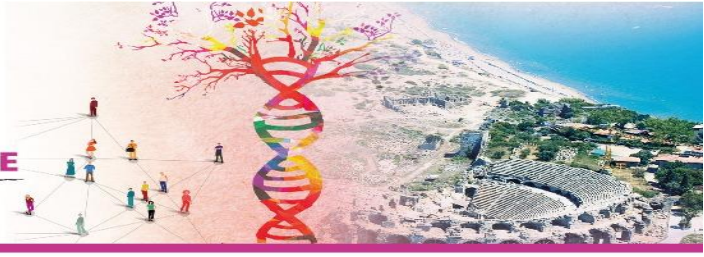


EVIDENCE-BASED APPROACHES IN THE TREATMENT OF VAGINISMUS: THE BIOPSYCHOSOCIAL MODEL

Gülin Özdamar Ünal

Department of Psychiatry, Faculty of Medicine, Süleyman Demirel University

Vaginismus, classified under genito-pelvic pain/penetration disorders in DSM-5, is characterized by persistent difficulties with vaginal penetration due to involuntary contraction of the pelvic floor muscles. It is typically accompanied by intense fear, avoidance behaviors, and negative emotional responses toward sexual activity. Although the etiology is multifactorial, the central role of anxiety, maladaptive beliefs, and conditioned avoidance behaviors necessitates psychological intervention as the mainstay of treatment.

Psychiatrists are well-positioned to manage the psychotherapeutic aspects of vaginismus. Cognitive-behavioral therapy (CBT) has shown the strongest evidence base. Treatment usually includes psychoeducation on anatomy and the sexual response cycle, cognitive restructuring of irrational beliefs, gradual exposure to feared situations through desensitization techniques, and the use of graded vaginal dilators combined with relaxation training. Techniques such as directed masturbation and mirror work are also helpful in improving body awareness and reducing avoidance.

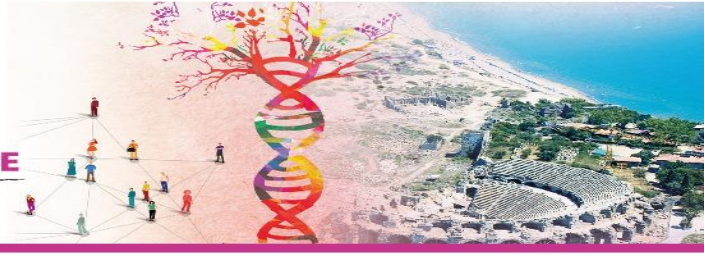
However, several unproven or potentially harmful treatment methods are still used, often leading to retraumatization or treatment resistance. Hymenectomy, for instance, is based on the misconception that structural barriers are responsible for penetration difficulties. It not only fails to address the underlying fear and avoidance patterns but may exacerbate psychological distress.

Another problematic approach is sexual intercourse under anesthesia, sometimes promoted as a “cure.” This method completely disregards the psychological and behavioral dimensions of the disorder. Such experiences may reinforce helplessness and dissociation and can severely damage the individual’s sexual autonomy and trust in therapeutic processes.

Short-term or superficial psychotherapies that avoid gradual exposure work and instead focus solely on insight or supportive counseling often fail to produce sustainable improvement. Without targeted behavioral interventions, these methods leave the core fear-response cycle untouched.

Hypnotherapy has also been suggested for vaginismus treatment in some settings. While hypnosis might contribute to relaxation and reduction of anticipatory anxiety in selected patients, there is insufficient empirical support for its standalone efficacy. Furthermore, relying on passive techniques may inadvertently reinforce the patient’s belief that change is not under her control.

Successful treatment requires a structured and collaborative therapeutic alliance that empowers the individual, helps her build tolerance to fear-inducing situations, and gradually restores sexual



agency. While cultural and interpersonal factors may shape symptom expression, treatment should focus on enhancing emotional safety, body familiarity, and sexual confidence through progressive and active methods.

In conclusion, vaginismus is a condition that responds best to evidence-based psychotherapeutic strategies centered on behavioral exposure and cognitive restructuring. Psychiatrists should be cautious about outdated or inappropriate interventions that neglect the psychological underpinnings of the disorder. Raising awareness of such ineffective methods is essential to protect patients and promote ethical, patient-centered care.

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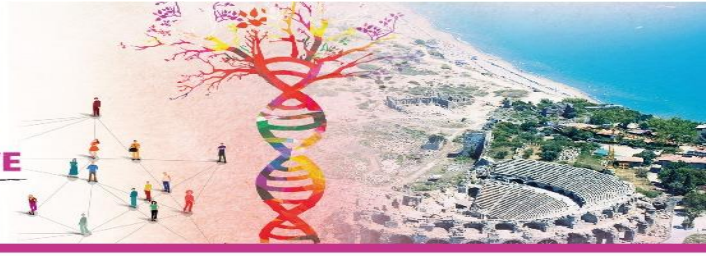


BRAIN SLEEP MAP: NEW HORIZONS WITH IMAGING TECHNOLOGIES AND CHEMICAL BALANCES

Gülsel Yalçın Raşa

Ankara Etlik City Hospital

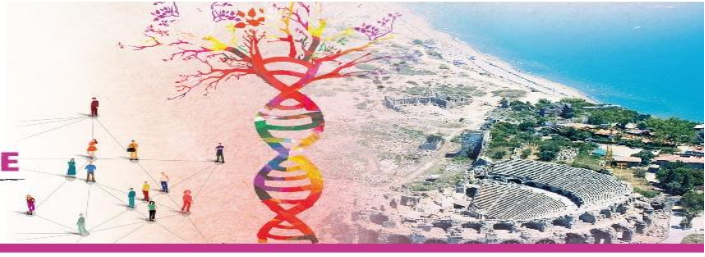
The year 2024 stood out with valuable studies in terms of sleep science, especially as a result of the integration of neuroimaging and neurochemical mechanisms. Thanks to the combined use of technologies such as functional magnetic resonance imaging (fMRI), positron emission tomography (PET) and electroencephalography (EEG), regional activity changes in the brain during sleep stages could be mapped more clearly than ever before.

A prospective study published this year evaluated the sleep and 24-hour activity rhythms of participants. No one was diagnosed with dementia at the beginning. At a mean follow-up of 7.8 years (2018 to 2021), researchers measured amyloid burden on PET. Sleep and activity were assessed by actigraphy for 7 days and nights to determine objective sleep and 24-hour activity rhythms. Plasma analyses looked at baseline amyloid-beta (Aβ) levels and phosphorylated tau (p-tau) and p-tau levels. In conclusion, this study highlights a link between fragmented sleep in 24-hour activity rhythms and increased Aβ accumulation at 7.8 years of follow-up (especially in APOE4 carriers)(1).

Understanding how sleep affects the glymphatic system and human brain networks is crucial to elucidating the neurophysiological mechanisms underlying the decline in memory functioning associated with aging. A 2024 study analyzed data collected from older adults via magnetic resonance imaging (MRI) and polysomnographic recordings. In older adults, inadequate sleep appears to disrupt the brain's glymphatic system, which is responsible for clearing toxins. This finding further supports the link between sleep and neurodegenerative diseases like Alzheimer's (2).

In a prominent biochemical study from 2024, researchers identified elements in the blood that could help determine whether a person had been awake for more than 24 hours. While taking a series of blood samples, the researchers used machine learning to identify five biomarkers of interest from hundreds of metabolites. By comparing the levels of these five biomarkers in the same person, the researchers were able to determine with almost 95% accuracy whether the person had been awake for more than 24 hours. Given that approximately 20 percent of road crashes worldwide are caused by lack of sleep, this approach to detecting acute sleep deprivation offers the potential to reduce crashes through "post-crash analysis" assessments (3).

In conclusion, the year 2024 marks a revolutionary period in terms of understanding sleep science not only at the symptom level but also at a holistic level with neurochemical and neuroimaging. These developments indicate that both diagnostic and therapeutic approaches may change radically in the coming years.



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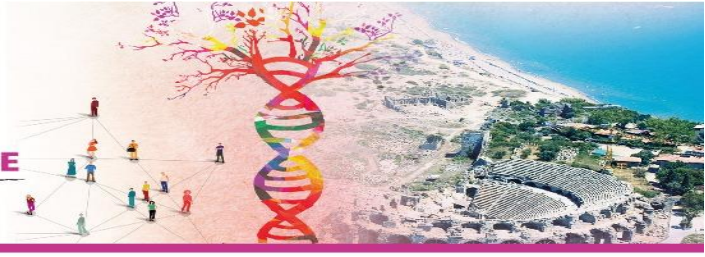


RECOGNIZING AND ASSESSING DELIRIUM

Gülşen Teksin

Department of Psychiatry, Faculty of Medicine, Tekirdağ Namık Kemal University

Question 1: How do we recognize delirium?

Delirium is an acute and fluctuating disturbance in attention and consciousness. Just as organ failure is critical for bodily systems, delirium can be considered a form of brain failure. It is typically caused by an underlying medical condition. If not diagnosed promptly and accurately, it carries a high risk of mortality.

Question 2: What are the masks of delirium? With which conditions can it be confused, and what are the diagnostic pitfalls?

Clinically, delirium is a "master of disguise." It can mimic a wide range of other clinical conditions, often leading to misdiagnosis. Advanced clinical assessment requires identifying which conditions may resemble delirium and recognizing the clues that help differentiate it.

Question 3: How do we conduct an advanced assessment? What should be done to confirm delirium and identify its cause?

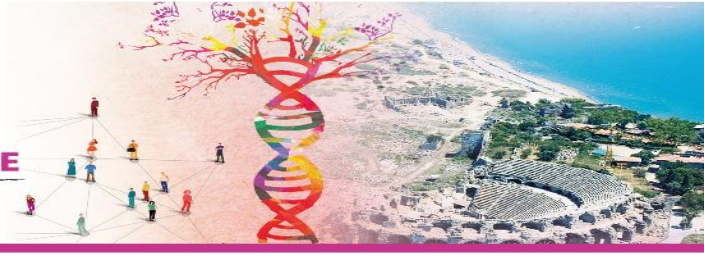
Confirming the diagnosis requires a systematic evaluation. Psychiatrists are generally familiar with the diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders. Structured tools such as the Confusion Assessment Method are also highly effective in clinical practice (Wei et al., 2008).

Question 4: How does delirium present across different clinical settings?

Delirium in an elderly internal medicine patient may present quite differently from delirium in a younger intensive care patient. This section explores how delirium manifests across diverse clinical populations and the specific challenges each presents.

Question 5: Once delirium is diagnosed, how broad is the psychiatrist's responsibility?

Delirium is often initially recognized by consultation-liaison psychiatrists. They are typically consulted due to symptoms such as agitation, hallucinations, disorientation, or



acute changes in mental status—and frequently make the initial diagnosis. But an important question arises: Is the psychiatrist's role limited to symptom control after diagnosis? Recent clinical guidelines suggest a much broader responsibility (Meagher et al., 2008).

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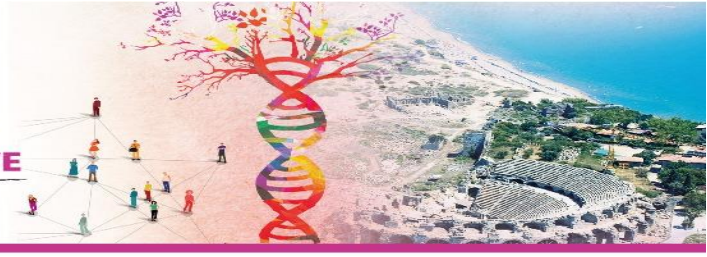


THOSE WHO DECİDE TO STAY İN THE RELATİONSHİP: REBUİLDİNG TRUST AND ENCOUNTERED BARRİERS

Hafize Gülnur ŞEN

İstinye University Faculty of Medicine, Department of Psychiatry

Infidelity is one of the most disruptive crises in marital relationships. After infidelity, couples often experience intense dilemmas between staying or leaving. In addition to external factors such as societal expectations, family structure, and the presence of children, individual psychodynamics also deepen this process. This section of the panel examines the psychological and emotional challenges faced by individuals who decide to stay after infidelity, the difficulties encountered in the therapeutic process, and the barriers to rebuilding trust from the perspective of family and couples therapy.

1. Psychodynamics of the Separation Decision

• After infidelity, separation not only affects the relationship but also deeply impacts an individual's self-perception, sense of belonging, and life scenario. The decision to separate is often intertwined with the following psychodynamic processes:

• Loss and Grief Process: Separation signifies the loss not only of the partner but also of the "constructed life," which leads to grief over the loss of a future.

• Identity Questioning: Questions such as “Who am I, what kind of relationship was I in, how did we get to this point?” lead the individual to reconstruct their identity.

• Alternating between anger, guilt, and a desire for freedom.

• Children and Societal Expectations: The decision to separate may conflict with the image of being a “good parent” and can put pressure on the individual.

2. Emotional and Psychological Difficulties of Leaving

• Choosing to leave after infidelity can be both liberating and traumatizing for many individuals. The following challenges are frequently encountered in therapeutic work:

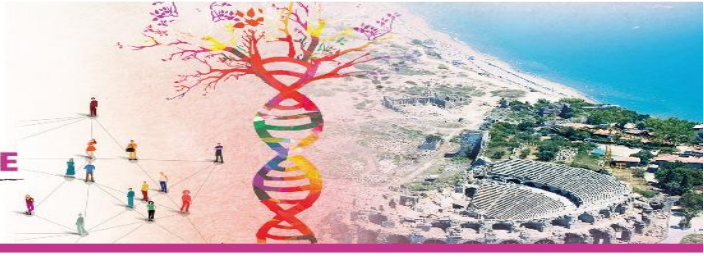
• Feelings of loneliness and worthlessness.

• Social Stigmatization: Especially for women, being separated can be culturally stigmatizing.

• Economic and Structural Changes: Establishing a new life requires both financial and emotional resources.

• Internalizing the Separation: Inner narratives such as “I failed” or “I will be alone” can make the process more difficult.

1. Rebuilding Trust and Encountered Barriers



• After infidelity, trust is shaken not only with the partner but also with relationships in general and the fundamental belief system about life. Even if the decision to separate has been made, the need to rebuild trust continues as an individual necessity. The main obstacles include:

• Incomplete or defensive explanations from the unfaithful partner hinder the rebuilding of trust.

• Lack of emotional empathy complicates the healing process.

• Issues of secrecy and transparency: Ongoing secrecy creates a constant state of vigilance.

• Impatience of the unfaithful partner: Statements like “It’s in the past, stop talking about it” suppress the process and re-traumatize the individual.

4. Therapeutic Approach and Intervention Principles

• In the therapeutic process, it would be beneficial to work according to the following principles:

• Creating space for emotions: Normalizing emotions such as anger, grief, and guilt.

• Acknowledging the grief process: Separation is also a loss and requires an appropriate grieving process.

• Processing the trust trauma: It is important to recognize that broken trust pertains not only to the partner but also to the individual's own instincts.

• Individual therapy needs: If necessary, individual psychotherapy should support identity reconstruction.

Conclusion

Leaving after infidelity is often not just a separation but a transformation of identity. This process can turn into an internal rebirth where the individual redefines their life, values, boundaries, and needs. The therapeutic space should ensure that this transformation is supported in a safe, meaningful, and inclusive manner.

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PATIENT WHOM OTHER DEPARTMENTS DO NOT WANT TO ADMIT DUE TO SUICIDE ATTEMPT

Hale Yapıcı Eser

Koç University School of Medicine, İstanbul

Patients who require hospitalization following a suicide attempt frequently encounter systemic barriers in general hospitals, where medical and surgical units may decline admission despite clear clinical need. This talk presents a structured synthesis of the literature addressing the multifaceted reasons behind such refusals, and aims to provide preliminary answers to critical clinical, ethical, and organizational questions frequently encountered by psychiatrists in these situations. Medical wards may deny admission due to concerns about legal liability, lack of training in managing suicidal behavior, or absence of appropriate infrastructure. The use of tools such has been shown to assist in triaging decisions within emergency departments, though their application remains inconsistent. General hospital inpatients who die by suicide often do so impulsively, during periods of unrecognized distress or delirium, and frequently without expressing suicidal ideation. These findings suggest that clearer interdepartmental protocols, improved psychiatric-medical liaison models, and hospital-wide education on suicide risk may help mitigate refusals and improve outcomes. A proposal for a consensus-building process and development of institutional pathways tailored to high-risk patients will be discussed.

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OBESITY AND DIABETES AS A TRANSDIAGNOSTIC DISORDER: WHAT THE PSYCHIATRIST SHOULD KNOW ABOUT GLP-1 AGONISTS

Hale Yapıcı Eser

Koç University School of Medicine, İstanbul

Obesity and type 2 diabetes mellitus (T2DM) are increasingly recognized not only as metabolic conditions but also as transdiagnostic syndromes with significant psychiatric and neurocognitive correlates. Glucagon-like peptide-1 receptor agonists (GLP-1 RAs), such as exenatide, liraglutide and semaglutide, have emerged as effective treatments targeting both glycemic control and weight loss. However, accumulating evidence suggests that their mechanisms extend beyond metabolic regulation. GLP-1 receptors are widely distributed in brain regions implicated in mood, cognition, and reward processing, including the hippocampus, hypothalamus, and ventral tegmental area. Recent studies demonstrate that GLP-1 RAs possess neuroprotective properties, enhancing neurogenesis, reducing neuroinflammation, and modulating dopaminergic signaling. Clinical and preclinical findings indicate potential benefits for affective symptoms, stress responses, and cognitive functions—domains frequently impaired in obesity and T2DM patients. For instance, exenatide use in obese individuals with T2DM was associated with increased perceived stress and higher depressive scores, mediated by stress reactivity rather than direct mood effects. Moreover, polymorphisms in the GLP-1 receptor gene have been linked to alterations in reward learning and anhedonia. These findings align with broader systematic reviews indicating GLP-1's regulatory role in reward circuitry and its influence on substance use behaviors. For psychiatrists, understanding the neurobehavioral effects of GLP-1 agonists offers new perspectives for treating comorbid psychiatric symptoms in metabolic disorders and opens a translational research frontier connecting endocrinology and psychiatry.

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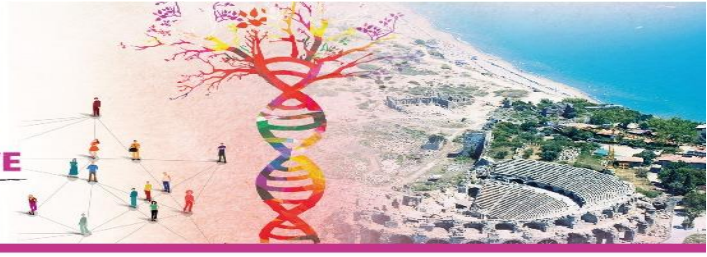


THROUGH THİCK AND THİN: FORENSİC PSYCHİATRİC CHALLENGES İN FAMİLY LAW

Hatice Kaya

Erenköy Mental Health and Neurological Diseases Training and Research Hospital

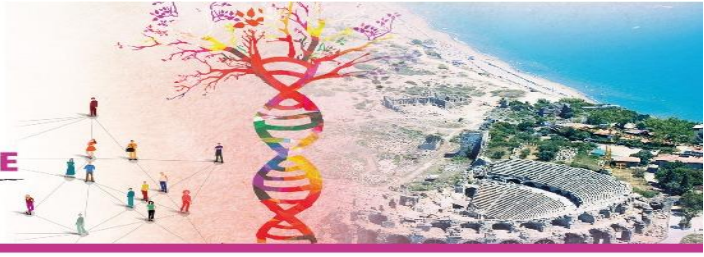
Custody refers to the set of rights and responsibilities granted to parents for the care, protection, and supervision of their minor children. While historically seen as the parents' absolute authority over their children, custody is now recognized as both a right of the parents and a responsibility aimed at meeting the needs and ensuring the welfare of the child. In divorce cases, decisions regarding child custody and the establishment of personal relationships with the child are evaluated based on the principle of the best interests of the child. According to Article 182 of the Turkish Civil Code (TCC), the judge must consider the child's physical and mental development when making decisions (1).

Custody rights are assessed on a case-by-case basis. However, they may be restricted in cases of psychiatric conditions that impair parenting functions, such as active psychotic disorders, treatment-resistant bipolar disorder, substance dependency, and severe personality disorders. The establishment of personal relationships with the child may only be restricted if it poses a significant risk to the child's psychosocial development (2).

In assessing a parent, adult psychiatrists should not only conduct diagnostic evaluations but also objectively evaluate parenting capacity. This assessment should include evaluating the entire family, determining the level of interaction between the family and the child, and assessing caregivers or third parties involved (e.g., teachers). Psychological tests should also be utilized, and assessments conducted by professionals specializing in children should be considered. In particular, in cases involving parental alienation syndrome (PAS), where a child develops irrational hostility toward one parent, often due to manipulation, a comprehensive evaluation by child and adolescent mental health specialists is essential. These findings should be considered when making decisions (3).

Another frequent issue in divorce proceedings is the accusation of mental illness by one party against the other. Such claims can lead to stigmatization and cause individuals to avoid seeking treatment. Therefore, these claims must be evaluated carefully, and reports should be prepared impartially, based on scientific evidence and in line with ethical principles.

Assessments of suitability for adoption are conducted within the framework of Articles 305–320 of the TCC (1). These assessments should holistically evaluate the individual's mental stability, parenting skills, and the environmental conditions they provide. In addition to structured psychiatric interviews, tools such as personality inventories, social evaluations, and consultations with addiction treatment centers (e.g., AMATEM) can be utilized to enhance diagnostic evaluations.



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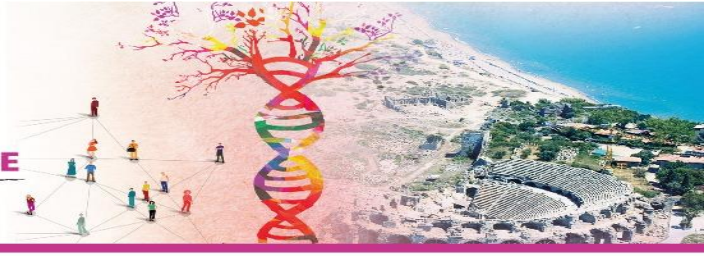

INAPPROPRİATE REPORT PREPARATİON REQUESTS: ETHİCAL AND PRACTİCAL CHALLENGES FACED BY YOUNG PSYCHİATRİSTS

Hatice Öztürk

Adana City Training and Research Hospital

We will focus on a significant problem area we encounter in the early years of our professional lives, particularly during critical assignments like mandatory service: inappropriate report preparation requests. Unfortunately, we often face situations where our patients have diagnostic expectations that do not align with our medical assessments, and they insist on having their reports prepared according to their wishes. These insistent demands can sometimes escalate to verbal and even physical threats. Furthermore, the frequent pressure from the administration to finalize reports hastily, often without the opportunity to conduct necessary examinations, puts us in a serious ethical dilemma. Moreover, when we disagree with a colleague's decision in certain cases, or when we receive special and unethical report preparation requests from our colleagues for a specific patient, we experience a profound conflict with our professional principles. One of the most distressing situations is the questioning of our right to make independent decisions and the potential for investigations to be opened regarding our completely medically justified health board decisions (1). These situations not only wear us down professionally as young psychiatrists but also psychologically, increasing feelings of burnout and damaging our faith in the profession. In this presentation, we will examine the different dimensions of these challenges in more depth, try to offer solutions in light of ethical principles, and emphasize the importance of professional solidarity in this regard.

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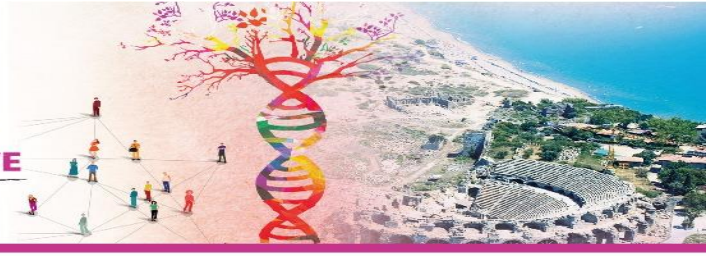

SELECTİON OF INDUCTİON AGENT İN ECT ANESTHESİA

Hayri Can Özden

Department of Psychiatry, Hacettepe University Faculty of Medicine

Electroconvulsive therapy (ECT) has been recognized as an effective method in the treatment of many psychiatric disorders. Thanks to the use of anesthesia, ECT has become much safer and is now associated with fewer complications. The primary purpose of using an induction anesthetic agent during ECT is to eliminate the awareness of muscle paralysis in the patient. In addition, the use of short-acting induction anesthetics in ECT helps to prevent musculoskeletal complications.

Commonly used anesthetic agents for induction include methohexital, thiopental, etomidate, alfentanil, remifentanil, propofol, and ketamine. The selection of anesthetics for ECT may vary from country to country, hospital to hospital, and depending on the experience of the practitioner. Induction anesthetic agents have dose-dependent effects that may increase the seizure threshold, which can negatively affect seizure induction and seizure quality. Furthermore, various side effects may occur following the use of each agent. An ideal agent for anesthesia induction in ECT should have minimal anticonvulsant properties and should not have hemodynamic effects that could interfere with an effective and safe ECT procedure. However, no such "ideal drug" currently exists, and induction agents differ in these respects.

The commonly used agents each have their advantages and disadvantages. Methohexital, an "ultra-short-acting" barbiturate with minimal anticonvulsant properties, is considered the gold standard for induction anesthesia, although it is not widely available globally. Propofol, one of the most frequently used agents, is considered safe in terms of its cardiovascular effects, but it is known to raise the seizure threshold. Studies have shown that etomidate, compared to propofol, is associated with longer seizure duration and better seizure quality. However, etomidate also has the potential to suppress adrenocortical function. In recent years, the antidepressant effects of ketamine have been increasingly studied, leading to its more frequent use in ECT. Although ketamine demonstrates superiority in terms of seizure duration and efficacy, its adverse effects on cognitive functions, the cardiovascular system, perceptual disturbances, and alterations in consciousness limit its use as a sole agent in ECT. In recent years, some authors have suggested the combined use of propofol and ketamine for ECT, as this combination is thought to preserve hemodynamics and reduce side effects. Research suggests that ketamine may balance the anticonvulsant effects of propofol, prolong seizure duration, and enhance the therapeutic efficacy of the treatment.

In summary, there is no definitive data on the efficacy, safety, or superiority of one induction anesthetic agent over another in ECT. However, in light of recent research and meta-analyses, our understanding of the advantages and disadvantages of these agents is gradually increasing. This

session aims to introduce the induction agents used in ECT anesthesia and to compare them in terms of their side effects, hemodynamic impacts, and effects on seizure threshold.

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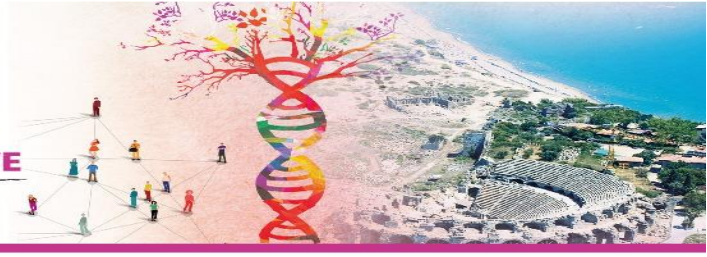


PSYCHEDELİCS AS A NOVEL TREATMENT MODALİTY (?)

Hayri Can Özden

Department of Psychiatry, Hacettepe University Faculty of Medicine

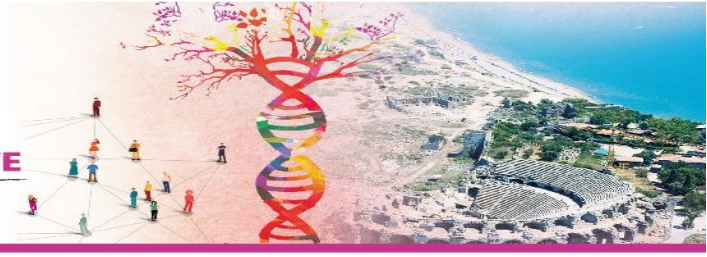
Major depressive disorder (MDD) continues to be a leading cause of disability, impairment, and even mortality, due to its high prevalence and the fact that approximately 30% of individuals receiving treatment do not achieve an adequate therapeutic response. Therefore, there is a pressing need for novel treatment modalities in depression.

One such emerging modality that has gained increasing attention in recent years as a "new treatment option" for major depression is the use of psychedelics. Classical psychedelics—including psilocybin, 1-propionyl-lysergic acid diethylamide, 5-methoxy-N,N-dimethyltryptamine, ayahuasca, mescaline, and 2,5-dimethoxy-4-bromophenethylamine—primarily exert their effects through the 5HT-2A serotonin receptor. This mechanism is distinct from that of serotonin reuptake inhibitors and is proposed to be associated with clinical response through rapid increases in neuroplasticity, formation of new connections between neural circuits, and changes in brain entropy.

Psychedelics produce a range of profound psychological effects, such as hallucinations, out-of-body experiences, sensations of "enlightenment" or "emotional release," and other mystical-type experiences. Notably, these effects—and the underlying biological mechanisms—have been observed to persist even after the substance is cleared from the body.

In the literature, there are proponents who argue that these effects, when experienced in an appropriate therapeutic setting and with psychological support, lead to improvements in depressive symptoms. Some studies have also shown that psychedelics, when used in patients with major depression, are associated with reduced rumination and increased cognitive flexibility—findings that are supported by neuroimaging data and linked to their antidepressant effects. The rapid and long-lasting effects of psychedelics are viewed by some as a potential advantage over existing antidepressant treatments.

However, despite these promising results, there are also authors who report unfavorable outcomes, such as lack of the desired therapeutic effect, abuse potential, psychotic symptoms following use, and gastrointestinal and cardiovascular side effects. Moreover, the absence of a standardized treatment protocol involving psychedelics, and the unclear therapeutic processes conducted under the influence of the substance, pose challenges to the feasibility and testability of psychedelic-assisted treatments. Additionally, there is a lack of sufficient data on the long-term physical and psychological effects that may arise from chronic use.



In this session, psychedelic substances will be introduced and their mechanisms of action briefly summarized. Current literature on their antidepressant effects and adverse outcomes will be reviewed, and the limitations of psychedelic therapies as well as the unanswered questions surrounding their use will be discussed.

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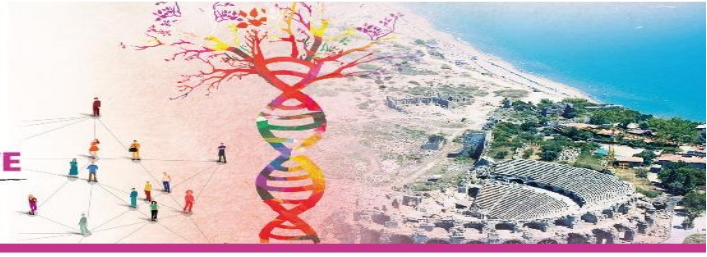


PAİN AND EMPATHY: AN OVERVİEW OF NEURAL PROCESSES

Hayriye Mihrimah Öztürk

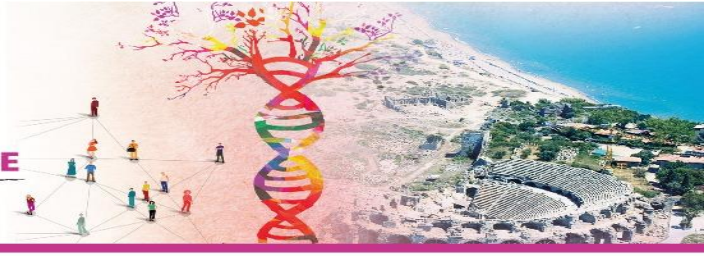
Kırıkkale University Faculty of Medicine, Department of Psychiatry

Empathy for pain involves perceiving, understanding and responding to the pain/pain of others. While a variety of definitions of empathy have been proposed, two core components are consistent across numerous conceptualizations: an affective response to another person that often, but not always, involves sharing that person's emotional state, and a cognitive ability to take the other person's perspective while maintaining a distinction between self and other (Jackson 2005, Timmers 2018). Pain is a multifaceted experience involving sensory discrimination, emotional motivation, and cognitive appraisal, and can be influenced by both emotional and cognitive factors.

Research shows that pain, a form of physical and psychological distress, can be socially transmitted from the person in pain to others through empathy. As suffering individuals communicate socially, others gradually understand their feelings or emotional states by observing their behaviors, cognitions, and emotional states during the interaction. In this process, pain is transferred from the suffering individual to others, creating pain empathy (Timmers 2018).

Even though the neural processing of self-pain perception has been studied extensively, less is known about how we perceive pain in others, although this aspect has important psychological implications. Research investigating emotional responses to encounters with someone who is suffering shows inconsistencies in both personal distress and empathic concern responses to the suffering of others, and the extent to which these are related to the activation of brain regions involved in processing the suffering of others. Several brain regions have been consistently associated with pain processing. These include the anterior cingulate cortex, the insula and, with less reliability, the thalamus and the primary somatosensory cortex (Jackson 2005, Lamm 2011). For instance, research showing a positive correlation between insula activation (anterior and posterior) and personal distress has shown that anterior insula activation is positively correlated with empathic anxiety during an empathic pain task (Timmers 2018).

fMRI studies have shown that when we observe others in pain, brain regions such as the anterior cingulate cortex (ACC) and the anterior insula are activated (Timmers 2018). A meta-analysis revealed that neural activation when observing others in pain overlaps with the direct experience of pain, including recruitment of the AI, aMCC, and precuneus (Lamm 2011). This suggests that some of the mechanisms that are activated when we feel our own pain are also activated when we observe others in pain.



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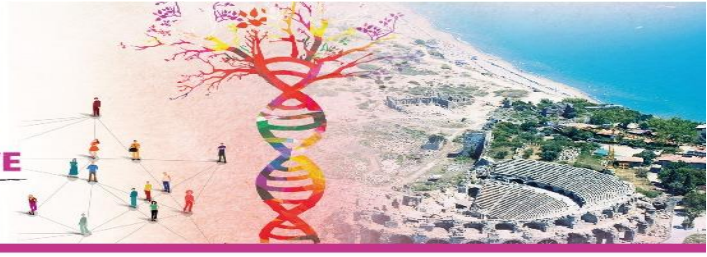


HYPERACTİVE DELİRİUM İN INPATİENT SERVİCES

Hayriye Mihrimah Öztürk

Kırıkkale Üniversitesi Tıp Fakültesi Psikiyatri AD

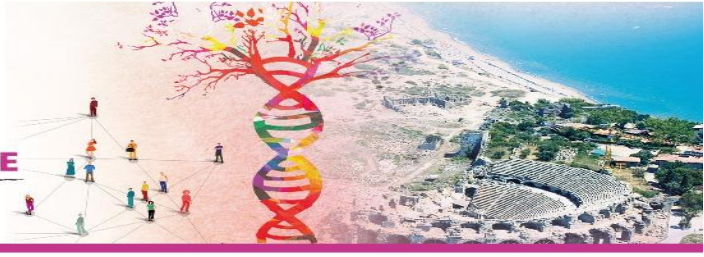
Delirium, also known as acute confusional state, is characterized by a sudden onset of cognitive impairment (Inouye 2014). Delirium, a syndrome characterized by an acute change in attention, consciousness, and cognition, is caused by a medical condition that cannot be better explained by a pre-existing neurocognitive disorder (Inouye 2014, Wilson 2020). Delirium occurs in 50% of hospitalized older adults. In 30-40% of cases, delirium is preventable but often fatal (Inouye 2014, Ormseth 2023).

Delirium is a common comorbidity of dementia and usually indicates more severe disease, poor physical health, and higher mortality. Patients can range clinically from decreased responsiveness near coma to hyperarousal and severe agitation. The characteristics of delirium tend to fluctuate throughout the day (Wilson 2020).

Because multiple factors are involved in the etiology of delirium, there are many possible neurobiological processes that contribute to its pathogenesis, including neuroinflammation, cerebral vascular dysfunction, impaired cerebral metabolism, neurotransmitter imbalance, and impaired neural network connectivity (Ormseth 2023). Predisposing and precipitating factors play a role in the development of delirium. Clinical symptoms of delirium include impaired attention (sustaining/focusing/shifting), impaired goal-directed thinking and planning, memory impairment, and perceptual disturbances (elementary hallucinations, paranoid delusions). There are hyperactive, hypoactive, and mixed types.

Treatment of delirium includes management of the underlying condition and symptomatic management. Nonpharmacologic approaches to initial symptom management are paramount and are recognized as the most effective strategy for delirium (Inouye 2014). These approaches include discontinuation or dose reduction of psychoactive medications, family involvement for orientation and comfort, behavioral methods for sleep and relaxation, ensuring sleep-wake cycles, early mobilization, ensuring vision and hearing, providing a quiet soothing environment, and pain management (Inouye 2014, Wilson 2020).

Although useful, nonpharmacologic approaches are not always effective in preventing or treating delirium, so clinicians often attempt to treat delirium with pharmacologic agents (Wilson 2020). Antipsychotics are the first line of pharmacotherapy, with haloperidol being the most commonly used due to its wide dose range and variety of uses. However, recent studies and reviews have shown that haloperidol or other antipsychotics are not as effective as thought. The large-scale MIND-USA study of 566 ICU patients showed that antipsychotics had no effect on treatment response, survival, duration of delirium, or number of days survived without delirium/coma



(Wilson 2020). The Society of Critical Care Medicine (SCCM) does not routinely recommend the use of haloperidol or atypical antipsychotics in the treatment of delirium (Wilson 2020).

Studies show an impaired circadian rhythm of serum melatonin levels in patients who develop delirium (Wilson 2020). Melatonin and the melatonin receptor agonist ramelteon have been used in the treatment of delirium (particularly sleep-wake cycle disorder), but no consistent evidence has emerged to support the use of these agents (Inouye 2014, Wilson 2020). A recent meta-analysis showed that melatonin treatment has a preventive effect on delirium (Wilson 2020). Dexmedetomidine, an alpha-2 agonist, has been shown to reduce delirium-related agitation (Inouye 2014, Wilson 2020). Other treatments, such as cholinesterase inhibitors and antiepileptic drugs, have not been shown to be effective in treating delirium (Wilson 2020).

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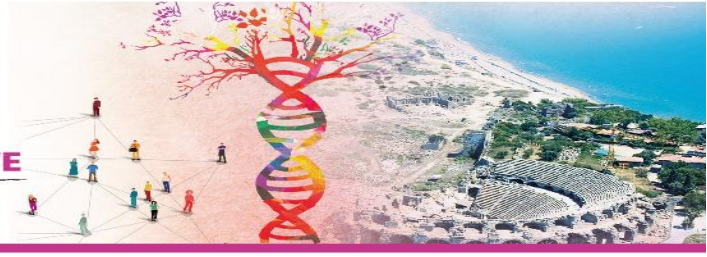


CAN ADDİCTİON TREATMENT BE PROVİDED İN PENAL İNSTİTUTİONS? HOW İS İT DONE?

Hüseyin Ozan TORUN

İzmir Şehir Hastanesi

Alcohol and substance use disorders are a common health problem among inmates. In today's conditions, it is now a great necessity for these treatments to be provided in penal institutions. Addiction treatments can also be provided in penal institutions, and there are various approaches and issues to implement these treatments effectively.

In penal institutions, attempts are being made to create structured treatment programs that include both institutional and post-release care. These programs usually include individual and group therapy sessions within the institution and then community treatment after release. Probation in our country is of great importance in this regard (Azbel et al., 2022).

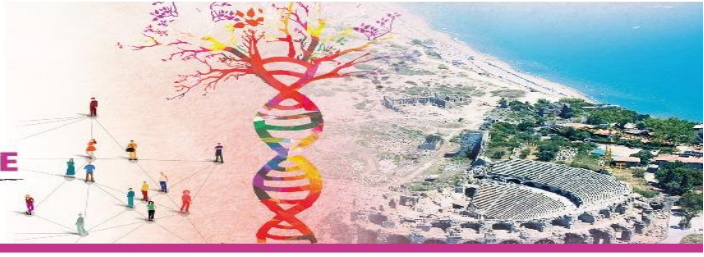
In addition to medical treatments, psychosocial interventions are also of vital importance. These can include cognitive-behavioral therapy and other forms of counseling aimed at preventing relapse and supporting recovery.

Ensuring that participation in treatment programs is voluntary is essential to respect individual autonomy and avoid coercion. Avoiding coercive practices is of critical importance. Treatment should be based on informed consent and voluntary participation. Efforts should also be made to reduce stigma among inmates receiving treatment, as stigma can undermine the effectiveness of rehabilitation efforts (Hyatt & Lobmaier, 2020).

The hospital referral process for convicted psychiatric patients involves several key steps and considerations to ensure timely and appropriate care. The process is often complex because of the intersection of legal and medical systems.

Referral processes require clear guidelines and communication between referring entities (e.g., prisons, courts) and psychiatric facilities. Lack of clarity in referral procedures can lead to inefficiencies and delays. Implementing standardized referral forms and flowcharts can help streamline the process and ensure that all necessary information is provided (Mohamed, 2025).

Addiction treatment in prisons can be effective if it includes structured programs, medication-assisted treatment, and psychosocial interventions. Key considerations include ensuring voluntary participation, ensuring continuity of care, and providing adequate resources. Avoiding coercion and reducing stigma are also crucial to the success of these programs.



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METHODS FOR COMBATİNG PEER İNFLUENCE AND RİSK BEHAVİORS FOR ALCOHOL AND SUBSTANCE USE DİSORDERS İN ADOLESCENCE (AGES 11-17)

Hüseyin Ozan TORUN

İzmir Şehir Hastanesi

Significant progress has been made in developing prevention programs for preventing drug abuse in adolescence. The most effective interventions target specific risk and protective factors at the individual, family, and/or community levels and are guided by relevant psychosocial theories regarding the etiology of substance use and addiction.

Combating peer influence and risk behaviors related to alcohol and substance use disorders in adolescents involves understanding and addressing the social dynamics that contribute to these behaviors. Effective strategies should include both prevention and intervention approaches that target peer influence and social norms.

Peer relationships are very important in this age group. Continuing education is one of the most protective factors for adolescents. Therefore, great importance should be given to not losing one's education (Darlington-Bernard et al., 2023).

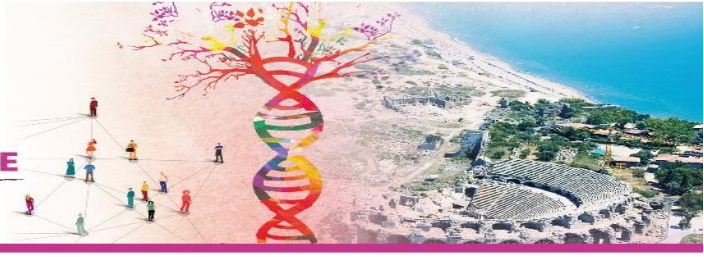
School-based programs are very important in terms of age. Programs that include social influence models focus on addressing peer pressure and social norms. These programs often involve peers in delivering interventions, which can be more relatable and effective for adolescents.

Informal peer-led interventions utilize natural peer interactions to disseminate information and influence behavior. These interventions have shown promising results in preventing substance use by positively leveraging peer influence.

Interventions such as Peer Network Counseling, which combines motivational interviewing with peer network strategies, have been effective in reducing substance use among adolescents. These interventions focus on changing the social environment and increasing peer support for prosocial behaviors (Herrmann et al., 2024).

Understanding peer selection and socialization is critical. Research highlights the importance of distinguishing between peer selection (selecting peers with similar behaviors) and peer socialization (adopting peers' behaviors). Effective programs need to address both processes to reduce substance use.

Adolescents' attitudes toward supporting skills that need to be developed should be emphasized. Self-awareness, self-management, social awareness, relationship skills, and responsible decision-making abilities should be developed (Castaldelli-Maia & Matakas, 2024). Effective strategies for combating peer influence and risk behaviors in adolescents include a combination of peer-led interventions, social influence models, and targeted efforts to reduce poor peer relationships. These approaches leverage the power of peer networks to promote positive



behaviors and reduce substance use, and emphasize the importance of addressing both peer selection and socialization processes.

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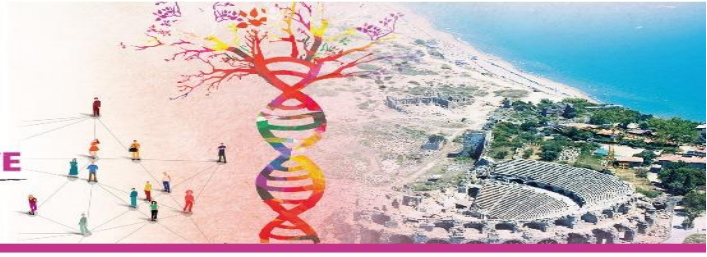


TREATMENT ADHERENCE İN SYSTEMİC DİSEASES PROBLEMS CAUSED BY ALCOHOL AND SUBSTANCE USE DİSORDERS İN CONSULTATİON-LİAİSON PSYCHİATRY PRACTİCE.

Hüseyin Ozan TORUN

İzmir Şehir Hastanesi

Alcohol and substance use disorders significantly affect treatment adherence in systemic diseases in consultation-liaison psychiatry practice. These disorders often complicate diagnosis and management and lead to difficulties in treatment adherence and outcomes.

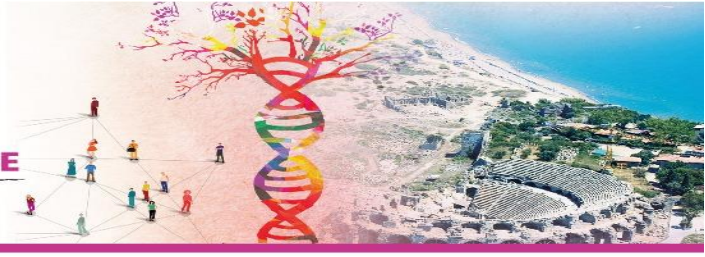
Alcohol and substance use disorders are often overlooked in general hospital settings and therefore underdiagnosed or misdiagnosed. This complicates the management of systemic diseases. The psychotropic effects of the substances used can mimic psychiatric disorders, making it difficult to make a correct diagnosis (Tucker et al. 2021).

The comorbidity of alcohol and substance use disorders with other psychiatric disorders is known as dual disorders and is becoming more common every year. Such conditions are also expected to be associated with poorer health outcomes, such as higher mortality and greater medical disease burden.

Patient participation in follow-up care is generally low in patients with alcohol and substance use disorders. Only a small percentage of these patients receive ongoing psychiatric follow-up, which is crucial for remission and recovery. In addition, this group of patients has psychosocial disadvantages. Patients with substance use disorders often face psychosocial disadvantages such as unstable housing and income, which can hinder treatment adherence (Hamm & Rosenthal, 2024).

Improving screening processes in hospitals can lead to better detection and management of substance use disorders. The development of integrated care models will be very helpful in this regard. Using a biopsychosocial model and integrating psychiatric care into general medical settings can improve management and outcomes for patients with substance use disorders. Furthermore, increasing psychiatric awareness among medical staff can improve diagnostic concordance and treatment planning, and ensure that patients receive appropriate interventions. Implementing multifaceted treatment plans that include medication, counseling, and support for psychosocial issues can improve treatment adherence and outcomes (Nordeck et al. 2018).

Alcohol and substance use disorders pose significant challenges to treatment adherence in systemic diseases within consultation-linkage psychiatry. Addressing these issues requires improved screening, integrated care models, and comprehensive treatment approaches to improve patient outcomes and adherence.



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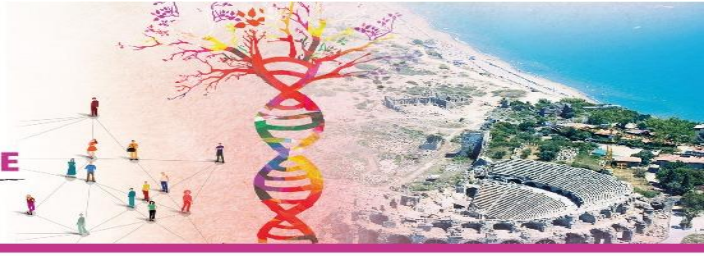
MILD BEHAVIORAL IMPAIRMENT: A PSYCHIATRIC WINDOW TO PRODROMAL DEMENTIA

İmge Coşkun Pektaş,

Gebze Fatih State Hospital, Department of Psychiatry, Specialist Physician

Neuropsychiatric symptoms (NPS) are common in patients with dementia, with prevalence rates as high as 97% after diagnosis (Peters et al., 2015)NPS are associated with more rapid cognitive decline, accelerated progression to severe dementia or death, and are also strongly associated with neuropathological markers of dementia (Peters et al., 2015). As a result of studies to identify and standardize neuropsychiatric symptoms, the concept and criteria for Mild Behavioral Impairment (MBI) were developed by the International Society for the Advancement of Alzheimer's Research and Treatment (ISTAART), a subgroup of the Alzheimer's Association (AA) (Ismail et al., 2016). According to these criteria, the patient should have clear behavioral, or personality changes observed by the informant or clinician in at least one of the following areas: decreased motivation, affective dysregulation, impulse control problems, social inappropriateness, or abnormal thinking and perception, starting later in life (≥50 years) and continuing intermittently for at least 6 months. Although these changes are severe enough to interfere with interpersonal relationships, social functioning, or work performance, the patient should be able to perform activities of daily living with minimal assistance or support. In addition, even if the patient has comorbid conditions, the behavioral or personality changes should not be due to another existing psychiatric disorder, general medical causes, or physiological effects of a substance/drug, and the patient should not meet the criteria for any dementia syndrome. According to these criteria, the patient may be diagnosed with MBI at the same time as mild cognitive impairment. Standardizing the assessment of MBI will help to define a target population for dementia treatment trials (Ismail et al., 2016).The Mild Behavioral Impairment Checklist (MBI-C) was developed for the detection of mild behavioral impairment because a measure with a wide range and a sufficient reference period was needed (Ismail et al., 2017). The scale has a total of 34 questions and each question is answered yes or no. The MBI-Checklist score was determined to be >8 to diagnose MBI (Ismail et al., 2017) . Widespread recognition of the concept of MBI as a possible prodromal stage of dementia among clinicians, researchers and clinical researchers will have important implications for improving the early detection, prevention and treatment of dementia and will help to better understand the early effects of neurodegenerative diseases (Ismail et al., 2016, 2017).



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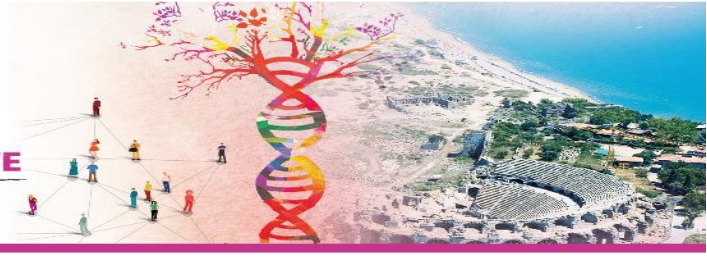

APPROACHİNG A CASE OF TRAUMA AND GRİEF FROM THE PERSPECTİVE OF SUPPORTİVE PSYCHOTHERAPY: A CASE REPORT

İrem ÖZKAYNAK DAĞLI

Eskişehir Osmangazi University Faculty of Medicine, Department of Psychiatry, Assistan Physician

Grief can be defined as a process in which individuals respond to the loss of a loved and valued person through emotional, cognitive, and behavioral reactions. Traumatic grief refers to a clinical condition that deviates from normal grief reactions, significantly impairs functioning, and is often intertwined with a history of trauma, particularly following sudden and unexpected losses. Early life traumas, especially those involving disruptions in secure attachment, may intensify reactions to subsequent losses. This case presentation will focus on the assessment and supportive psychotherapy process of a patient diagnosed with trauma and grief. Personal data that could reveal the patient's identity will not be disclosed, and written informed consent has been obtained from the patient for the case presentation. The patient has received approximately 25 sessions of supportive psychotherapy, and the therapy process is ongoing.

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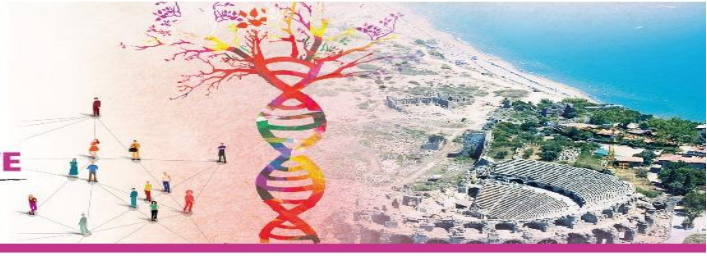


THE ROLE OF CONSULTATİON LİAİSON PSYCHİATRİSTS IN REDUCİNG THE STİGMA ASSOCİATED WİTH MENTAL ILLNESSES İN GENERAL HOSPİTAL PRACTİCE: UNİTE MENTAL AND PHYSİCAL HEALTH

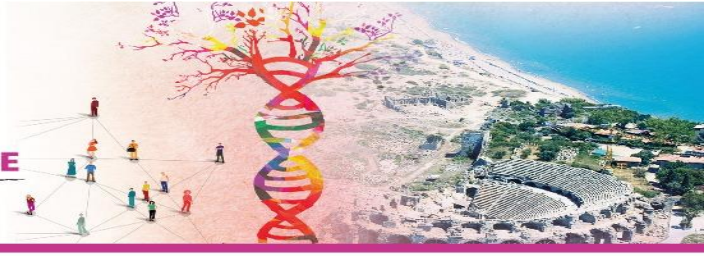
Doç. Dr. M. İrem Yıldız

Hacettepe Üniversitesi Tıp Fakültesi Psikiyatri Anabilim Dalı

Psychological factors such as chronic stress, poor psychological functioning and mental health disorders often contribute to the development of physical conditions such as obesity, diabetes, chronic heart disease and cardiovascular disease. Inversely, chronic and challenging illnesses with difficult-to-accept treatments also contribute to the development of mental illness. Thus, psychiatric illnesses frequently accompany physical illnesses and significantly affect patients' compliance with and response to treatment. The views, judgments and attitudes of physicians other than psychiatrists towards psychiatry and mental illnesses determine the health care received by patients with mental illnesses in relation to their physical illnesses. Appropriate consultation with the psychiatry department regarding patients' mental complaints and the effective implementation of consultation recommendations are also affected by these perspectives and attitudes. If we want to achieve a biopsychosocial medicine that aims to address patients' physical and psychological needs together, that does not see the mental and physical as separate and unrelated, we need to overcome our own professional mind/body dualism and stop distinguishing between 'mental' and 'physical' health. Consultation liaison psychiatry should see it as one of its goals to eliminate this dualism and to combat prejudice and stigmatization of psychiatry and psychiatric illness.

Promoting the development of positive attitudes towards people with mental illness among healthcare professionals working in general hospital services is likely to improve the quality of care provided to this vulnerable population. Similarly, reducing stigmatizing attitudes towards psychiatry and psychiatric treatment can be expected to have a beneficial impact on appropriate referral of general hospital patients and hence on early detection and treatment of psychiatric comorbidities. A better understanding of the cultural and other factors that influence these attitudes may help to improve the standards of mental health care in general hospitals.

This presentation will discuss ways in which consultation liaison psychiatrists can help patients receive better physical and mental care by reducing the stigma attached to mental illnesses and people with mental illnesses, so that a biopsychosocial approach that eliminates the body-mind dichotomy becomes dominant in general hospital services.



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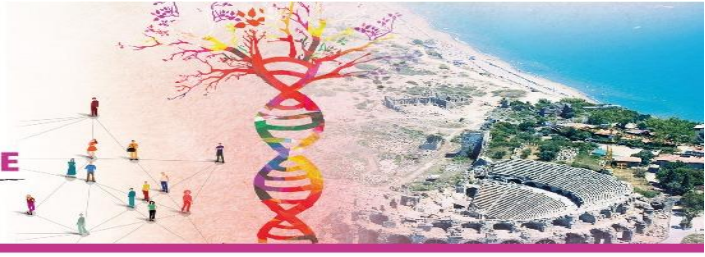

THE ROLE OF PSYCHİATRİSTS İN BARİATRİC SURGERY

İrem Ekmekci

Gazi University, Ankara

Bariatric surgery is an effective treatment modality for individuals with severe obesity, resulting in significant and sustained weight loss as well as improvements in metabolic and cardiovascular comorbidities. However, the success of surgical intervention is contingent not only on medical and surgical factors but also on psychological preparedness and long-term behavioral adherence. Psychiatrists play an essential role in the multidisciplinary assessment and management of bariatric surgery candidates, contributing to both preoperative evaluation and postoperative care.

The preoperative psychiatric assessment serves multiple functions. Psychiatrists evaluate patients for the presence of mental health disorders that may interfere with informed consent, adherence to postoperative recommendations, or psychological adaptation after surgery. Commonly screened conditions include major depressive disorder, anxiety disorders, substance use disorders, eating disorders (particularly binge eating), and personality pathology. While psychiatric illness is not an absolute contraindication to surgery, unmanaged or severe psychopathology may warrant deferral or treatment prior to proceeding. Additionally, psychiatrists assess the patient's decision-making capacity, level of social support, and coping strategies, which are critical for navigating the postoperative period (Sarwer et al., 2016).

Another central function of psychiatric involvement is to address patient expectations and motivation. Unrealistic beliefs—such as assuming surgery will resolve all emotional or interpersonal issues—can lead to postoperative disappointment and psychological distress. Furthermore, significant changes in body image and social identity following weight loss may precipitate adjustment difficulties. Psychiatric input ensures that patients have a realistic understanding of the surgical process and are psychologically prepared for its challenges and implications (de Zwaan et al., 2011).

Psychiatric care does not end with the surgery itself. Long-term mental health follow-up is important, particularly given the evidence of increased vulnerability to certain psychiatric conditions postoperatively. Research indicates a heightened risk of depressive episodes, substance misuse (especially alcohol), eating pathology, and suicidality in subsets of patients following bariatric surgery (Mitchell et al., 2015). Psychiatrists contribute by offering pharmacologic management when needed, providing psychotherapy (e.g., cognitive-behavioral therapy), and working collaboratively with the broader multidisciplinary team to support patient adjustment and behavioral compliance.

In sum, psychiatrists serve a multifaceted role in the bariatric surgery pathway, encompassing assessment, risk mitigation, therapeutic support, and long-term follow-up. Their involvement is integral to improving psychosocial outcomes, enhancing patient safety, and supporting durable

surgical success. As such, the inclusion of psychiatric expertise within bariatric surgery programs is not only beneficial but essential to providing comprehensive, patient-centered care.

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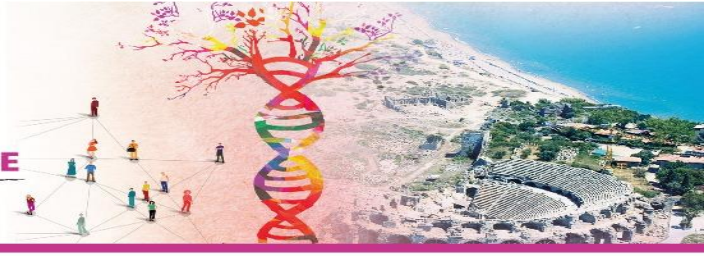


TREATMENT REFUSAL AMONG CANCER PATIENTS

İrem Ekmekci

Gazi University, Ankara

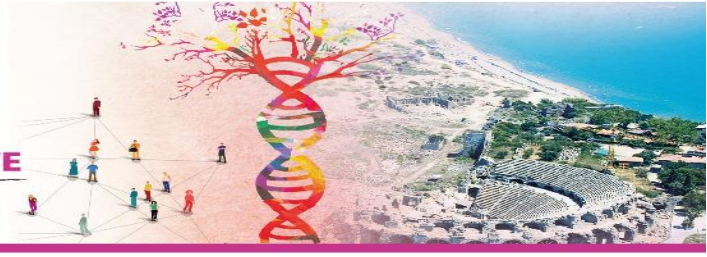
Treatment refusal among cancer patients is a complex and multifactorial phenomenon that poses significant challenges for healthcare professionals. Despite advances in cancer detection and treatment, some patients choose to decline recommended therapies, including surgery, chemotherapy, radiation, or targeted therapies. Understanding the reasons behind such refusals is crucial for promoting patient-centered care and optimizing clinical outcomes.

Several factors influence a patient's decision to refuse cancer treatment. These may include psychological, cultural, social, and spiritual beliefs. For instance, fear of side effects, mistrust in medical systems, previous negative experiences with healthcare, or the desire to seek alternative therapies can contribute to treatment refusal. In some cases, patients may not perceive their condition as life-threatening or may prioritize quality of life over treatment longevity (Balboni et al., 2013). Cultural values and religious beliefs can also shape attitudes toward illness and treatment. In certain communities, illness may be perceived as a spiritual trial, and treatment refusal may be seen as acceptance of divine will.

Cognitive and emotional states, such as denial, depression, or cognitive impairment, can further complicate decision-making. Elderly patients or those with lower health literacy may have difficulty comprehending the risks and benefits of treatment. Communication barriers between patients and providers—whether due to language, inadequate explanation of treatment options, or failure to address patient concerns—also play a role. Studies have shown that patients who feel uninvolved in their care or unsupported emotionally are more likely to refuse treatment (Houldin et al., 2006).

The impact of treatment refusal on patient outcomes is significant. Multiple studies have demonstrated that refusal of standard cancer treatments is associated with increased mortality and decreased quality of life. For example, a population-based study by Choi et al. (2015) on patients with non-small cell lung cancer found that those who refused treatment had a substantially lower survival rate compared to those who received therapy. However, some patients may find personal meaning or psychological peace in refusing treatment, particularly if they are in advanced stages of disease and wish to avoid the burden of aggressive interventions.

Healthcare professionals have an ethical responsibility to respect patient autonomy while ensuring informed decision-making. This requires clinicians to assess the patient's decision-making capacity, provide clear and compassionate information about prognosis and treatment options, and explore underlying reasons for refusal. In some cases, involving a multidisciplinary team—including palliative care, psychiatry, social work, and chaplaincy—can help address the complex needs of these patients. Shared decision-making models and culturally sensitive communication strategies can foster trust and support more informed choices.



In conclusion, treatment refusal among cancer patients is a multifaceted issue requiring nuanced understanding and compassionate care. Recognizing the interplay of medical, psychological, and cultural factors can help clinicians support patients in making informed and values-consistent decisions.

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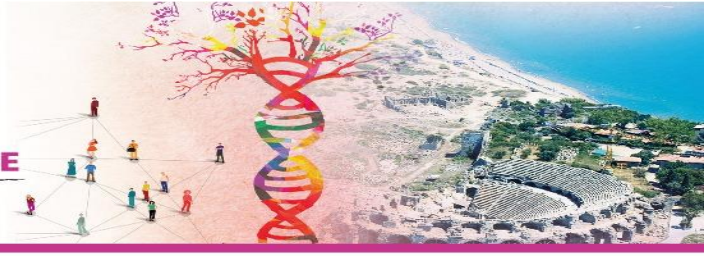
PREGNANCY AND SLEEP HARMONY: DYNAMİCS OF NORMAL SLEEP AND CHANGES İN THE MATERNİTY PROCESS

Kader Semra Karataş

Department of Psychiatry, Faculty of Medicine, Kütahya Health Sciences University

Sleep is a different dimension of consciousness affected by the dynamics of many systems such as reversible neurobiological, neurophysiological, neuroendocrine, circadian rhythm. Sleep has an important role in the renewal of the body, growth, regulation of metabolism, conservation of energy, neuronal plasticity and maturation, strengthening and protection of the learning and memory system. The restorative theory is a theory that is stated to be important in sleep dynamics that comes to the fore with the examination of anabolism and catabolism cycles. The body being catabolic throughout the day, the regulation of protein metabolism as a result of the effectiveness of the anabolic cycle during sleep, and the relationship between growth hormone (GH) secreted during the NREM period have also been shown. Therefore, in order for any repair process of the organism not to be disrupted, first the NREM period and then the REM period are regulated. In the NREM phase, the release of hypothalomopituitary adrenal hormones ACTH, cortisol, TSH is inhibited, while the release of GH and prolactin is activated. The peptide called ghrelin released from the stomach is effective in GH release. It has been reported that leptin released from adipose tissue increases NREM N3 sleep and decreases REM sleep. Excitatory neuropeptides such as orexin (hypocretin) and ghrelin cause wakefulness and increased appetite, while leptin released during sleep causes a decrease in appetite and regulates energy metabolism. The main factor determining the circadian cycle is the dark and light cycle. In addition, physical activity, timing of meals, melatonin and social factors are also important in the formation of the 24-hour circadian rhythm in the setting of the endogenous clock with the rhythmic oscillation of the inner core of the suprachiasmatic nucleus in the hypothalamus and the sensitivity of the shell to light (1).

Pregnancy, perhaps the most special phase of a woman's life, is a process in which physiological, psychological and social changes occur. Fetal growth and development during pregnancy affect the sleep-wake cycle with changes in the anatomical, physiological, biochemical hormonal system and circadian cycle in the woman's body to prepare for birth. In the physiologically based interaction of hormones, the basic physiological sleep changes seen during the menstrual cycle, especially the increase in progesterone levels in the peri-ovulatory and mid-luteal phases associated with the increase in progesterone in the luteal phase, increase wakefulness after sleep onset (WASO) and lead to sleep fragmentation. When the luteal phase of the menstrual cycle, when postovulatory progesterone and estradiol are high, is compared to the follicular phase when progesterone is low, increased EEG activity is seen in the frequency range of sleep spindles (12-16 Hz) in NREM sleep. Postpartum objective sleep measurements reveal significant differences between mothers and non-mothers. Postpartum mothers have decreased sleep efficiency (SE), total sleep time (TST), and REM sleep percentage compared to non-pregnant women, and SE



improves over time, from 79.7% in the 2nd week to 90.2% in the 16th week after birth (2). Actigraphy studies have shown that parents' TST and SE decrease after birth, while wakefulness after sleep onset (WASO) increases. These changes are most evident in the first four weeks after birth, but begin to improve by 16 weeks (3).

As a result, women's sleep dynamics differ due to neurobiological, neurophysiological, neuroendocrine, and circadian changes during the menstrual cycle, pregnancy, and menopause.

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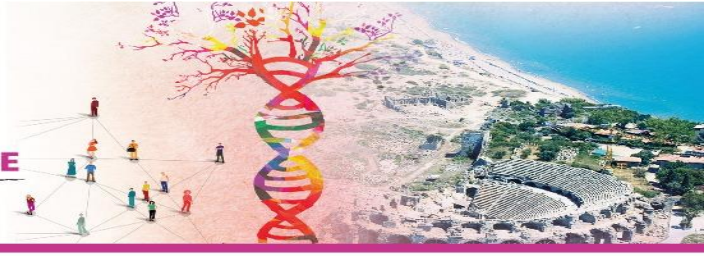

PHENOMENOLOGİCAL INTERPRETATİON OF ASSOCİATİVE PROCESSES AND THE OBSERVER'S ROLE

Mehmed Ediz Çelik

Selçuk Üniversitesi Tıp Fakültesi Psikiyatri Anabilim Dalı

This presentation addresses "Structural Thought Disorders" within a phenomenological framework, suggesting that disorganized associations, flight of ideas, and neologisms are not exclusive to schizophrenia or other psychotic disorders. Instead, they may appear in mood disorders, personality disorders (PDs), and even nonclinical populations. Although conventional psychiatric approaches classify these signs as primarily "pathological," recent perspectives propose a continuum in which normal and abnormal forms of thought may overlap (Sass 1992). Such a view challenges rigid boundaries between healthy and disturbed thinking, indicating that these phenomena may not be limited to extreme cases.

From Karl Jaspers's foundational phenomenological psychopathology (Jaspers 1913) to modern research, investigators strive to grasp formal thought disorder by considering subjective logic. For instance, flight of ideas can merge with a patient's heightened energy in mania, whereas transiently disorganized associations can emerge in nonclinical individuals under high stress or insufficient sleep. Crucially, the interviewer's stance matters. A phenomenological approach includes exploring the interviewer's biases, mood, and emotional responses. If the clinician is exhausted or focused narrowly on diagnosis, subtle aspects of the patient's narrative may be overlooked or inadvertently exacerbated, while an empathic, curious posture fosters more open disclosure.

Case vignettes illustrate how seemingly "disorganized" speech may reflect distinct experiential states. In schizophrenia, it can align with a subjective sense of self-fragmentation; in mania, it may express elevated mood and rapid ideation; in nonclinical contexts, it might be a short-lived byproduct of stress. Failing to consider underlying subjective meaning can lead to oversimplified diagnoses. This presentation highlights that formal thought disorders are not exclusive to a single diagnostic group but may manifest along a broader spectrum.

Beyond psychotic illnesses, transient paranoid or chaotic thinking may surface in borderline PD, and flight of ideas or blocking can occur in mood disorders. Here, recognizing the interplay between the patient's expressive style and the interviewer's responses is crucial. The "intersubjective field," an idea rooted in Jaspers's emphasis on understanding (Verstehen), underscores how the clinician's emotional and cognitive states shape the therapeutic encounter. By "bracketing" their preconceptions, interviewers can appreciate the patient's lived experience more fully.

Ultimately, the presentation's central message is that structural (formal) thought disorders transcend simple categorical explanations. Rather than being confined to psychosis alone, they represent multifaceted phenomena calling for a phenomenological lens. This approach demands

awareness of both patient and observer factors, enhancing diagnostic accuracy and the therapeutic alliance. Beneath apparently incoherent speech may lie existential concerns, affective fluctuations, or unique communicative styles. Recognizing that normal and pathological thought processes often interweave underscores the fluid nature of these phenomena, which are seldom sharply demarcated. In sum, appreciating the subjective dimension of disorganized thinking, alongside the clinician's role in shaping the assessment, can significantly enrich our understanding and care of individuals presenting with these forms of communication.

Additional contemporary work (Stanghellini and Fuchs 2013) underscores integrating phenomenological sensitivity into clinical practice fosters deeper insight into patients' experiences, reducing premature judgments and encouraging empathetic engagement. A broader view of formal thought anomalies thus emerges, requiring clinicians' reflective participation.

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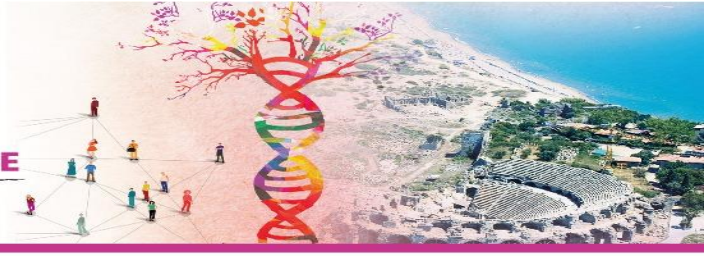


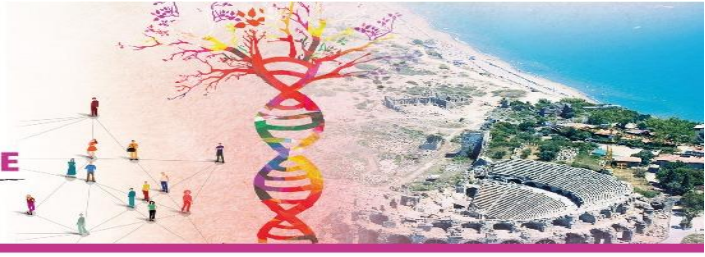
VANILLA, KINK AND BEYOND: RETHINKING THE BOUNDARIES OF SEXUALITY

Meliha Öztürk

Serbest Hekim-İstanbul

In this presentation, we aim to explore the effects of BDSM((Bondage and Discipline, Dominance and Submission, Sadism and Masochism) practices on individuals, relationships, and society; examine the boundaries and potential risks of BDSM; and finally, address the question of how to become a kink-aware clinician. BDSM practices can significantly influence individuals, relationships, and society. Psychologically, consensual BDSM may enhance trust, communication, and self-awareness, contributing positively to mental health. In relationships, BDSM can foster intimacy, mutual understanding, and role clarity, strengthening bonds. However, if practiced non-consensually or unsafely, it may lead to psychological harm, trauma, or social stigma. Society's perception of BDSM varies, often influenced by cultural norms and misconceptions, which can affect individuals' social acceptance and legal considerations. Overall, when conducted responsibly and consensually, BDSM can promote personal growth and healthy relational dynamics, but risks remain if boundaries are violated. Understanding these impacts requires a nuanced approach that considers individual differences and societal contexts. Unusual sexual behaviours can carry potential risks and boundaries, both physical and psychological. These behaviours may increase the likelihood of injury, sexually transmitted infections, or emotional distress if performed without consent or proper safety measures. It is essential to recognize personal limits and communicate openly with partners. Engaging in risky activities without adequate knowledge or precautions can lead to long-term psychological consequences, such as guilt or anxiety. Healthcare professionals emphasize the importance of informed consent and safe practices to minimize harm. Understanding individual boundaries and seeking professional advice when exploring unconventional behaviours can help ensure safety and well-being. Overall, awareness and responsibility are crucial when engaging in atypical sexual activities.

Becoming a kink-aware therapist involves developing a nonjudgmental, informed, and affirmative stance toward clients who engage in kink, BDSM, or other alternative sexual practices. Research from the past seven years emphasizes the importance of self-awareness, ongoing education, and supervision in addressing therapists' implicit biases and avoiding pathologization. Effective kink-aware therapists adopt a sex-positive and consent-focused framework, understanding kink as a valid expression of intimacy and identity. Building cultural competence in this area requires engaging with kink communities, relevant literature, and clinical training that includes non-normative sexualities. This approach fosters safer therapeutic spaces and enhances trust and openness in the therapeutic alliance.



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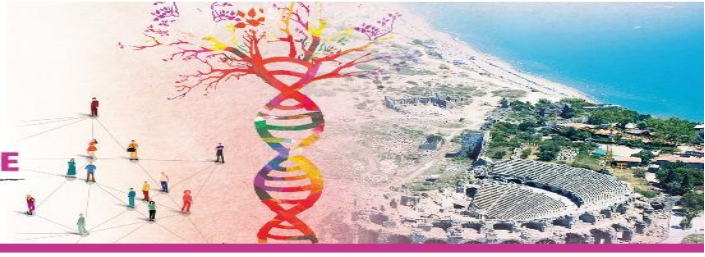


BRAIN EXCITABILITY: ITS NEUROBIOLOGY, MEASUREMENT, AND MODULATION

Melike Kocahasan

Koç University School of Medicine, Istanbul, Türkiye

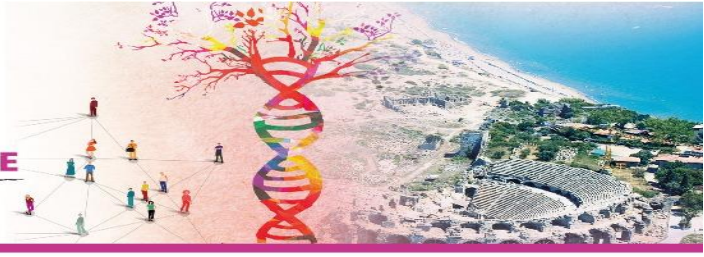
In this presentation, participants will be introduced to the concept of neuronal excitability, a core feature of the human brain that enables rapid signal transmission and dynamic adaptation. We will begin with a historical overview to contemporary understanding of action potentials (AP)—short bursts of electrical activity generated by ion flow across neuronal membranes (Bear et al. 2007).

The physiological mechanisms that underlie excitability will be discussed in detail, including resting membrane potential, ion channels, and ion pumps such as the Na^+/K^+ ATPase. The role of sodium (Na^+) and potassium (K^+) ions in generating the AP will be illustrated step by step. These processes form the basis for neuronal communication and set the stage for more complex phenomena such as learning and memory (Bear et al. 2007).

In the second part of the talk, we will explore synaptic plasticity, with a focus on long-term potentiation (LTP)—a process through which repeated stimulation strengthens synaptic connections. We will highlight the role of N-methyl-D-aspartate (NMDA) receptors in calcium-mediated intracellular signaling, leading to increased postsynaptic sensitivity (Citri and Malenka 2008). These insights lay the groundwork for understanding how neuronal circuits adapt over time.

The final section of the presentation will introduce non-invasive neuromodulation techniques. The basis of neuromodulation will be explained and the neuromodulation techniques will be introduced and compared. The transcranial direct current stimulation (tDCS) and transcranial magnetic stimulation (TMS) will be dicussed further detailly. These techniques not only offer therapeutic potential in neuropsychiatric disorders but also serve as tools to probe and modulate brain function (Lewis ve ark. 2016).

Overall, this presentation will provide a conceptual and practical framework for understanding brain excitability and its modulation. Attendees will gain foundational insights into how electrical signals give rise to complex mental functions and how we can begin to influence these processes with modern neuromodulatory approaches.



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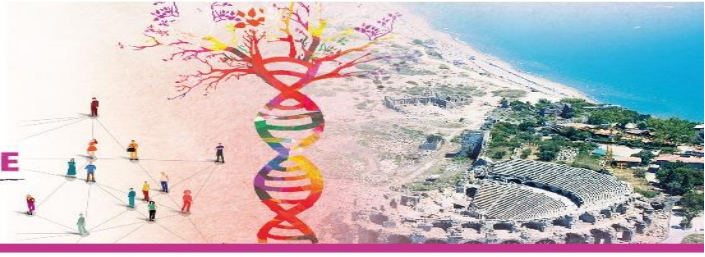

THE ROLE AND IMPACT OF THE UNIT FOR THE PREVENTION OF SEXUAL VIOLENCE AND THE PROMOTION OF GENDER EQUALITY

Meltem Çınar Bozdağ

Ağrı Eğitim ve Araştırma Hastanesi

Within professional organizations, establishing dedicated mechanisms to address sexual violence is essential. The Unit for the Prevention of Sexual Violence and the Promotion of Gender Equality of the Psychiatric Association of Türkiye (PAT) serves as a notable example of institutional responsibility and care. Established under the auspices of the PAT Central Executive Board, the Unit comprises at least five appointed members, with diverse representation from various working groups and committees, and includes a mandatory minimum of three women members. Its mission is clear: to prevent sexual violence, support those affected, and promote a culture of gender equality [1].

The Unit operates on principles of confidentiality, prompt response, empathy, and strong ethical commitment. Upon receiving a report of sexual harassment or violence, the procedure is initiated solely based on the testimony of the applicant, with no requirement to present supporting evidence in order to begin the investigation. At least two members of the Unit—and, if requested, a legal advisor—meet with the applicant to ensure that they feel safe, heard, and informed. The process prioritizes minimizing trauma, empowering the survivor, and addressing the systemic roots of violence.

The responsibilities of the Unit extend beyond reactive measures. It actively organizes educational programs, promotes awareness, and collaborates with external organizations to enhance the broader response to sexual violence. Additionally, it engages in the development of internal policies aimed at fostering an inclusive and respectful environment for individuals of all genders.

By addressing power imbalances, supporting survivors, and advocating for systemic change, the Unit exemplifies the endeavor to establish not only a safer workplace but also a more equitable professional field. Its work demonstrates that ethics, care, and justice can—and must—coexist within medical and academic institutions.

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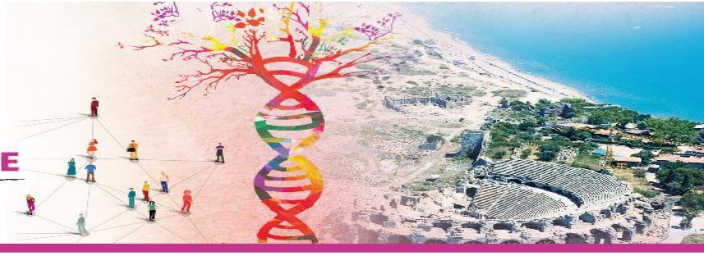


UNDERSTANDİNG PSYCHOSİS İN THE CONTEXT OF HUMAN HİSTORY

Merve Cura

Child and Adolescent Psychiatrist, Private Practitioner, Ankara, Turkey

Psychosis represents not merely a cluster of neuropsychiatric symptoms but a profound existential rupture that challenges the boundaries of human consciousness and cultural order. Across history, this enigmatic experience has been interpreted as madness, prophecy, divine illumination, or social deviance—each shaped by prevailing epistemic frameworks, cultural norms, and political ideologies. This presentation seeks to reconceptualize psychosis not simply as a diagnostic entity, but as a manifestation of disrupted subjectivity and fractured meaning-making at both individual and societal levels.

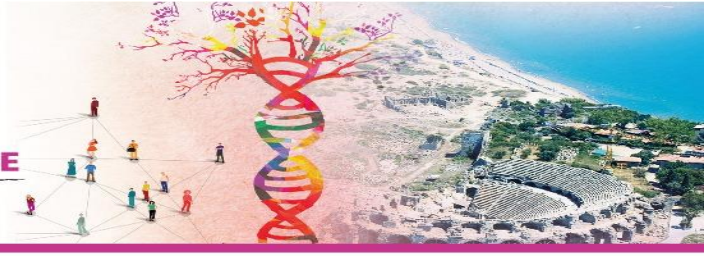
In Ancient Greece, madness was often viewed as a sacred phenomenon. In *Phaedrus*, Plato describes "divine madness" as a means of accessing truth beyond rational comprehension. The trance states of oracles, while now pathologized as hallucinations, were once considered privileged gateways to higher knowledge. During the Middle Ages, these same phenomena were reinterpreted through a theological lens—conflated with heresy, demonic possession, and witchcraft. By the seventeenth century, the emergence of psychiatric institutions signaled a shift: as Foucault (2006) argues, modernity consolidated reason by excluding madness, enclosing it within new medical and social architectures. This exclusion extended to collective memory, solidifying psychosis as both clinical anomaly and social transgression.

Psychosis, in this framework, becomes not only a clinical condition but a symbolic return of what history has sought to repress: irrationality, violence, alterity. According to Scull (2015), the cultural construction of madness reflects a society's anxieties and values—changing across time, yet always revealing what the normative order cannot contain. In this sense, psychotic experiences may externalize what a culture collectively disavows, turning personal crisis into a mirror for historical trauma.

From a psychoanalytic perspective, psychosis is conceptualized as either a failure of repression or a structural exclusion from the Symbolic Order. Delusions are not arbitrary distortions, but urgent attempts by the subject to impose coherence upon a fragmented world. Though perceived as illogical, they operate within an internally consistent narrative logic.

Parnas and Zahavi (2002) propose a phenomenological view of psychosis as a disturbance in the individual's embodied and temporal relationship with the world. Here, psychosis is not simply a set of symptoms, but a disintegration of ontological continuity—marked by collapse in self-world boundaries, temporal orientation, and intersubjective attunement. It reflects a state not merely of suffering, but of existential estrangement.

This presentation advocates for an integrative understanding of psychosis that encompasses neurobiological, phenomenological, philosophical, and cultural dimensions. At its core,



psychosis reveals the limits of human subjectivity, the fragility of meaning, and the ways in which the mind and culture intersect in the construction—and deconstruction—of reality.

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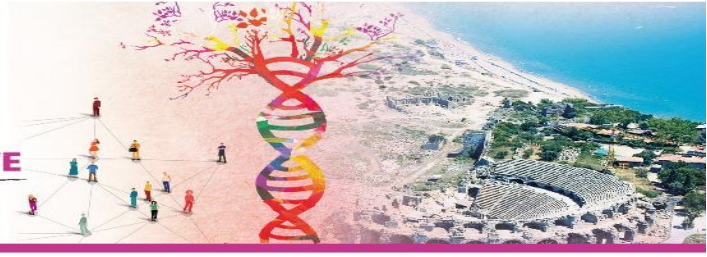

PSYCHODRAMA İN THE CLİNİC: PSYCHODRAMA WİTH PATİENTS İN THE PSYCHİATRİC WARD

Merve Cura

Child and Adolescent Psychiatrist, Private Practitioner, Ankara, Turkey

Group-based psychotherapy has become an essential component of psychiatric inpatient care, providing a structured yet flexible framework for improving emotional regulation, insight, interpersonal functioning, and treatment adherence. This presentation examines the clinical utility of psychodrama within this broader context, drawing on evidence from national and international studies.

Psychodrama—a method rooted in action and role exploration—offers unique advantages within inpatient settings, particularly through techniques such as role reversal, doubling, and enactment. These methods facilitate emotional expression, increase empathy, and enable patients to reframe interpersonal experiences in a safe, shared environment. An Israeli study involving an open psychodrama group for inpatients found reductions in feelings of loneliness and alienation, while simultaneously promoting group cohesion and emotional containment (Rosenbaum & Ron, 2018). Similarly, a randomized controlled trial in Turkey involving inpatients diagnosed with opioid use disorder reported significant decreases in anxiety and higher long-term treatment adherence following psychodrama sessions (Yıldırım et al., 2020).

In a systematic review of 18 clinical trials, Şarlak and Öztürk (2021) highlighted psychodrama's broad therapeutic impact across multiple domains—including reductions in depressive symptoms, improvements in coping skills, and enhanced social functioning. These findings not only support the viability of psychodrama itself but also reflect the broader therapeutic value of structured group interventions within psychiatric care.

In conclusion, while psychodrama is sometimes viewed as a niche or adjunctive modality, emerging empirical evidence increasingly positions it as a clinically relevant and adaptable intervention—particularly for inpatient populations. Its integration within multidisciplinary treatment frameworks may serve to enrich therapeutic engagement and foster deeper psychological change.

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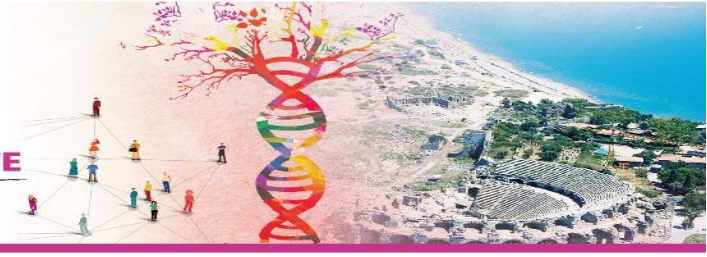
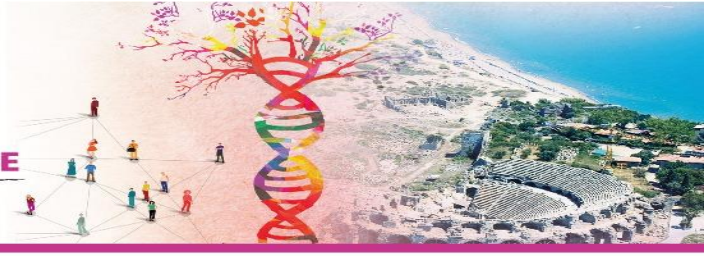


DİFFİCULT CONDİTİONS FOR TALKİNG ABOUT SEXUALİTY: WORKİNG CONDİTİONS, SOCİO-CULTURAL DYNAMİCS, PRİVACY AND TRUST

Merve Gümüşay

Haydarpaşa Numune Training and Research Hospital

Sexuality is a complex concept that encompasses biological, psychological, mental, spiritual, emotional, relational, social, economic, cultural, and political dimensions. It is influenced by gender, heteronormativity, class, and race-based pressures, and is shaped by cultural norms and scenarios. Sexuality is experienced and expressed through thoughts, desires, fantasies, beliefs, attitudes, values, behaviors, practices, roles, and relationships. When discussing sexuality, it is important to consider sexual rights and pleasure, as well as addressing any sexual problems individuals may be facing. These problems are common, with studies showing that at least one in three people, regardless of gender, experience some form of sexual dysfunction in their lifetime. Along with a lack of education, psychosocial and cultural factors also play a significant role in the developmentand continuation of sexual dysfunctions. Conservative attitudes towards sexuality, a lack of formal sexual education, the perception of sexuality as a taboo, prevalence of sexual myths, family attitudes, subculture perspectives, psychological traumas and the emphasis on virginity can all contribute to the prevalence of sexual problems in societies where sexual liberalism is not widely accepted. These same psychosocial and cultural factors can also make it difficult for individuals to talk about their sexuality. In traditional societies, discussing sexuality may be considered shameful or inappropriate, with women often facing more restrictions than men. In psychiatric outpatient services, one of the challenges is being able to address patients' multidimensional needs within a limited time frame. Factors such as short examination times, difficulty in ensuring privacy, and not being able to see the same physician due to working conditions can all impact the patient-physician relationship and make it difficult to discuss sexuality. In outpatient clinics, it is crucial to create an environment that allows individuals and couples to feel comfortable and safe expressing themselves. When individuals feel safe both individually and socially, they are more likely to talk openly and honestly about their sexuality. Overcoming the barriers that make it difficult to talk about sexuality is essential for individuals and couples to access accurate and scientific information, establish healthy relationships, and become aware of their sexual health. Therefore, it is important to prioritize creating a safe and supportive environment for discussing sexuality in healthcare settings.



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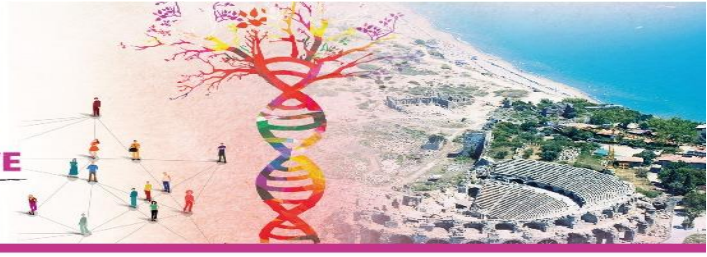

DECIDING TO CONTINUE A RELATIONSHIP AFTER INFIDELITY: REBULDING TRUST AND DIFFICULTIES

Merve Yiğit Başkan

Serbest Hekim

Infidelity is a common occurrence in couple therapy and one of the most difficult situations for couple therapists. The revelation of a partner's affair (sexual or emotional) comes as a shock to the hurt partner, even when doubts exist. The loss of trust in a relationship is no different from a physical loss. The process of grief includes five emotional stages to recovery from loss: Denial, anger, bargaining, depression, acceptance. In addition, the hurt partner often suffers from a Post-Traumatic Stress Disorder (PTSD) reaction following an affair's discovery. Recurrent recollections and intrusive visualizations, flashbacks, oscillating moods, confusion, irritability, shame, hyper-vigilance, avoidance, detachment, loss of focus and hopelessness about the future can be observed. Sleep disorders, generalized anxiety, depression, obsessions and intrusive thoughts may occur. Betrayed partner experiences insecurity, decreased self-esteem and numbness.

It is important to note that these reactions are normal responses and can benefit from couple therapy. An affair shakes everything that the hurt partner believes in their understanding of themselves and the world. If both partners want to give their relationship a chance; they can learn to atone, attune and attach through couple therapy. Learning to trust again after betrayal is a slow process and extremely challenging. However, both partners must first accept that they each have work to do to recover from the pain.

Rebuilding trust is handled in three stages: Atone, attune and attach. For these aims the betrayer must end the affair and be willing to apologize for cheating in a sincere way and promise not to repeat it. The unfaithful partner must be honest, use full disclosure about the affair and find a way to atone or express remorse, deal with the traumatic feelings after the discovery and be willing to ask and answer questions. On the other hand the betrayed partner should express feelings without accusations and try to use "I" messages. Our purpose is to help the betrayed person find a way forgive or at least accept their partner's actions and work towards forgiveness. Both partners should learn talking about intense feelings respectfully without blame, judgment, criticism and contempt. They also need to be more attuned and to spend regular time together with rituals of connection. Partners need to find a way to connect emotionally and sexually or attach.

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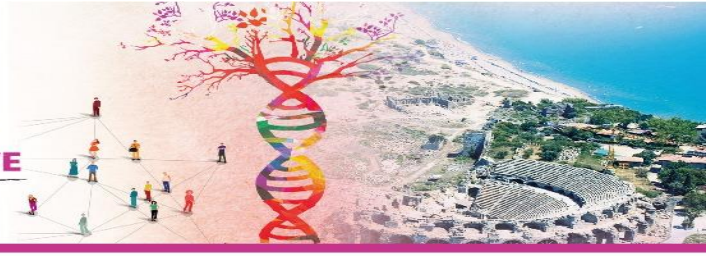


CO-OCCURRİNG ALCOHOL WİTHDRAWAL AND TRAUMATİC BRAİN INJURY

Muhammed Hakan Aksu

Gazi Üniversitesi Tıp Fakültesi Psikiyatri Anabilim Dalı

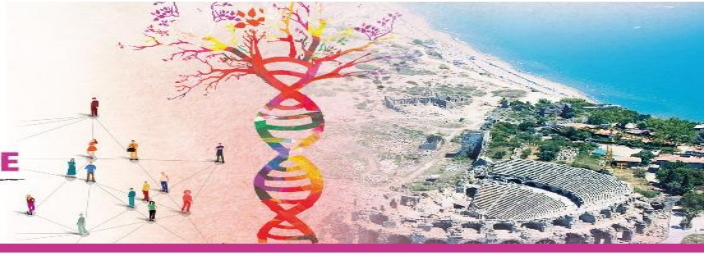
Traumatic brain injury (TBI) and alcohol withdrawal (AW) are significant causes of morbidity and mortality, even when considered separately. However, the co-occurrence of these two clinical conditions poses substantial complexities in both diagnostic and therapeutic approaches. The frequent presentation of trauma-related hospital admissions in individuals with a history of alcohol dependence underscores the clinical importance of TBI and AW comorbidity. The direct and indirect effects of alcohol on brain function predispose individuals to neurological and psychiatric comorbidities, while AW syndrome encompasses a range of physical, psychological, and neurological symptoms resulting from the abrupt cessation or reduction of alcohol consumption.

In cases where TBI is complicated by AW, the clinical picture can become further obscured. AW symptoms, such as tremor, anxiety, diaphoresis, seizures, and delirium tremens, which arise from alcohol's impact on neurotransmitter systems, can overlap with or exacerbate the direct neurological findings of trauma. Distinguishing between acute TBI complications like cerebral edema and hemorrhage, and AW-induced agitation and confusion, is critically important. Furthermore, post-TBI cognitive and behavioral changes can coincide with the psychiatric symptoms of AW, complicating accurate diagnosis.

From a therapeutic standpoint, the co-existence of TBI and AW necessitates a multidisciplinary approach. The primary goal is the safe and effective management of AW symptoms. Benzodiazepines are commonly used pharmacological agents to control severe AW symptoms. However, the level of sedation and the potential risk of respiratory depression must be carefully evaluated in the presence of TBI. Concurrently, the neurological effects of TBI should be closely monitored, and neurological consultation should be sought when necessary. The management of complications such as increased intracranial pressure and seizures should be addressed independently of AW treatment.

In the long term, the treatment of underlying alcohol dependence is a crucial component of the recovery process following TBI. Psychoeducation, motivational interviewing, support groups, and pharmacotherapies (e.g., naltrexone, acamprosate) are strategies aimed at achieving alcohol abstinence and preventing relapse. In individuals with post-TBI cognitive and behavioral issues, the adaptation of these treatments and their integration with neuropsychological rehabilitation may be required.

In conclusion, AW complicated by TBI is a complex clinical entity requiring careful and individualized management. Both the control of acute withdrawal symptoms and the



management of the neurological effects of trauma must be addressed concurrently, while long-term treatment should focus on alcohol dependence and the rehabilitation of potential neuropsychiatric sequelae. This holistic approach can enhance patients' chances of recovery and reduce the risk of long-term complications.

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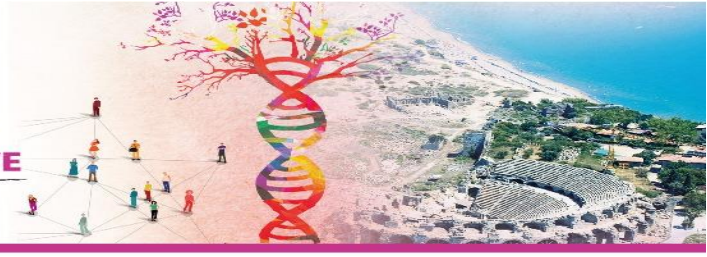


COMORBİDİTY OF SCHİZOPHRENİA AND OBSESSİVE-COMPULSİVE DİSORDER (OCD): CLİNİCAL FEATURES AND TREATMENT APPROACHES

Nılay Bılgın

Turkan Ozılhan State Hospıtal

The comorbidity of schizophrenia and Obsessive-Compulsive Disorder (OCD) has garnered increasing attention in the psychiatric literature. The prevalence of obsessive-compulsive symptoms (OCS) in individuals with schizophrenia is reported to be as high as 25%, while the rate of diagnosable OCD is approximately 12%. These figures are significantly higher than those in the general population, suggesting the possibility of shared pathophysiological mechanisms.

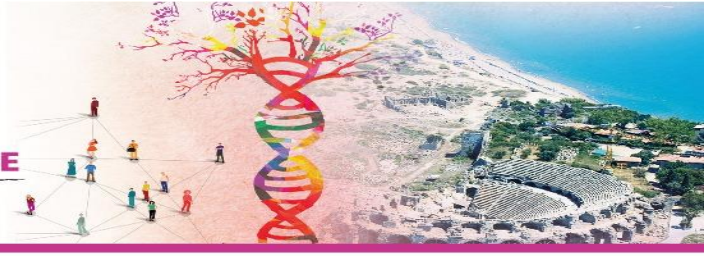
Historically, Kraepelin classified OCD as a "neurosis," while Bleuler noted the presence of obsession-like symptoms in patients with schizophrenia. Since the 1990s, the term "schizo-obsessive disorder" has been proposed, implying that such patients may represent a distinct clinical subtype. Clinically, these individuals often exhibit a heavier symptom burden, poorer overall functioning, elevated suicide risk, more severe positive and negative symptoms, and lower quality of life compared to patients diagnosed solely with schizophrenia.

The diagnostic process is often complex. The distinction between obsessions and delusions is not always clear-cut, as lack of insight can cause obsessive thoughts to resemble psychotic content. DSM-5 has acknowledged this ambiguity by including the specifier "with absent insight" under the diagnostic criteria for OCD.

Pharmacological treatment commonly involves the combination of antipsychotics and selective serotonin reuptake inhibitors (SSRIs). However, some antipsychotics — particularly those with high serotonergic (5-HT2A) and low dopaminergic (D2) receptor affinity, such as clozapine, olanzapine, and high-dose risperidone — may exacerbate or induce OCS. In contrast, agents like aripiprazole (a partial D2 and 5-HT1A agonist), amisulpride (a primary D2 blocker), and haloperidol appear to have more neutral or even reducing effects on obsessive symptoms. The positive correlation observed between 5-HT1A receptor partial agonism and OCS induction suggests that serotonergic modulation may influence symptom emergence via dopaminergic pathways.

Cognitive Behavioral Therapy (CBT), particularly Exposure and Response Prevention (ERP), remains the most effective psychotherapy for OCD. In patients with schizophrenia and comorbid OCD, CBT can be beneficial once psychotic symptoms are stabilized and the patient is capable of therapeutic engagement.

In conclusion, the comorbidity of schizophrenia and OCD necessitates nuanced diagnostic and therapeutic approaches. From a spectrum perspective, it is increasingly recognized that these disorders may represent dimensional expressions of shared vulnerabilities. In the future, clearer definitions of subtypes such as "schizo-obsessive disorder" may emerge, improving classification and treatment strategies.



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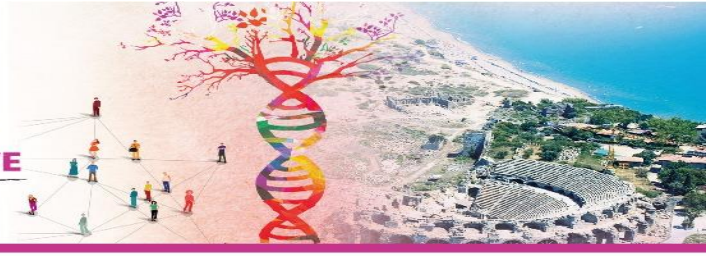


STIGMA RELATED TO MENTAL ILLNESS IN EMERGENCY AND INPATIENT SERVICES

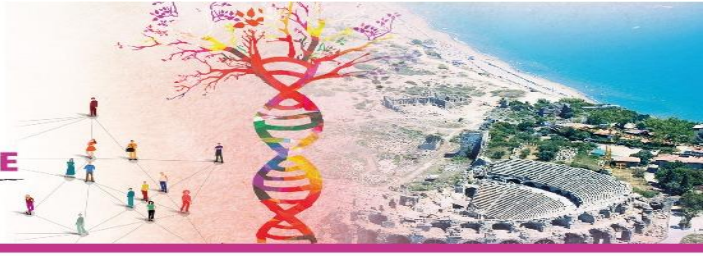
Nilgün Oktar Erdoğan

Pamukkale University Faculty of Medicine, Department of Psychiatry

Although healthcare professionals are expected to provide compassionate and unbiased care, they may—often unintentionally—contribute to the stigmatization of individuals with mental health conditions. This stigma can have serious consequences, limiting access to appropriate care, worsening health inequalities, and increasing both morbidity and mortality among people living with serious mental illness (SMI). Evidence shows that individuals with SMI are two to three times more likely to die prematurely than the general population. Their risk of death from infections such as HIV, hepatitis, and gastrointestinal illnesses is twice as high; they are three times more likely to die from respiratory infections, and four times more likely to die from pneumonia (Wahlbeck, 2011). These outcomes cannot be explained by lifestyle factors alone. One important contributor is diagnostic overshadowing—a tendency to attribute physical symptoms to a person's psychiatric diagnosis, which leads to missed or delayed treatment (van Nieuwenhuizen, 2013). The physical health of individuals with mental illness has long been neglected within health systems, and this oversight continues today. Stigmatization in healthcare takes place on three interconnected levels: structural, interpersonal, and internalized. Structural stigma includes barriers like inadequate funding for mental health, poor integration between physical and mental healthcare, limited psychiatric education in medical training, and unequal access to resources. Interpersonal stigma arises from interactions between patients and healthcare workers and often involves misinformation, prejudice, and discriminatory behaviors. Internalized stigma occurs when individuals absorb negative societal attitudes, leading to feelings of shame, social withdrawal, reduced self-esteem, and lower treatment adherence. Healthcare professionals' attitudes can either reinforce or help alleviate this self-stigma (Henderson, 2014).

Emergency departments and inpatient units are settings where stigma can be especially pronounced. Patients with mental illness may be made to wait longer, receive lower triage priority, or be left out of decision-making processes. In many cases, care is overly focused on medication, while important elements like psychotherapy, rehabilitation, and social support are overlooked.

Encouragingly, there is growing evidence that even small, focused efforts can lead to meaningful changes in how mental illness is perceived within healthcare settings. Simple measures that promote awareness, empathy, and critical self-reflection among professionals have shown promise in reducing stigma and improving the quality of care. These findings suggest that changing attitudes does not always require large-scale reforms—consistent, well-designed educational approaches can make a real difference.



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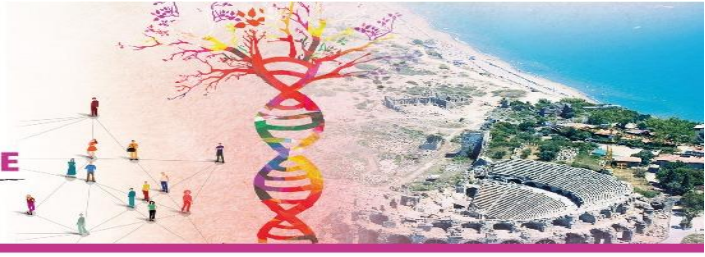

TRAUMA, TİME, MEMORY, AND REPRESENTATİON

Nur Nihal TÜRKEL

Ankara Ceza İnfaz Kurumları Kampüs Devlet Hastanesi

T

Trauma upends the neat march of Chronos—the measurable, cause-and-effect time that calendars and wristwatches record. A single shock can snap the linear arrow, scattering moments so completely that the present is forever ambushed by fragments of the past. Yet the survivor does not float in a timeless void; instead, life shifts into the realm of Kairos, an ever-unfolding “now” where experience is felt, not counted. In this existential register, yesterday’s terror can flare up inside today’s sunlight, and a heartbeat can feel as long as a season. From a phenomenological and psychoanalytic view, this shift is less a defect than a radical re-ordering of how subjectivity temporalizes the world. When the psyche is overwhelmed, it re-draws its own private map of time—one that no longer obeys external clocks. Memory becomes vivid but unanchored; identity feels both hyper-present and strangely absent. The traumatized person lives inside a dialectic: Chronos still ticks in the background, but Kairos claims center stage, demanding that each sensation be met as if for the first time. Representation—whether through words, images, movement, or even silence—acts as a bridge between these two modes. A journal entry strings scattered scenes into narrative beads, giving Chronos a foothold. A painting suspends the unbearable instant in color and shape, letting Kairos breathe without suffocating the present. Breathwork, rhythm, and mindful attention teach the nervous system to recognize that “then” is not identical with “now,” even if the body still trembles at the echo.

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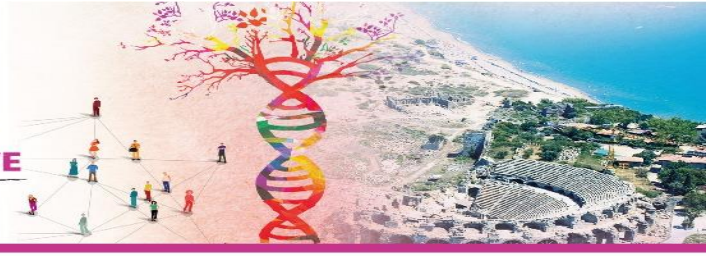


THE DIGITALIZED MIND: COGNITION, BEHAVIOUR AND MENTAL HEALH IN THE AGE OF TECHNOLOGY

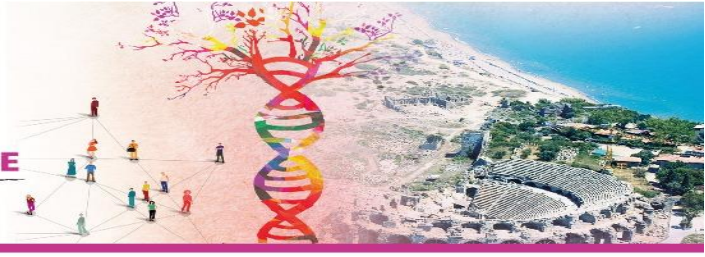
Nur Temizkan

Department of Psychiatry, Gazi University Faculty of Medicine

The digital age has changed the way people access, understand, and interact with information. These technologies allow individuals to stay connected and follow current events anytime and anywhere. However, having such easy access to information also brings new emotional and mental challenges (Graham ve ark. 2019). As digital tools become more integrated into daily life, people's thoughts, emotions, and behaviors have also shifted. Along with these changes, new psychological terms have emerged to describe how individuals experience the digital world and its effects on mental health.

FOMO (Fear of Missing Out) was first introduced in 2004 to describe a common feeling on social media. It refers to the anxiety or worry that others might be enjoying experiences while one is not. People with FOMO often feel pressure to stay constantly informed about others' lives. Studies show that FOMO is linked to higher levels of anxiety, depression, and stress. It may also lead to avoidance of social situations and increased loneliness. These patterns can contribute to sleep problems, unhealthy behaviors, and lower life satisfaction by negatively impacting emotional, physical, and relational well-being (Liu ve ark. 2023). In contrast, JOMO (Joy of Missing Out) describes the positive emotional state of intentionally stepping back from social media and social interaction. Rather than feeling obligated to stay connected, individuals with JOMO embrace solitude and focus on their own well-being. Research suggests that this approach can lower stress and anxiety, support a greater sense of self-acceptance and inner peace.

Another growing digital behavior is doomscrolling, which refers to the compulsive consumption of negative or distressing news online. Social media algorithms often prioritize emotionally charged content, making it easier for users to fall into cycles of consuming bad news. This habit has been linked to elevated psychological distress. (Satici ve ark. 2023). Additionally, short video formats on social media platforms have introduced a phenomenon often described as "15-second traumas." These emotionally intense videos are designed to provoke strong reactions and can affect mental health when consumed repeatedly. Overexposure to such content may reduce emotional regulation. One study found that excessive use of short-form videos is associated with symptoms such as depression and sleep difficulties. (Graham ve ark. 2019). Understanding these digital behaviors is important for mental health professionals to better recognize and support the experiences of their patients in today's online world.



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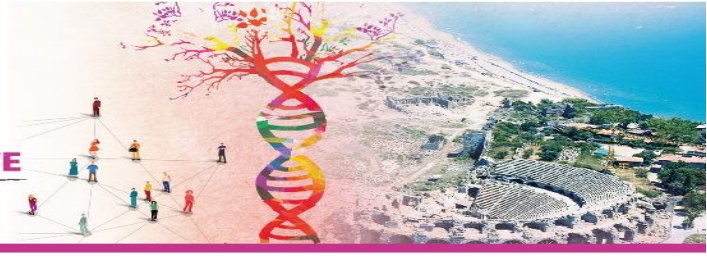


GLOBAL INSOMNIA: NEW PERSPECTIVES IN EPIDEMIOLOGICAL AND CLINICAL RESEARCH

Onur Durmaz

University of Health Sciences, Erenköy Mental Health and Neurological Diseases Training and Research Hospital, Kadıköy, Istanbul

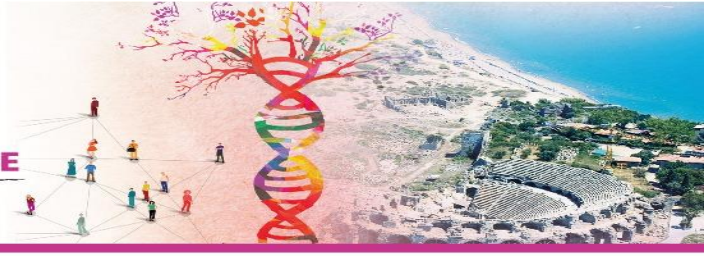
Insomnia has become an increasingly significant public health concern worldwide, particularly in developed and developing countries. Although the classification of insomnia has largely moved away from strict etiological distinctions, it remains a condition closely associated with various psychiatric and physical health problems. Recent studies have focused on new epidemiological and clinical perspectives regarding insomnia. Key factors driving these updated approaches include the ongoing complexity of its etiological mechanisms, evolving modern life conditions and expectations, the proliferation of digital technologies and applications, limited availability of objective data concerning the presence and severity of insomnia, and observable sociocultural and healthcare system differences across populations.

Accordingly, numerous studies have been conducted to refine the definition of insomnia, identify appropriate interventions and preventive measures, and evaluate its burden and potential consequences on healthcare systems. In recent years, changes in working conditions following the COVID-19 pandemic, disruptions in circadian rhythms, increased screen exposure, and heightened psychological stress–both directly and indirectly related to the pandemic–have contributed to shifts in insomnia prevalence.

Despite the well-established efficacy of cognitive behavioral therapy (CBT) as a first-line intervention for insomnia, accessibility to such treatments remains limited. However, notable progress has been made in recent years in terms of mobile and telepsychiatry-based individual therapy applications. Additionally, neurobiological research has brought forth promising pharmacological treatments with comparatively higher efficacy.

At the global level, insomnia contributes to decreased work productivity, performance loss, and early retirement, posing a considerable burden on functional capacity. It also leads to increased healthcare costs and service utilization. Although insomnia often presents as a comorbid, bidirectional symptom of various psychiatric and physical disorders, its tendency to persist beyond the resolution of initial precipitating factors supports the notion that it should be considered a disorder in its own right. This underscores the importance of early and appropriate interventions.

This presentation aims to evaluate insomnia from current epidemiological and clinical perspectives and to discuss evidence-based intervention strategies. By examining the etiological and perpetuating factors of insomnia, it seeks to raise awareness and explore the contemporary role of treatment approaches in clinical practice.



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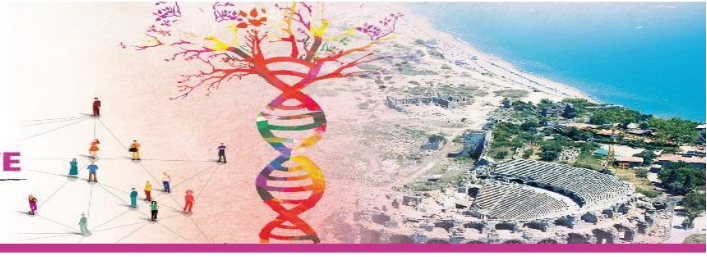

USE OF PSYCHODRAMA IN PSYCHIATRY RESIDENCY TRAINING

Osman Zülkif TOPAK

Pamukkale University Faculty of Medicine, Department of Psychiatry, Denizli, Turkey

Over the last years, ıt can be said that biological psychiatry and psychoterapy have moved in divergent directions. Biological psychiatry and drug therapy has become rich in methodology but conceptually limited, with a drift toward biological reductionism. Psychoterapy has become relatively limited in methodology, but conceptually rich. Although the richment of biology has led to major contributions in discovering gene by environment interactions; psychiatry's biologically reductionistic conceptual focus can interfere with the development of a nuanced clinical perspective based on emerging knowledge that might help more treatment resistant patients become treatment responders. In the psychiatry specialization education process, not only the biological factors, but also the importance of psychosocial factors in the causation and treatment of mental disorders must be known. Therefore, resident psychiatrists must have knowledge about the biological, psychological and social processes of patients.

Psychodrama, developed by Moreno, is a psychotherapy method that allows people to explore their mental problems by staging them. Psychodrama increases the awareness of the person who is alienated from his or herself; and thus a creative and relational development can be achieved thanks to the catharsis value of play and drama. Studies have shown that psychodrama methods can improve the expression of emotions, catharsis, problem solving and coping skills in various psychiatric illnesses. Psychodrama provides individuals with the opportunity to realise and try out coping skills by addressing their conflicts or difficulties through dramatic role-plays. We can say that matching, mirroring and role reversal are the most commonly used techniques in psychodrama therapy. In this course, workings will be conducted on the use of psychodynamically oriented psychotherapy and psychodrama in the psychiatry speciality process.

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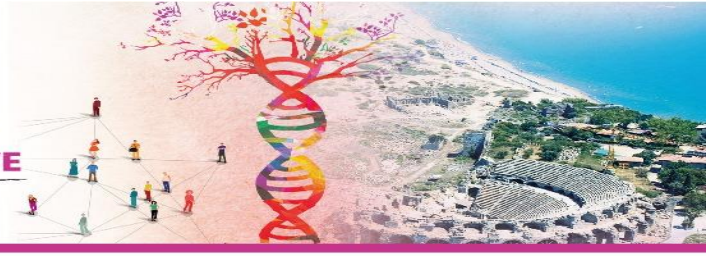


OBSESSIVE COMPULSIVE DISORDER: CAN QEEG PREDICT THE RESPONSE TO DTMS?

Özden Orhan

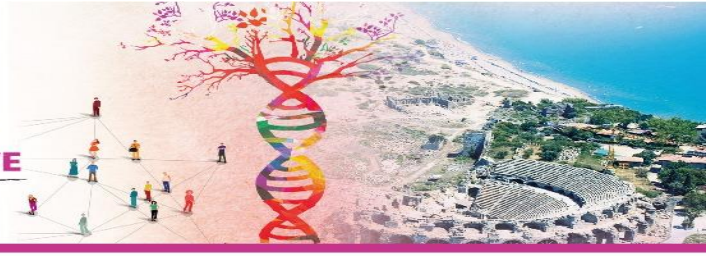
Haydarpaşa Numune Training and Research Hospital, Department of Psychiatry, Istanbul, Turkey

Obsessive-compulsive disorder (OCD) is a chronic and debilitating psychiatric condition. Although selective serotonin reuptake inhibitors (SSRIs) are considered first-line pharmacological treatments, a substantial proportion of patients exhibit inadequate therapeutic response. This limitation has led to the exploration of novel treatment modalities such as deep transcranial magnetic stimulation (dTMS). However, identifying reliable predictors of dTMS response remains a significant clinical challenge.

The primary dTMS targets in OCD are the medial prefrontal cortex (mPFC) and anterior cingulate cortex (ACC), consistent with neuroimaging studies demonstrating impairments in the cortico-striato-thalamo-cortical (CSTC) circuit (Tendler et al. 2016). In previous studies, applying 20 Hz dTMS via the H7-coil to these regions for six weeks led to significant improvement in Yale-Brown Obsessive Compulsive Scale (Y-BOCS) scores in patients receiving SSRI treatment, indicating the efficacy and reliability of dTMS (Carmi et al. 2018).

Baseline cortical excitability has been recognized as a key factor contributing to both inter- and intra-individual variability in response to TMS interventions (Siebner and Rothwell, 2003). Accordingly, quantitative electroencephalography (QEEG) has been proposed as a noninvasive method to identify neurophysiological predictors of treatment response.

This study aimed to examine whether resting-state QEEG features could predict treatment response to dTMS in patients with OCD. Retrospective analysis was conducted on 52 patients (mean age: 31.88±11.51 years; M/F: 23/29) who received 25 sessions of dTMS between January 2018 and May 2019 at a private psychiatric clinic in Istanbul. All participants were assessed using the Y-BOCS, Beck Depression Inventory (BDI), and resting-state EEG recordings prior to treatment. EEG data were obtained using a 19-channel monopolar cap and analyzed via Fourier transformation. Absolute power (μV^2) was computed across all electrodes for delta (0.5–4 Hz), theta (4–8 Hz), alpha (8–13 Hz), beta (13–30 Hz), and gamma (30–70 Hz) bands. Patients were categorized into “responsive” (≥30% reduction in Y-BOCS scores; n=42) and “non-responsive” (n=10) groups. The responsive group demonstrated significantly higher alpha and theta absolute power values across all electrodes. No significant differences were observed in sociodemographic characteristics or baseline Y-BOCS and BDI scores between the groups, except for a higher score on the time-occupied-by-obsessions item in the responsive group.



These findings suggest that elevated baseline alpha and theta activity may serve as potential predictors of favorable response to dTMS in OCD. QEEG-based biomarkers may offer a valuable approach to guide personalized neuromodulation strategies and improve clinical outcomes.

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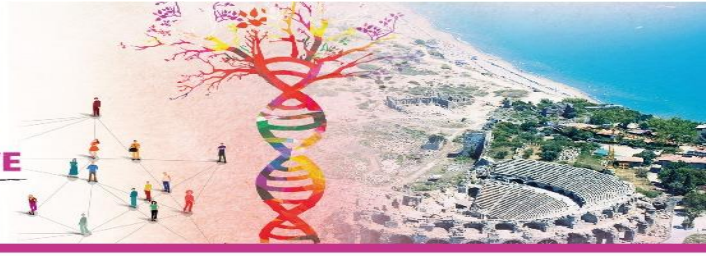

10 SORUDA PSİKİYATRİDE YETERLİK VE TPD YETERLİK SINAVI

EĞİTİM PROGRAMLARINI GELİŞTİRME ALT KURULU (EPGAK)

Özge Şahmelikoğlu Onur

Tekirdağ Namık Kemal Üniversitesi Tıp Fakültesi, Psikiyatri ABD

The primary aim of psychiatric specialty training is to develop a high level of clinical competence in the field of psychiatry. Graduates of this program are expected to possess a solid theoretical foundation and sufficient clinical experience concerning the etiology, pathogenesis, diagnosis, treatment, care, and prevention of psychiatric disorders and related medical conditions. Moreover, the program should equip psychiatric residents not only with clinical skills but also with competencies in roles associated with the broader scope of medical practice—such as acting as health consultants, legal experts, public educators, clinical or hospital administrators, and scientific researchers. Trainees are also expected to complete the program with an awareness of their own strengths and limitations, as well as a recognition of the necessity for ongoing professional development. The curriculum must be clearly defined and include specific, valid learning objectives. These objectives should encompass theoretical knowledge, clinical skills, and professional attitudes. The quality of the training is reflected in the resident's ability to conceptualize psychiatric disorders within biological, psychological, and sociocultural frameworks, and to effectively perform patient history taking, diagnostic evaluation, treatment planning, and follow-up. The core goal of the program should be to provide a competency-based training model that ensures full proficiency in these areas. Clinical documentation plays a critical role in assessing the quality of specialty training. These records should include comprehensive patient histories, mental status examinations, physical and neurological evaluations, well-structured treatment plans, systematically maintained progress notes, performed diagnostic and therapeutic procedures, and discharge summaries (epicrises). Each institution must have a functional system and infrastructure that ensures regular review and supervision of these records for educational purposes. Tıpta Uzmanlık Kurulu Müfredat Oluşturma ve Standartları Geliştirme Sistemi (TUKMOS) serves this purpose. The internalization and retention of knowledge acquired during psychiatric specialty training, along with participation in continuous professional development activities, hold undeniable importance. In this session we will try to find the answers of what are the responsibilities of Eğitim Programlarını Geliştirme Alt Kurulu (EPGAK) Subcommittee for Curriculum Development (EPGAK) for psychiatric specialty training and in the context of continuing professional development and lifelong learning. This presentation will also provide an overview of the role assumed by EPGAK in the TUKMOS Mental Health and Disorders framework.

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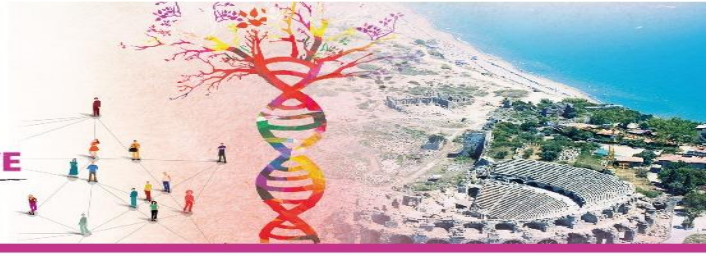

PHARMACOLOGICAL AND NON-PHARMACOLOGICAL APPROACH TO DELIRIUM

Özge Şahmelikoğlu Onur

Tekirdağ Namık Kemal Üniversitesi Tıp Fakültesi, Psikiyatri ABD

Delirium is a sudden deterioration in attention and cognitive function that can develop quickly and may fluctuate throughout the day. Delirium can lead to negative clinical outcomes, including higher mortality rates, longer hospital stays, iatrogenic complications, readmissions, and an increased risk of developing dementia (1). While the conventional approach to managing delirium has focused on addressing the underlying medical causes, various pharmacologic treatments have also been employed to manage common delirium symptoms, such as agitation and hallucinations (2). Despite the frequent use of pharmacologic agents, including antipsychotics, in both ICU and non-ICU settings for delirium symptom management, the evidence supporting their effectiveness — and whether the benefits outweigh the risks — in hospitalized patients is still uncertain. No individual pharmacological agent can effectively treat delirium. Currently, clinicians should focus on the underlying risk factors that contribute to delirium. Non-pharmacological interventions should be prioritized. While there may be cases where medications are required to manage hyperactive behaviors in delirious patients, it is important to recognize that these treatments do not address the root cause of delirium. No single pharmacological agent can prevent delirium-related brain dysfunction. Active monitoring for delirium is essential, along with attention to factors that may put patients at risk for developing it (3). In this session we will try to find the answers of the principles of non-pharmacological and pharmacological approaches in delirium treatment/prevention. We also try to discuss what we should not do in the treatment of delirium in older persons.

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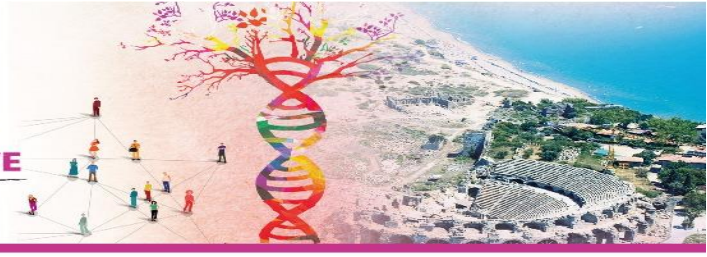

CLİNİCAL AND ETHİCAL PARADOXES BEHİND BARS: DECİSİON-MAKİNG İN THE GREY AREAS OF FORENSİC PSYCHİATRY İN PRİSONS

Pınar Çelikkıran Erdem

Bakirkoy Prof. Dr. Mazhar Osman Mental Health and Neurological Diseases Training and Research Hospital

This presentation aims to address some fundamental issues in the psychiatric assessment of individuals within the criminal justice system. The starting point will be the diagnostic challenges associated with malingering during forensic evaluations. The intricacies of diagnosing malingering and the importance of clinical observation, psychological assessment tools, and behavioral indicators that can facilitate the assessment of individuals suspected of malingering will be explored. Additionally, the ethical and legal challenges encountered during evaluating malingering cases will be addressed.

The second discussion will cover the criteria for psychiatric hospitalization of referred inmates. Current challenges in referral procedures and the use of telepsychiatry in prison settings will be examined. The effectiveness, reliability, and ethical issues of telepsychiatry will be discussed, along with strategies for more efficiently integrating these technological advancements into psychiatric care within correctional facilities.

The following discussion will concentrate on the standards -both medical and legal- governing the preparation of psychiatric expert reports essential for determining the postponement of the execution of sentences for prisoners with psychiatric disorders. Additionally, the status of prisoners undergoing psychiatric treatment within correctional facilities will be discussed. Within this context, examples of expert reports will be presented based on relevant legal provisions.

The fourth discussion will explore the treatment of individuals convicted of sexual offenses, along with the ethical and clinical considerations psychiatrists must take into account when preparing requested reports in this context. The main aspects of these reports and how treatment processes should be designed from both ethical and legal perspectives will be discussed.

Finally, the ethical and legal aspects of psychiatric evaluations conducted in settings where privacy cannot be ensured, such as prisons, will be discussed. The ethical principles and legal procedures for reporting such evaluations will be reviewed, emphasizing the importance of upholding ethical standards regarding privacy.

This presentation aims to offer an understanding of the challenges encountered in forensic psychiatric practice, focusing on the scientific, ethical, and legal aspects of psychiatric evaluations of the inmates. The goal is to raise awareness among psychiatrists about these issues and offer possible improvements to existing practices.

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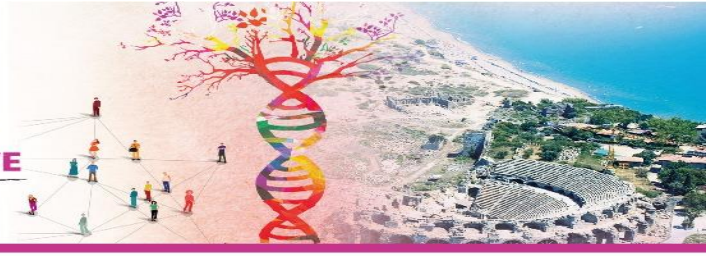
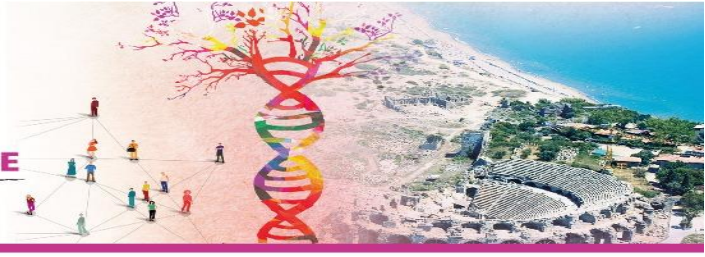


NON-SUİCİDAL SELF-İNJURY İN ADOLESCENCE AND YOUNG ADULTHOOD: A PREDİCTOR OF SUİCİDE?

Pınar Kızılay Çankaya

Private practice, Psychiatry, Ankara, Turkey; Gazi University, Institutes of Health Sciences, Department of Medical Pharmacology, Ankara, Turkey

Non-suicidal self-injury (NSSI) is defined by the intentional and repeated harm to body tissues without suicidal intent. The most common forms of self-injury include cutting the skin, hitting, skin irritation, self-hitting, stabbing, biting, burning, and interfering with wound healing. NSSI is a significant global public health issue due to its high prevalence, especially among adolescents, and its harmful effects on emotional and cognitive development. The lifetime prevalence of NSSI is reported to be 17.2% in adolescents, 13.4% in young adults, and 5.5% in adults. Although NSSI generally tends to decrease over time, it may persist into late adolescence and adulthood. In contrast, suicide involves self-harming behaviors that lead to the end of one's life. Suicidal thoughts and behaviors are categorized into suicidal ideation, suicide plans, suicide threats, and suicide attempts. Suicide is a global concern, with rising rates in many countries, particularly among young people. It has been documented that 6–37% of individuals who engage in self-harm also attempt suicide, and 41–68% of those who attempt suicide have a history of self-harm. Factors such as female gender, family-related variables, peer bullying, depression, previous NSSI, and negative self-perception are prospective predictors of NSSI. Several studies have highlighted negative self-perception as a regulatory mechanism in the relationship between intrapersonal and interpersonal variables and NSSI. A review published in 2020 indicated that NSSI predicts subsequent suicide attempts, with this relationship being more pronounced in women and individuals with borderline personality disorders, mood disorders, or depressive symptoms. Notably, recurrent NSSI is associated with an increased risk of suicide attempts. Research has demonstrated that NSSI serves various functions, acting as a tool in both internal processes (such as emotion regulation and self-punishment) and interpersonal interactions (such as influencing others' behavior). It has been shown that individuals who self-harm often struggle with recognizing, experiencing, and expressing emotions appropriately. Additionally, those with difficulties in emotion regulation often exhibit inadequate problem-solving capacities, using self-harm as a coping mechanism to manage overwhelming negative thoughts and emotions.



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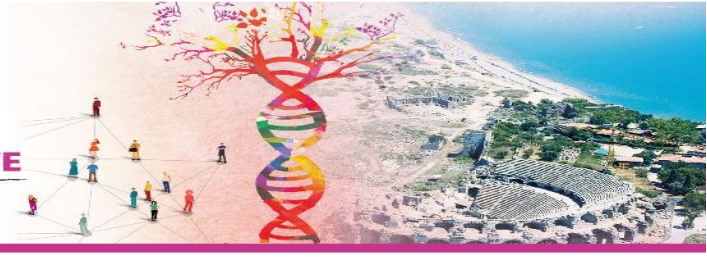


ADULT ADHD IS OVERDIAGNOSED

Elif Yıldız, Selçuk University, Faculty of Medicine, Department of Psychiatry, Konya, Türkiye

Hacer Söylemez, Selçuk University, Faculty of Medicine, Department of Psychiatry, Konya, Türkiye

Pınar Kızılay Çankaya, Private practice, Psychiatry, Ankara, Turkey; Gazi University, Institute of Health Sciences, Department of Medical Pharmacology, Ankara, Türkiye

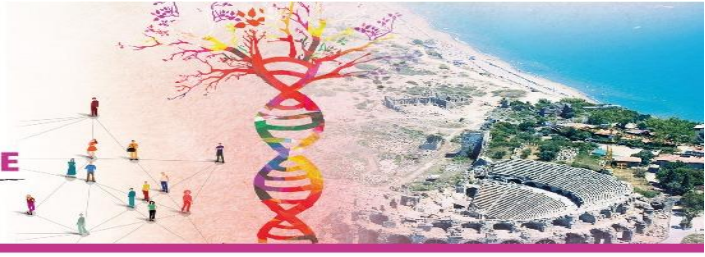
Recently, there has been a notable increase in the number of adults diagnosed with attention deficit hyperactivity disorder (ADHD). While this trend may be partially attributed to heightened awareness and improved access to care, accumulating evidence suggests that adult ADHD is frequently overdiagnosed in various contexts. The contributing factors include alterations in diagnostic thresholds, expanded symptom definitions, and increased self-reported attention difficulties.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) characterizes ADHD as a neurodevelopmental disorder that manifests before the age of 12 years and significantly impairs functioning. However, the revised criterion D now emphasizes ambiguous and subjective concepts such as “interference” or “reduced quality of functioning” rather than clinically significant impairment. This shift in language affords clinicians a greater interpretive latitude, thereby increasing the risk of false positives (Gascon et al. 2022).

Moreover, in contemporary high-performance societies, particularly in North America, normal variations in the attention span and productivity are readily pathologized. This overmedicalization of everyday cognitive challenges can lead to an increased prevalence of ADHD diagnoses and may result in heightened stimulant prescriptions without comprehensive diagnostic evaluations (Paris et al., 2015). Research indicates that relying solely on symptom checklists without a thorough developmental history or differential diagnosis is insufficient for establishing a reliable diagnosis in adulthood (Adamou et al., 2024).

Notably, many core symptoms of ADHD, such as distractibility, impulsivity, and forgetfulness, are nonspecific and overlap with other psychiatric disorders, including anxiety, depression, trauma-related disorders, and personality disorders. If these conditions are not adequately assessed and excluded, there is a risk of misattributing the symptoms to ADHD.

Adult ADHD is a legitimate and impairing condition. However, recent data suggest that in some instances, the diagnosis may be rendered too hastily or without comprehensive evaluation, leading to misdiagnosis and inappropriate treatment. A comprehensive clinical assessment should incorporate developmental history, exclude differential diagnoses, and rely on objective criteria rather than subjective interpretations. To avoid overdiagnosis, diagnostic precision and scientific rigor must remain central to psychiatric evaluations.



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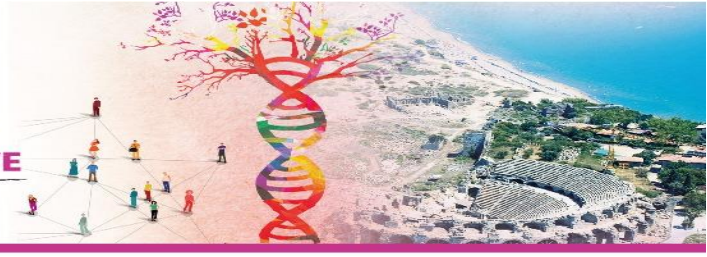


DIAGNOSTIC CONFUSION IN ADULT PSYCHIATRY OF CHILDHOOD BIPOLAR PATIENTS

Rukiye Tekdemir

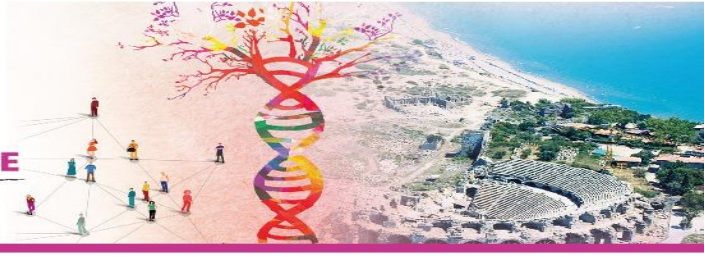
Selçuk Üniversitesi Tıp Fakültesi, Psikiyatri Anabilim Dalı, Konya, Türkiye

Evidence indicates that in approximately 60% of individuals with Bipolar Disorder (BD), the onset of mood symptoms occurs before the age of 18. However, despite this early manifestation, the average delay in receiving a formal diagnosis spans nearly nine years. During this protracted diagnostic journey, patients are typically evaluated by at least four different clinicians and receive, on average, three alternative psychiatric diagnoses before BD is finally identified. This diagnostic delay is consistently associated with adverse outcomes, including treatment resistance, higher rates of hospitalization, increased suicide risk, and impaired psychosocial functioning.

One of the primary barriers to accurate and timely diagnosis lies in the transition from child and adolescent mental health services to adult psychiatric care. Early-onset BD often presents with developmental stage-specific symptomatology, which can differ significantly from adult presentations. Moreover, the current diagnostic frameworks, including DSM-5, often lack the developmental sensitivity needed to adequately assess mood disorders across age spans. This gap contributes to frequent misdiagnoses such as attention-deficit/hyperactivity disorder (ADHD), conduct disorder, or major depressive disorder during childhood and adolescence.

Further complicating the diagnostic picture are the high rates of symptom overlap and psychiatric comorbidities in early-onset BD, including anxiety disorders, substance use disorders, and neurodevelopmental conditions. The lack of longitudinal follow-up systems and the absence of specialized transition clinics exacerbate the challenge, resulting in fragmented care and a loss of clinical continuity. Adult psychiatry settings often have limited access to detailed early developmental and psychiatric histories, which are crucial for contextualizing current symptomatology.

Addressing these challenges necessitates a systemic shift toward early identification, developmental contextualization of symptoms, and integrated care models. Improved clinician training in the recognition of pediatric-onset BD, enhanced diagnostic tools tailored to developmental stages, and the establishment of transitional mental health services are critical for bridging this gap.



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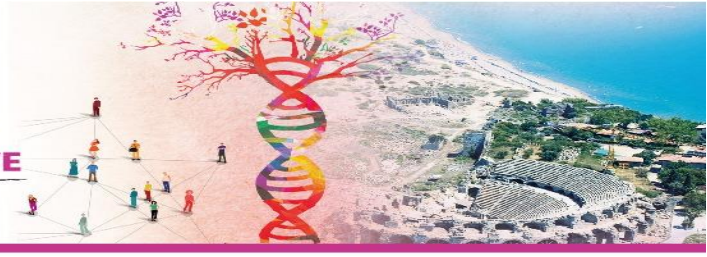


FROM VANILLA TO KINK: RETHINKING THE BOUNDARIES OF SEXUALITY

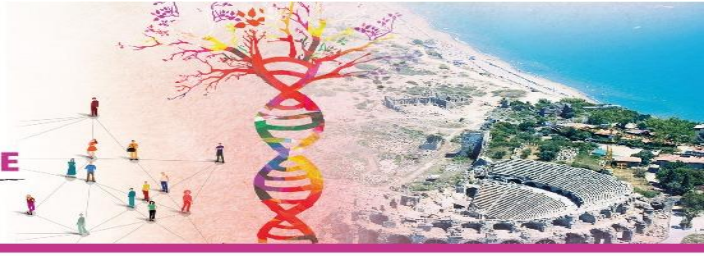
Rümeysa Taşdelen

İstanbul Galata Üniversitesi, Sanat ve Sosyal Bilimler Fk., Psikoloji (İng)

Sexuality is a multifaceted concept that encompasses sexual identity, orientation, desire, emotional intimacy, and the interaction between individuals and social roles. It is shaped not only by biological factors, but also by psychological, sociocultural, economic, political, moral, and religious influences. (Yılmaz Esencan & Kızılkaya Beji, 2015). The notion of what is "normal" in sexuality cannot be defined through rigid categories, particularly in a field where biological determinants are limited and psychosocial variability is significant. Sexual desire and satisfaction vary not only across individuals, but even within the same person across different periods of life or with different partners. Furthermore, societal attitudes toward sexuality have shifted throughout history; the behaviors deemed acceptable or deviant are largely dependent on the cultural and temporal context. The same sexual act may be considered ordinary and acceptable in one society, while it may be labeled taboo or deviant in another. Therefore, what is viewed as “abnormal” from a conventional perspective may be entirely natural and non-pathological for the person engaging in the behavior (Bozon and Rennes, 2015).

The term “vanilla sex” refers to conventional sexual encounters characterized by predictability, emotional intimacy, and cultural normativity. In contrast, “kinky sex” involves practices outside mainstream sexual norms, such as fantasy, role play, and BDSM (bondage, discipline, dominance, submission, sadism, and masochism). These practices allow individuals to explore their sexual boundaries in a consensual, safe, and often creative manner. Vanilla and kinky practices can be viewed as points along a sexual behavior spectrum, and each individual may situate themselves differently along this continuum. Many behaviors previously categorized as paraphilias are now informally considered under the umbrella of kink, and are only regarded as disorders when they cause significant distress or impairment in functioning (Larva & Rantala, 2024). As global living conditions improve and individualistic, pleasure-oriented lifestyles become more prominent, sexual diversity becomes more visible, and mental health professionals increasingly encounter a broader range of sexual issues in clinical practice.

This session, planned in a “Ten Questions, One Topic” format, will address the diversity of sexual behavior and the conceptual boundaries of sexuality. The aim is to raise awareness of sexual diversity, stimulate critical thinking, and offer a scientifically grounded framework for understanding contemporary sexual expression.



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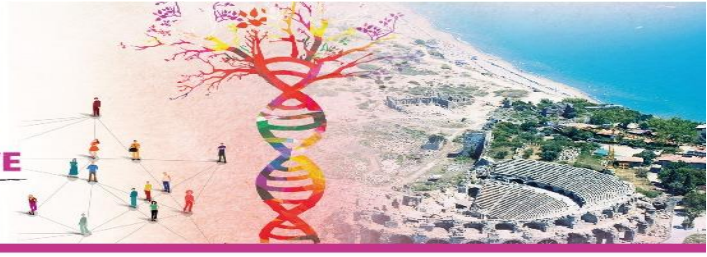


UNDERSTANDING GENDER INEQUALITY AND SEXUAL VIOLENCE IN PROFESSIONAL SETTINGS

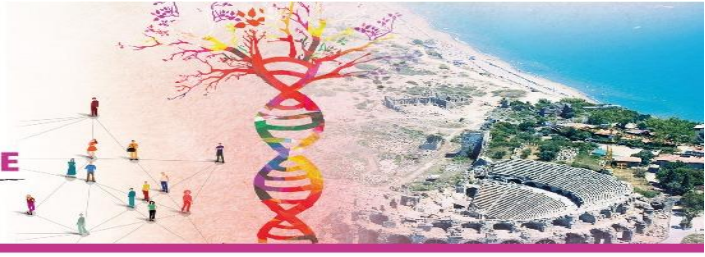
Rümeysa Taşdelen

İstanbul Galata Üniversitesi, Sanat ve Sosyal Bilimler Fk., Psikoloji (İng) Bölümü

Gender inequality remains one of the most persistent and deeply rooted challenges in both global and local contexts. It arises not only from biological differences but, more importantly, from socially constructed roles and expectations assigned to individuals based on their gender, gender identity, or sexual orientation. While biological sex may define someone as male or female at birth, gender refers to culturally and historically shaped norms associated with femininity and masculinity. These norms often lead to systemic discrimination that limits equal opportunities in education, work, politics, and healthcare.

One of the most harmful manifestations of gender inequality is sexual violence, which is not merely an individual act but a structural issue embedded in patriarchal systems. Sexual violence includes any sexual act or attempt without consent, often involving the abuse of power, authority, or influence. It affects women and LGBTQ+ individuals disproportionately and occurs in settings ranging from romantic relationships to academic and professional hierarchies. Victims often face barriers in speaking out—fear of judgment, institutional inaction, or social stigma. This silence protects perpetrators and perpetuates a culture where sexual violence is normalized or ignored. Addressing this issue requires more than isolated punishments—it demands a transformation of the structures and attitudes that allow it to persist. Efforts to ensure gender equality and prevent sexual violence must be comprehensive. Awareness-raising, institutional accountability, safe reporting mechanisms, legal and psychological support, and a strong ethical framework are crucial. International agreements like CEDAW and the Istanbul Convention provide a legal and moral guide for creating safer, more equitable environments (Council of, 2011) (United, 1979). By viewing sexual violence as a consequence of broader gender injustice, we are reminded that change begins not only with policy but with reshaping the culture of silence into one of support, respect, and equality.

In the first part of this event, which was planned to introduce the Sexual Violence Prevention and Gender Equality Support Unit, established within the Turkish Psychiatry Association in 2021 in order to effectively combat issues such as sexual harassment, sexual assault and gender inequality and to create a safe, fair and egalitarian environment within the professional organization, to our colleagues, the topics of sexual violence and gender inequality will be explaine.



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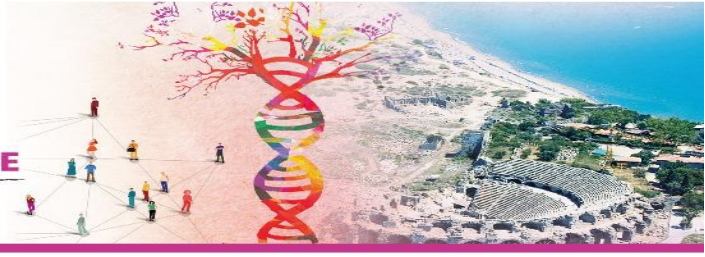


NOVEL APPROACHES FOR MAJOR DEPRESSIVE DISORDER

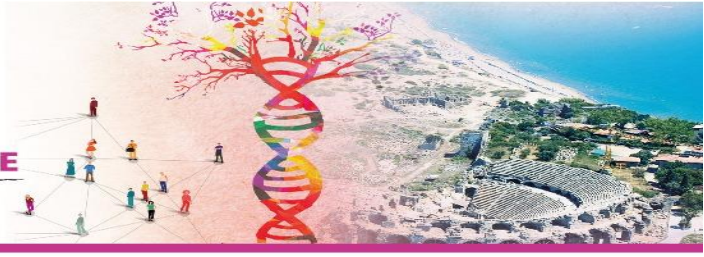
Saba Cicek

Ankara Etlik City Hospital

Major depressive disorder (MDD) continues to represent a global health burden, with a significant portion of patients experiencing inadequate response to first-line treatments. This phenomenon of treatment-resistant depression (TRD) has catalyzed the development of novel pharmacological and neuromodulatory strategies targeting previously underexplored neurobiological pathways.

Among recent innovations, psychedelics such as psilocybin have shown considerable promise. Psilocybin is a serotonergic compound that exerts its effects primarily through 5-HT2A receptor agonism. Clinical trials have demonstrated rapid and sustained antidepressant responses following administration in TRD populations. Its potential to induce enduring neuroplastic changes and enhance emotional processing marks it as a transformative candidate in depression therapeutics [1]. Another major development is the combination agent dextromethorphan-bupropion, which employs an NMDA antagonistic and monoaminergic mechanism. Dextromethorphan modulates glutamatergic neurotransmission, while bupropion contributes dopaminergic and noradrenergic activity. Together, they produce faster antidepressant effects compared to traditional treatments and are approved for use in MDD, including patients who have not responded to SSRIs [2]. Zuranolone, an oral neuroactive steroid that modulates GABA-A receptors, represents a novel approach particularly for postpartum depression but has also shown promise in general MDD populations. With its short-duration regimen and rapid symptom reduction, zuranolone highlights the therapeutic relevance of the GABAergic system in mood regulation. The gut-brain axis has emerged as a promising target in depression treatment. Probiotic supplementation may influence mood through anti-inflammatory and neuromodulatory pathways. While evidence is still preliminary, findings suggest that specific strains may have beneficial effects as adjunctive therapies in depression, potentially modifying the microbiota and systemic immune responses [3]. In addition to pharmacologic strategies, neuromodulation techniques such as repetitive transcranial magnetic stimulation (rTMS), theta burst stimulation (TBS), and deep brain stimulation (DBS) are advancing as effective options for TRD. These interventions directly target dysfunctional neural circuits associated with mood regulation, with growing evidence supporting their efficacy and safety. Novel approaches, including closed-loop systems and individualized target mapping, are under investigation to enhance response rates [2].

In summary, contemporary biological treatment strategies in depression are increasingly diverse, targeting glutamatergic, GABAergic, serotonergic, and neuroinflammatory systems, as well as the brain-gut axis. These advances offer hope for individuals with TRD and represent a paradigm shift toward mechanistically tailored interventions.



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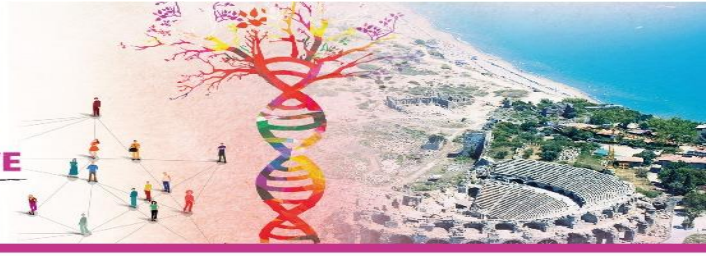

THE INDISPENSABLE POWER OF ECT

Saliha DEMİREL-ÖZSOY

Erciyes Üniversitesi Tıp Fakültesi Psikiyatri Anabilim Dalı

Electroconvulsive therapy (ECT) is a standard psychiatric treatment based on the principle of inducing a generalized seizure by administering electrical currents through the scalp under controlled conditions. Since its first application on schizophrenia patients by Cerletti and Bini in 1938, when its efficacy was demonstrated, ECT has continued to maintain its place among modern treatments. Today, it remains an enduring somatic treatment for severe psychiatric disorders such as depression, bipolar disorder, and schizophrenia, as well as in life-threatening psychiatric conditions like refusal to eat or drink, severe suicide risk, and catatonia (Prudic 2024). Although ECT is often reserved for cases where pharmacological treatment has failed, where standard medication cannot be used, or where a rapid response is necessary, its efficacy extends to a broad range of clinical applications. Despite some negative perceptions surrounding ECT, advancements in its application techniques, the introduction of general anesthesia, improvements in monitoring and cardiopulmonary management have significantly enhanced its safety and effectiveness, and still remains among the indispensable treatments. ECT can be safely administered across all patient groups, including those considered high-risk, such as the elderly, patients with medical comorbidities, pregnant women, and adolescents. It is among the safest procedures performed under general anesthesia, with a very low risk of death and serious complications (Prudic 2024). Misconceptions and stigma associated with ECT can prevent appropriate psychiatric patients from benefiting from this treatment. Therefore, there is a pressing need to combat these negative perceptions and promote a more objective understanding of the therapy. This presentation reviews the historical development, mechanism of action, application, efficacy, and safety of ECT, emphasizing the reasons for its indispensability (Demirel Özsoy 2025).

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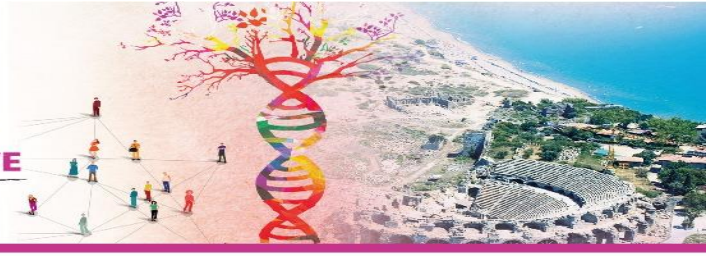


SUİCİDE İN INDİVİDUALS WİTH DİSABİLİTİES

Sare AYDIN

Tokat Gaziosmanpaşa University Faculty of Medicine, Department of Psychiatry

Suicide is a major public health issue that arises as a result of an individual's biopsychosocial dynamics. The risk of suicide in individuals with physical disabilities is higher compared to the general population, influenced by numerous psychological, social, and environmental factors (Khazem, 2018). Disability leads to permanent limitations in an individual's ability to perform daily life activities, negatively impacting mental health and serving as a risk factor for suicidal thoughts and behaviors.

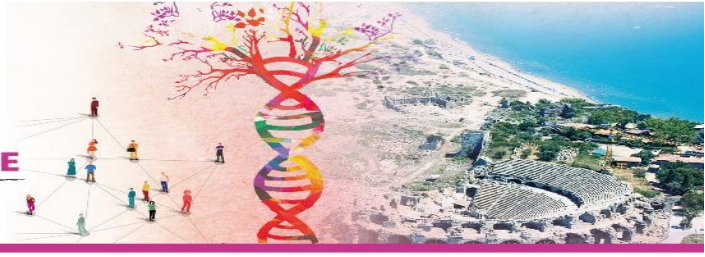
The primary factors increasing suicide risk in individuals with physical disabilities include chronic pain, a sense of dependency, social isolation, low self-efficacy, economic disadvantages, and stigmatization (Khazem, 2018). The loss of functional capacity due to disability can adversely affect self-esteem. Particularly, conditions such as traumatic injuries, stroke, multiple sclerosis, muscular diseases, and amputations can significantly elevate suicide risk.

Psychiatric comorbidity is one of the most critical variables increasing suicide risk in individuals with physical disabilities. Research indicates that these individuals have lower self-esteem and higher levels of depression and anxiety. Additionally, the most common risk factors associated with suicidal thoughts and attempts among physically disabled individuals include the disability itself, perceived burdensomeness, depressive symptoms, stigmatization, loneliness, and lack of social connection (Kumar et al., 2024).

Social factors also play a crucial role in suicidal behavior. Studies suggest that negative societal reactions toward individuals with disabilities are among the primary causes of emotional distress, adversely affecting their mental health and paving the way for psychological issues such as depression and anxiety (Cusforth, 1951). Furthermore, barriers in education and employment can hinder economic independence, limiting the integration of individuals into society. Lack of family and social support can intensify feelings of loneliness, further increasing the risk of suicide.

Preventing suicide in individuals with physical disabilities requires a biopsychosocial approach. First and foremost, making psychosocial support services more accessible is of critical importance. Therapy, support groups, and psychoeducation programs tailored for disabled individuals can be effective in enhancing their emotional resilience. Community-based approaches are also essential. Developing employment policies for individuals with disabilities, rehabilitation programs that support independent living skills, and projects that promote social participation can enhance life satisfaction and reduce suicide risk.

Facilitating access to healthcare services, particularly mental health support systems, is crucial. Awareness campaigns and anti-stigmatization programs for individuals with disabilities can support their integration into society and reduce social isolation.



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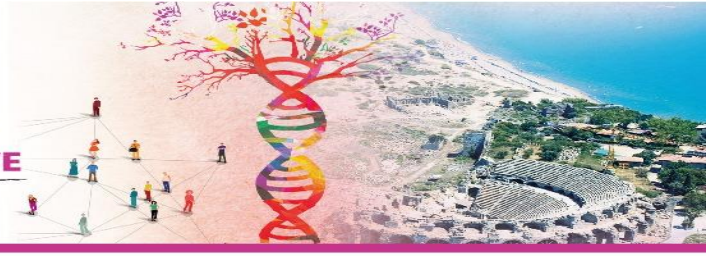

WHAT IS INFIDELITY? HOW DO COUPLES APPLY TO PSYCHIATRY CLINICS?

Selcen Doğru

Serbest Hekim

The literal meaning of loyalty is; sincere devotion, solid and strong friendship. Infidelity can be defined as emotional and or physical closeness experienced by a third person or persons outside of the current relationship. In recent years, virtual infidelities have also been observed quite frequently. The lies, behaviors and infidelity that emerge from these closenesses are described as cheating when the partner learns of the act. While infidelity is a choice made in a relationship, cheating is the result of this choice. Infidelity destroys the sense of trust that forms the backbone of a marriage and is also a breach of contract. If we compare marriages to a journey, it is the most serious road accident on the journey. It makes the betrayed person experience feelings similar to those they felt during the death of their loved ones.

Cheating is one of the top three reasons for divorce. Although many individuals stated that they would divorce in such a situation before infidelity, 70-80% of the same individuals continued their relationships after infidelity. Cheating rates in romantic relationships also vary by gender. It is seen that men's cheating rates are higher than women's cheating rates. In a study conducted by Kinsey, Pomeron and Martin on married couples, women's cheating rates were determined as 26% and men's as 50%. Research shows that men perceive sexual cheating as more dangerous, while women perceive emotional cheating as more dangerous. When cheating occurs, the person who is cheated on begins to experience many different emotions. The reactions given as a result of being cheated on are also quite subjective and can vary from person to person. After the crisis that occurs due to cheating, people may experience both sociological and psychological life-threatening situations and they may apply to psychiatric outpatient clinics individually or as a couple.

Individuals who apply individually may experience loss of functionality, self-confidence problems, sleep disorders, eating disorders, depression, anxiety, post-traumatic stress symptoms, thoughts of suicide, death, harming oneself or one's partner.

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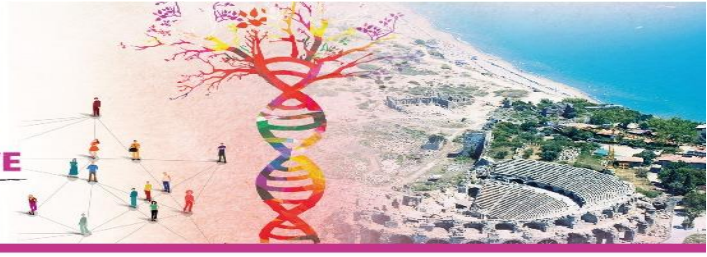


THE DİGİTALİZED MİND: COGNİTİON, BEHAVİOR, AND MENTAL HEALTH İN THE AGE OF TECHNOLOGY

Selin Özcelep
Department of Psychiatry, Gazi University Faculty of Medicine

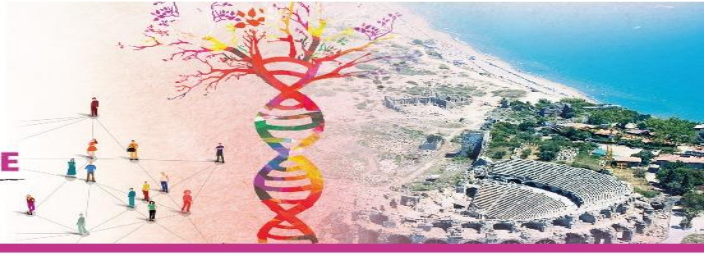
With the transformation of individuals' lifestyles through digitalization, new diagnostic and explanatory concepts have emerged within the field of psychiatry. Among these, hikikomori, digital disinhibition, and digital detox have gained prominence, offering important conceptual frameworks for evaluating the mental health impacts of digital technologies—particularly among young individuals.

Hikikomori is characterized by an individual's withdrawal from social life for at least six months, refraining from leaving home and experiencing significant impairment in social functioning. In recent years, the interaction between this phenomenon and digital media has attracted increasing attention. A systematic review highlighted that hikikomori syndrome is closely associated with digital technologies. It was noted that the amount of time spent online reinforces social isolation and reduces the visibility of this withdrawal (Sales-Filho et al., 2023). This suggests that digital platforms are becoming passive facilitators of social detachment.

Digital disinhibition refers to the expression of behaviors online that individuals would not typically exhibit in face-to-face settings—such as aggression, trolling, or excessive self-disclosure. These behaviors are more frequently observed in individuals with low self-control or difficulty interpreting social cues (Voggeser et al., 2018). The anonymity of online interactions, physical invisibility, and the asynchronous nature of communication allow individuals to disengage from empathic boundaries and act impulsively.

Digital detox, on the other hand, refers to a controlled withdrawal from digital devices and social media platforms to restore psychological balance. A recent comprehensive review found that individuals often engage in digital detox practices due to issues like attention deficits, stress, anxiety, and social burnout (Setia et al., 2025). These interventions were shown to enhance mental well-being, help reconstruct the individual's relationship with technology, and promote digital awareness.

These three concepts offer a timely, integrative, and clinically applicable lens for understanding the psychiatric implications of digitalization. They serve as valuable tools for clinicians and researchers to assess the cognitive and behavioral consequences of prolonged digital engagement and to guide appropriate interventions for mental wellness in the digital era.



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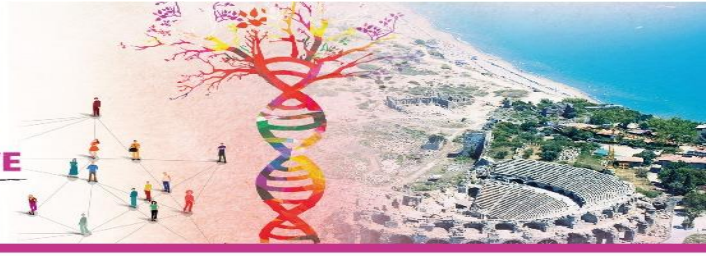

EVIDENCE-BASED PRACTICES FOR SUICIDE PREVENTION THROUGH THE PUBLIC MENTAL HEALTH PERSPECTIVE

Selin Tanyeri Kayahan

Yalvaç State Hospital, Isparta

According to the World Health Organization, suicide is the third leading cause of death among people aged 15-29, with more than 720,000 individuals dying from suicide each year. Nearly three-quarters of suicides worldwide occur in low- and middle-income countries. Suicide represents a significant public health issue, and the incidence of suicidal behavior in Türkiye has been rising over the years. As there is currently no robust and reliable method for assessing and predicting suicide risk, clinicians primarily conduct risk assessments based on critical factors, such as past suicidal behaviors or family history of suicide. However, strengthening the mental health of individuals and communities, as well as preventing suicidal behavior, necessitates the effective use of practices that address the social determinants of health alongside clinical health services.

There are evidence-based intervention studies aimed at preventing suicide at both the individual and community levels. Suicide prevention strategies require close collaboration among many sectors, including health, education, law, politics, and media. Training primary care physicians in depression recognition and treatment, training youth at school-based settings on suicide behaviors, screening for and appropriate evidence-based treatment of suicidal behaviors, and restriction of access to lethal means such as firearms or pesticides were consistently found to be effective strategies in suicide prevention. Recent evidence-based community suicide prevention practices emphasize interventions focused on strengthening social prescribing, crisis helplines, and educating individuals in the community on suicide prevention (gatekeeper training). Social prescriptions are intervention studies based on cooperation with social services designed to help individuals engage in social interactions in non-clinical environments. It is reported that social prescriptions provided alongside routine clinical health services can lower the risk of suicide by addressing factors such as loneliness and contributing to prevention. Crisis helplines are a prominent method in the fight against suicide at both the social and national levels. The primary purpose of these anonymous lines, accessible to individuals in active crisis at any time, is to ensure safety by intervening in crisis situations. While numerous studies on crisis lines exist, various methodological and ethical limitations hinder the evaluation of the method's effectiveness. Another study focuses on facilitating access to appropriate mental health services for individuals at high risk of suicide by educating sensitive members of the community. In this approach, known as gatekeeper training, members of the community are trained to recognize individuals and situations at high risk of suicide, facilitating timely access to appropriate health and social services. Although evidence on the effectiveness of interventions in high-risk situations is limited, studies in this area, particularly in public health, are promisingly ongoing.

BOARD EXAMINATION OF PSYCHIATRIC ASSOCIATION OF TÜRKIYE

Selin Tanyeri Kayahan

Yalvaç State Hospital, Isparta

The Psychiatric Association of Türkiye's Psychiatry Board Examination has been organized yearly since 2006. This proficiency exam consists of two phases: a written and a practical exam. The written exam to measure the candidate's basic and current psychiatric knowledge is held once a year and includes 100 multiple-choice questions. The exam duration is 90 minutes. The number of questions to be asked on each subject in this exam is determined according to the list of topics created by the Curriculum Board and is based on the Medical Specialty Board Curriculum Creation and Standards Determination System and the Core Theoretical Education Program, which are decisive in the field of medical specialization in Türkiye. The pass mark of the written exam is calculated using an internationally recognized criterion-referenced standard-setting method, considering the predetermined difficulty level of each question.

The written exam, held in a single center between 2006 and 2013, has been performed in three major cities of Türkiye (Ankara, Istanbul, and Izmir) since 2014. A pilot application for an online exam is planned to be carried out in 2025. Psychiatry specialists who have no obstacle to work in Türkiye and psychiatry trainees in the last year of their residency can apply for the written part of the board exam. Psychiatry specialists who have passed the written exam can apply for the practical exam.

In the second phase, the practical exam, the Objective Structured Clinical Examination (OSCE), is held once a year after the written exam. To apply for the practical exam, more than three years must not have passed since the candidate was successful in the written exam. This exam consists of six stations where standardized (simulated) patients are evaluated in an environment similar to real-world settings. Before the practical exam starts, candidates are informed in detail about the application method of the exam, instructions, total duration, and duration of each station. The exam evaluation is simultaneous, and it is determined in advance how any possible performance will be scored based on the objective and structured manual. In this way, it is aimed to provide a standardized measurement. During the practical exam, candidates are evaluated in terms of their clinical skills, such as mental state examination, interviewing skills, organization of laboratory tests, diagnostic evaluation skills, psychoeducation, management of patients, and creating and monitoring the treatment plan. At specific stations, skills that psychiatrists should demonstrate, including preparing forensic reports or reading scientific articles, are evaluated instead of simulated patient interviews. PAT Certificate of Proficiency is issued in both Turkish and English and presented to the holders at the National Psychiatry Congress following the exam. Colleagues who experienced the PAT Psychiatry Board Exam emphasized that it is a significant opportunity for psychiatrists to see themselves professionally in an exam where the evaluation is objective, structured, and standardized. Considering that psychiatry education is a process that continues not only during medical specialization training but also throughout our professional life, dissemination and maintenance of proficiency exams can contribute to the professional development motivation of psychiatrists and improve the practice of mental health services.

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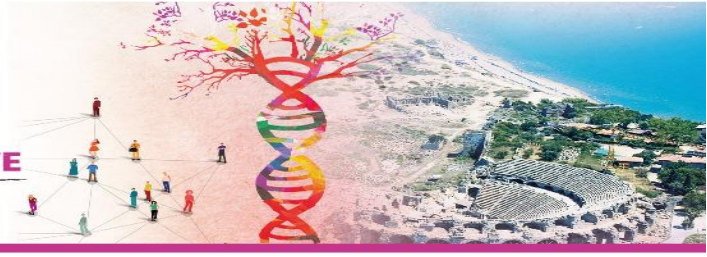


ETİOLOGY, DİAGNOSİS AND DİFFERENTİAL DİAGNOSİS İN CATATONİA

Serkan Yazıcı

Department of Psychiatry, Bursa City Hospital, Bursa, Turkey

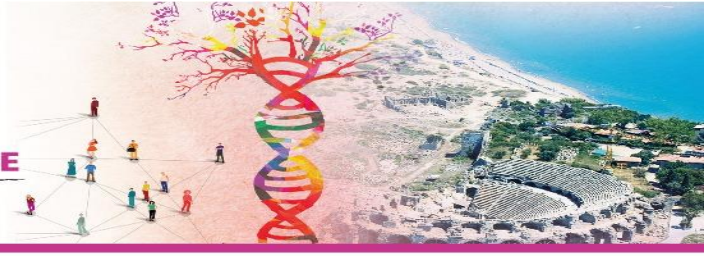
Due to the absence of a pathognomonic sign for the diagnosis of catatonia, the diagnosis is based on a combination of symptoms. The lack of a gold-standard biomarker also presents a significant issue regarding the validity of diagnostic criteria. Considering that symptoms can fluctuate over time, it is valuable to assess symptoms both cross-sectionally and longitudinally.

Catatonia can arise secondarily to both psychiatric disorders and non-psychiatric medical conditions. Psychiatric disorders, particularly those associated with catatonia, include Psychotic Disorders, Mood Disorders such as Major Depressive Disorder and Bipolar Disorder, and Autism Spectrum Disorders. Case reports have also linked catatonia with psychiatric disorders such as Obsessive-Compulsive Disorder, Anxiety Disorders, and Post-Traumatic Stress Disorder. Among the common underlying medical conditions associated with catatonia are inflammatory/autoimmune brain disorders such as systemic lupus erythematosus and encephalitis, epilepsy, central nervous system infections, structural, vascular, and degenerative brain lesions, toxins or medications, and endocrine and metabolic disorders (Oldham, 2018).

Whether the underlying cause is a primary psychiatric disorder or a non-psychiatric medical condition, emerging evidence suggests potential connections between the causes of catatonia and neuroinflammation. Furthermore, there is evidence of inflammatory associations in several syndromes thought to be related to catatonia, such as Akinetic Mutism and Neuroleptic Malignant Syndrome, which are also considered in the differential diagnosis. The terms "organic" or "secondary" catatonia have historically been used to refer to underlying medical or neurological etiologies. However, nowadays, neuroinflammatory etiologies and autoimmune disorders challenge the classical organic-psychiatric distinction.

In recent years, an increase in catatonia cases associated with antibody-mediated encephalitis, particularly anti-N-methyl-D-aspartate (NMDA) receptor antibody encephalitis, has been reported. Other autoimmune disorders, such as acute demyelinating encephalomyelitis and autoimmune encephalopathies associated with anti-neuronal antibodies, can also present with catatonia. The growing awareness of autoimmune encephalitis and related autoimmune psychiatric syndromes has led to the emergence of concepts such as autoimmune psychosis and autoimmune catatonia.

In conclusion, catatonia is a complex condition with various clinical presentations and may be associated with numerous underlying disorders. This complexity can present challenges in diagnosis, differential diagnosis, and treatment. Moreover, since prolonged or severe catatonia can lead to medical complications, in some cases, establishing a cause-and-effect relationship can be even more challenging. Emphasizing the importance of these issues in the differential diagnosis and management of catatonia will be beneficial for clinicians.



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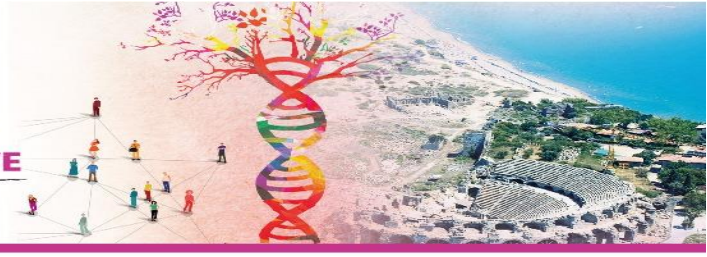


THE THERAPİST'S RESPONSİBİLİTY AND CHALLENGES İN THE SUPPORTİVE PSYCHOTHERAPY OF A PATİENT WİTH A SUİCİDE ATTEMPT

Suat Yalçın

Başakşehir Çam and Sakura City Hospital

Suicide Attempt

This presentation focuses on a clinical case involving suicidal ideation, approached within the framework of supportive psychotherapy. Key themes include the implementation of supportive interventions, the therapist's sense of helplessness, and the difficulties encountered in maintaining the structure of the therapeutic frame. Our primary aim is to present the complexity of a challenging case through an interactive format, offering a structured perspective under such demanding clinical conditions.

1. Establishing the Therapeutic Alliance

- Empathic Listening: Providing a non-judgmental, compassionate, and accepting space for the patient to express emotions.
- Building Trust: Developing a secure therapeutic relationship enables the individual to express their thoughts openly

2. Crisis Intervention

- Risk Assessment: Evaluating the intensity and frequency of suicidal thoughts, presence of a plan, and the level of preparation.
- Safety Planning: Collaboratively formulating a written safety plan to be utilized in times of acute crisis, including:
    - Identification of emergency contacts
    - Removal of potential means for self-harm (e.g., medication, sharp objects)
    - Introduction of alternative coping strategies

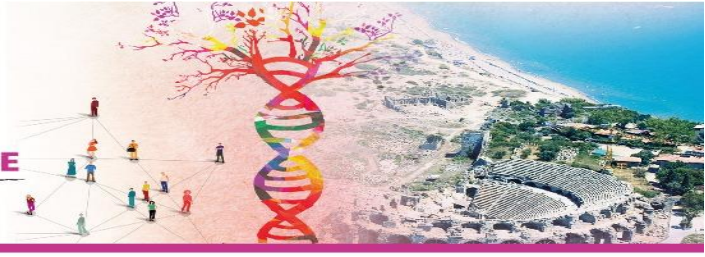
3. Support and Empowerment

- Enhancing Self-Esteem: Reinforcing the patient's strengths and promoting self-worth.
- Reality Testing: Fostering realistic perspectives for cognitive distortions of the patient
- Mobilizing Social Support: Encouraging the involvement of family members, friends and the other support networks in the therapeutic process.

4. Reconstructing Hope

- Future-Oriented Dialogue: Assisting the patient in identifying minor attainable goals and formulating actionable plans.
- Exploring Meaning in Life: Supporting the patient in exploring personal values and meaningful interpersonal connections.

5. Psychoeducation and Referral



- Psychoeducation: Providing information on the psychological underpinnings of suicidal ideation and its relationship with mental health disorders.
- Referral When Necessary: Facilitating access to psychiatric consultation and pharmacological interventions, medical treatment

6. Ongoing Monitoring and Follow-Up

- Scheduling more frequent sessions with patients deemed at high risk.
- Maintaining therapeutic contact through phone calls or other appropriate means between sessions when necessary.

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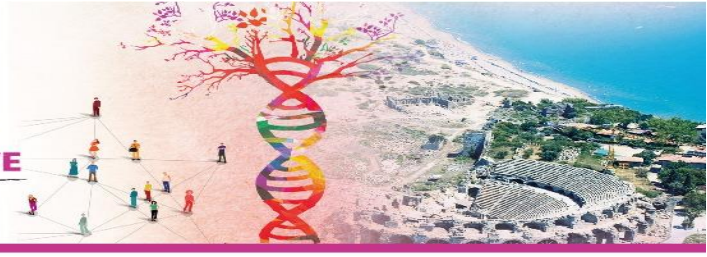

CRİSES ENCOUNTERED DURİNG MANDATORY SERVİCE AND THEİR MANAGEMENT

Suat Yalçın

Başakşehir Çam and Sakura City Hospital

Mobbing ranks among the most prominent ethical issues that professionals may either perpetrate or be subjected to in the workplace. When the conceptual framework and the mechanisms of recourse are not clearly understood, individuals often struggle to define their experience as mobbing, which in turn renders their coping strategies insufficient or ineffective.

This phenomenon can be encountered during especially at the beginning of the professional life, which constitutes an important part of the first professionalization stages of our profession and during transitional phases when departing from affiliated clinical settings. In such periods, where feelings of inadequacy and insecurity may be heightened, it is not uncommon to experience psychological violence firsthand. In these moments, individuals may also find themselves lacking support from the group dynamics within their institutional or peer environment. We aim for this work to serve as a structured presentation grounded in peer participation at every level, with the goal of contributing meaningfully to all our colleagues under the umbrella of our main professional organization, the Turkish Psychiatric Association.

Main Topics of the Presentation:

1. Identify and Document the Situation
2. Maintain Calm and Be Professional
3. Communicate and Seek Support
4. Access Professional Assistance
5. Research Your Legal Rights
6. Develop a Personal Safety and Protection Plan

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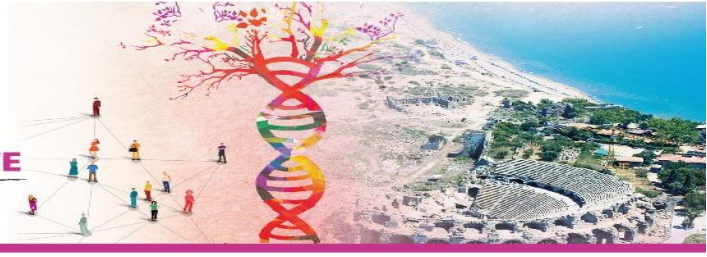


DIAGNOSIS AND EPIDEMIOLOGY OF VAGINISMUS:

CURRENT DATA AND CLINICAL FEATURES

Sinay ÖNEN

University of Health Sciences, Bursa Faculty of Medicine, Department of Psychiatry

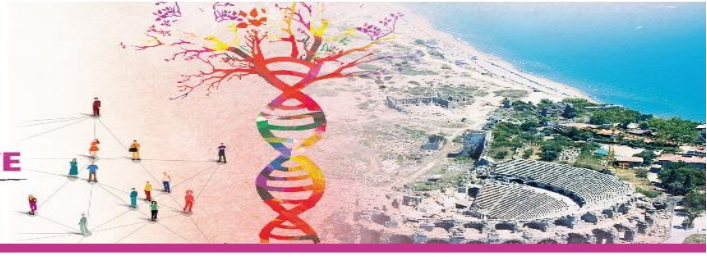
Vaginismus is a sexual dysfunction characterized by involuntary contractions of the outer third of the vaginal muscles that prevent sexual intercourse, leading to significant distress and interpersonal difficulties. While it was classified as an independent diagnosis in DSM-IV, it was combined with dyspareunia under the diagnosis of "Genito-Pelvic Pain/Penetration Disorder" in DSM-5. Prominent symptoms include pain during penetration, muscular contraction, and anxiety.

The prevalence of vaginismus varies between countries, ranging from 1% to 7% globally. It is more frequently observed in developing countries where sexuality is a taboo subject. In Turkey, it is reported as the most common reason for clinical presentation among female sexual dysfunctions, with rates between 41% and 75% in specialized sexual treatment clinics.

Etiologically, vaginismus is a multifactorial disorder, arising from the interplay of biological, psychological, relational, and sociocultural factors. Although biological causes are rare, vaginal atrophy, vestibulitis syndrome, endometriosis, or past intravaginal surgical interventions can contribute. Psychological factors include sexual trauma, childhood sexual abuse, fear related to first sexual experience, phobic responses to penetration, and catastrophizing of pain. The vaginismic response often emerges as a conditioned reaction to an initially painful sexual experience. Concerns about losing control during penetration, negative self-image, catastrophic cognitions related to pain, and genital incompatibility cognitions are among the cognitions related to penetration in vaginismus.

Sociocultural contributors include traditional gender roles, exaggerated importance attributed to virginity, and the perception of sexual experience as taboo—especially in conservative societies. Sexual myths, such as the belief that the vagina is too narrow or that the penis may cause internal damage, play a critical role in the development of vaginismus. Relational factors, such as lack of emotional intimacy or unresolved conflicts within the couple, may also lead to the emergence of vaginismus. A “supportive yet avoidant” partner who passively accommodates the woman’s fears can unintentionally contribute to the persistence of the disorder.

In differential diagnosis, vaginismus is distinguished from dyspareunia by the predominance of fear of pain and the frequent complete absence of penetration. The most essential tool in diagnosis is a detailed and empathetic sexual history. Vaginismus should also be approached as a couple’s issue. Partners may internalize the situation as a reflection of their inadequacy, potentially developing erectile dysfunction due to performance anxiety. Over time, men may also experience decreased sexual desire due to repeated failed attempts at intercourse. It is crucial to



remember that secondary psychological problems in both partners may complicate the diagnosis and treatment of vaginismus.

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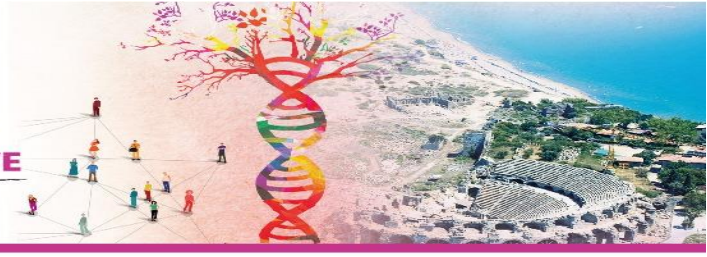


DİVERSE APPROACHES TO THE TREATMENT OF SUBSTANCE USE DİSORDERS RECENT ADVANCES İN PHARMACOLOGİCAL APPROACHES TO THE TREATMENT OF SUBSTANCE USE DİSORDERS

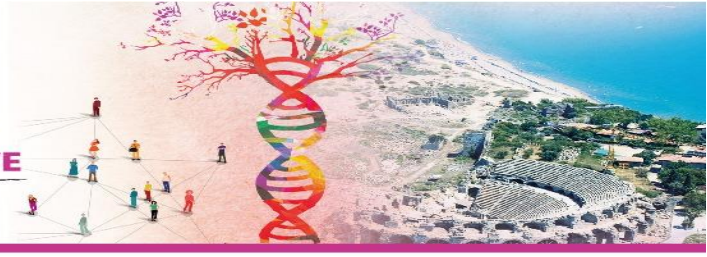
Şafak Yalçın Şahiner
Department of Psychiatry, Faculty of Medicine, Ankara University

Substance use disorder (SUD) remains a significant public health issue due to its chronic nature and high rates of relapse. Although important advancements have been made in pharmacological treatment approaches, craving and relapse behaviours remain some of the most treatment-resistant aspects of SUD. Agents such as naltrexone, bupropion and buprenorphine are commonly employed in the treatment of substance dependence, including alcohol, opioids and nicotine. However, these treatments may not be effective for everyone, as success in treatment is often limited by differences between individuals, psychiatric comorbidities, and environmental factors. Consequently, interest in alternative pharmacological agents has grown in recent years.

One such promising agent is N-acetylcysteine (NAC), which is primarily known as a glutathione precursor and antioxidant, but is also notable for its neuromodulatory properties. NAC has been shown to reduce drug-seeking behaviour and impulsive use by regulating extracellular glutamate levels. Preclinical studies have demonstrated its efficacy in treating cocaine, methamphetamine, and cannabis use disorders, and an increasing body of evidence from human studies also suggests reductions in both substance use frequency and craving [1]. Its favourable safety and side-effect profile make NAC an attractive option for use in young adults and patients with comorbid psychiatric disorders.

Another notable group of agents are glucagon-like peptide-1 receptor agonists (GLP-1RAs), which are widely used in the treatment of diabetes and obesity. It is hypothesised that these agents reshape reward processing by modulating the mesolimbic dopamine system. In animal models, GLP-1RAs have been shown to reduce conditioned place preference for substances such as cocaine, nicotine and alcohol. In humans, their effects on appetite and impulse control show promise for potential application in the field of addiction [2]. However, these findings remain preliminary and further randomised controlled trials are necessary.

Finally, one increasingly explored area of addiction treatment is the use of psychedelic agents. Unlike traditional antidepressants, serotonergic hallucinogens (e.g. psilocybin and LSD) appear to produce long-lasting therapeutic effects with only short-term administration. It is believed that psychedelics enhance neural plasticity in regions such as the anterior cingulate cortex and the default mode network, potentially disrupting the circuits associated with addiction that have become maladapted [3]. Early-phase studies on nicotine and alcohol use disorders have reported that even a single dose of psilocybin can reduce cravings and decrease the frequency of substance use. However, ethical, legal and safety considerations must be carefully addressed before broader clinical application can be considered.



In conclusion, alongside standard treatment approaches, emerging pharmacological agents offer new hope for cases of SUD that are resistant to treatment. NAC, GLP-1 receptor agonists and psychedelics are among the most innovative interventions currently under investigation; however, further robust studies are needed to assess their efficacy and safety in clinical populations.

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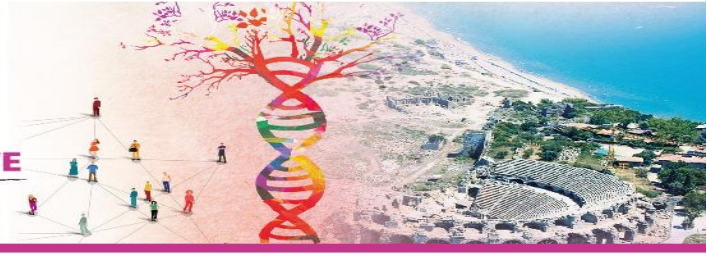


TELLİNG THE UNTOLD: SEXUALİTY İN PSYCHİATRY TRAİNİNG

Münevver Hacıoğlu Yıldırım[1], Şiirnaz Kükürt[2], Zeynep Yörümez[3], Muratcan Agaçe[3]
[1]Private Practice, İstanbul
[2]Department of Psychiatry, Bezmialem Vakif University, İstanbul
[3]Department of Psychiatry, Pamukkale University Faculty of Medicine, Denizli

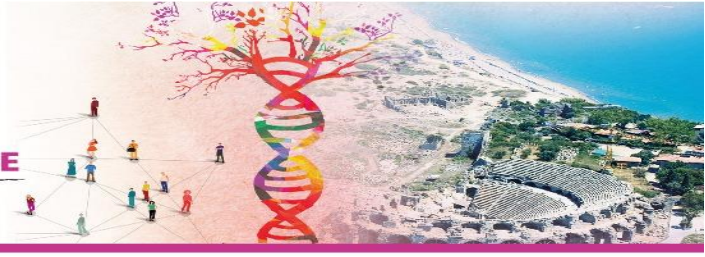
Although sexuality is an integral part of mental health, it is often overlooked in psychiatric residency training. In Turkey, psychiatry residents face significant challenges when addressing sexual health topics with patients. These difficulties are primarily shaped by cultural and societal taboos, but the lack of structured training further hinders residents' competencies. As a result, patients are deprived of comprehensive psychiatric care, and therapeutic relationships may suffer.

Sexual dysfunctions, with their biopsychosocial underpinnings, require a multidisciplinary approach. However, many psychiatry residents receive limited education and clinical exposure to these topics. This leads to significant shortcomings in diagnosis and treatment, exacerbated by discomfort in discussing sexuality. Studies show that psychiatric residents often feel incompetent in evaluating sexual dysfunctions, experience difficulties in clinical interviews, and rarely address the sexual side effects of psychopharmacological treatments. For instance, selective serotonin reuptake inhibitors (SSRIs), commonly used in depression treatment, frequently cause sexual dysfunctions. Without adequate training in managing these side effects, patients may prematurely discontinue medication or seek unverified alternatives.

Psychotherapeutic approaches for patients with sexual trauma are also insufficiently addressed in training. It is unrealistic to expect that such patients will disclose trauma during initial assessments. Training in trauma-informed care and desensitization techniques can improve psychiatric residents' sensitivity and therapeutic competence. While sexual therapy holds a significant place in psychiatric practice, it is rarely emphasized in formal education. In contrast to some countries that have dedicated curricula or clinical settings for sexual therapy, Turkish residents often rely on personal interest to pursue further education.

Furthermore, the mental health of LGBTQ+ individuals is superficially addressed in most programs. In Turkey, such topics are inconsistently covered, depending on individual supervisors and local attitudes. This gap leads to unstandardized approaches, insufficient sensitivity, and unmet needs in this population.

To address these deficiencies, sexuality, sexual trauma, and sexual therapy should be systematically integrated into psychiatric training programs. The curriculum must encourage multidisciplinary collaboration, utilize case-based teaching, and offer both theoretical and practical modules. Structured supervision, cultural competency, and reflective practice must be incorporated to develop therapeutic skills in sensitive domains. Through a standardized and



comprehensive approach, psychiatry residents can become more competent and confident in addressing sexual health, ultimately improving patient care.

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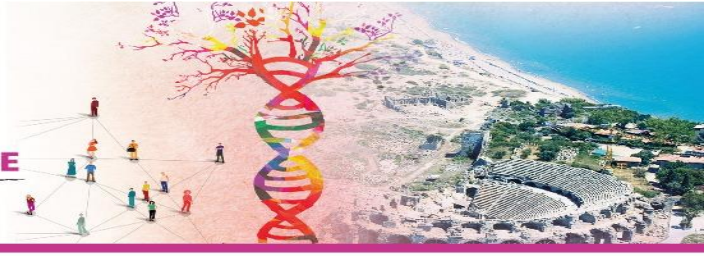


ASSESSMENT METHODS AND PSYCHIATRIC INTERVENTIONS IN TREATMENT ADHERENCE WITHIN CONSULTATION-LIAISON PSYCHIATRY

Talat SARIKAVAK

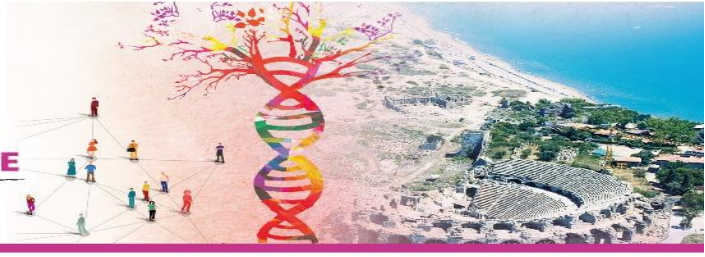
Istanbul Atlas University Faculty of Medicine

In the evolving landscape of consultation-liaison psychiatry, improving treatment adherence among patients with systemic medical illnesses has emerged as a critical concern. This presentation focuses on two integral components of managing nonadherence: the assessment methods used to evaluate patient adherence, and psychiatric intervention strategies employed when poor adherence is identified.

Assessment of treatment adherence is multifactorial and requires a comprehensive, biopsychosocial approach. Self-report questionnaires such as the Morisky Medication Adherence Scale (MMAS) and the Medication Adherence Rating Scale (MARS) are commonly used tools that offer quick screening but are susceptible to bias. More objective strategies include pill counts, pharmacy refill records, and electronic medication monitors. In hospital settings, direct observation or integration with nursing teams through interdisciplinary rounds can enrich the evaluation of adherence in real-time. Furthermore, assessing patients' insight, health literacy, beliefs about illness and treatment, and comorbid psychiatric symptoms (such as depression or cognitive dysfunction) is fundamental to a nuanced understanding of nonadherence.

When nonadherence is identified, psychiatric interventions are guided by a stepped-care model and tailored to the underlying psychosocial and clinical determinants. Motivational interviewing is a cornerstone intervention, aiming to resolve ambivalence and enhance intrinsic motivation. Cognitive-behavioral approaches address maladaptive beliefs, while psychoeducation fosters better understanding of disease and treatment necessity. For patients with comorbid psychiatric conditions, pharmacologic treatment or psychotherapeutic engagement is often essential. Importantly, establishing a therapeutic alliance and collaborative communication with the medical team are vital in implementing shared decision-making frameworks.

In conclusion, addressing treatment adherence in systemic disease contexts demands both accurate identification methods and individualized, evidence-based psychiatric strategies. Consultation-liaison psychiatrists are uniquely positioned to bridge the psychological and medical domains, ultimately contributing to better health outcomes and reduced healthcare burden.



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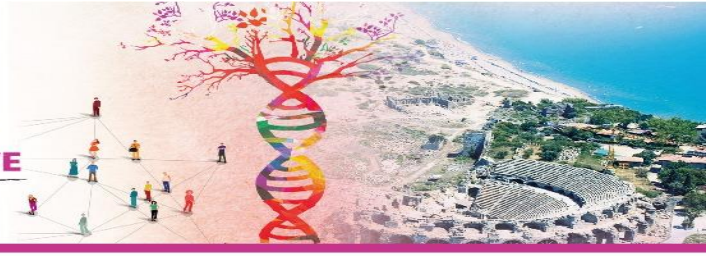


EARLY CHILDHOOD (0–10 YEARS): BUILDING RESILIENCE AND PROTECTIVE ENVIRONMENTS

Talat SARIKAVAK

Istanbul Atlas University Faculty of Medicine

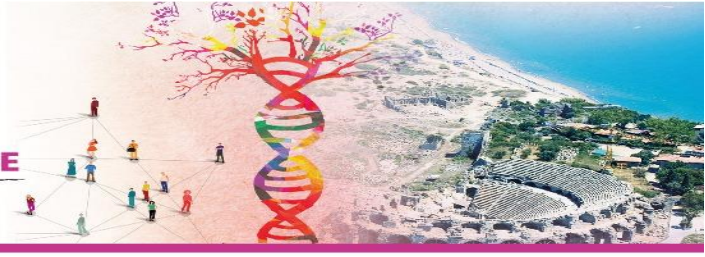
In the digital age, children are being exposed to screens and interactive media at increasingly earlier ages. This shift, while offering certain educational and entertainment benefits, has also introduced new psychological risks particularly in the form of behavioral addictions. Early childhood, defined as the period between birth and 10 years of age, is a critical developmental window in which foundational emotional, cognitive, and social skills are formed. During this time, children are particularly vulnerable to environmental influences, and unchecked exposure to digital content may contribute to problematic behaviors such as excessive screen use, gaming preoccupation, social withdrawal, and impaired self-regulation.

This presentation will explore how targeted, developmentally appropriate prevention strategies during early childhood can reduce long-term addiction risks by fostering resilience and supportive environments. A growing body of research highlights that behavioral pattern established during early childhood, especially around media use, can have a lasting impact on a child's neurodevelopment and social functioning. Preventing addiction at this stage requires a multifaceted approach, integrating parental awareness, educational guidance, and the promotion of emotionally enriching and socially interactive alternatives to screen-based activities.

Key protective factors include secure attachment relationships, consistent parenting, and limited, intentional exposure to digital technology. Children who experience emotionally supportive caregiving and consistent behavioral boundaries are more likely to develop impulse control, emotional regulation, and attention span traits strongly associated with lower risk of future addictive behaviors. Resilience, or the ability to adapt in the face of stress and adversity, is not an innate trait but one that can be cultivated through positive early life experiences, such as structured routines, responsive caregiving, and safe exploration environments.

Importantly, digital parenting practices play a crucial role. Studies show that parental co-viewing, screen time monitoring, and content mediation are associated with lower behavioral risk scores and better emotional outcomes in children. On the contrary, unsupervised or excessive media exposure in early childhood has been correlated with inattention, behavioral problems, and early signs of compulsive use. Therefore, equipping parents with evidence-based guidelines and accessible support tools is a central focus of prevention at this age.

This session will present effective intervention strategies, including early childhood education programs, family-based prevention models, and community-level initiatives aimed at strengthening digital literacy and media regulation. It will also review the current literature on early digital exposure and the differential susceptibility model, which posits that some children are



more sensitive to environmental influences—both negative and positive—depending on their genetic and temperamental makeup.

By implementing age-appropriate, context-sensitive, and family-oriented prevention strategies during early childhood, we can lay the groundwork for healthier digital behaviors and reduce the risk of behavioral addictions later in life.

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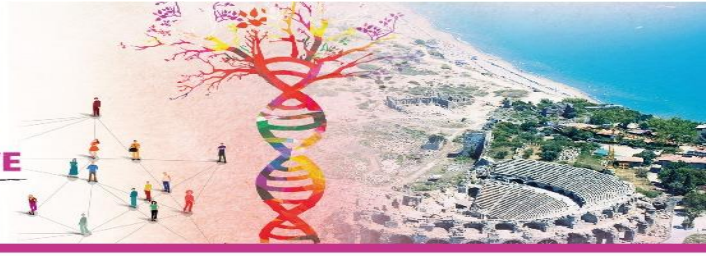

LET THE MOTHER STAY AWAKE, SO HER CHILD MAY GROW

TWO PERSPECTIVES, ONE REALITY:

SLEEP DURING PREGNANCY THROUGH THE EYES OF A MOTHER AND A PSYCHIATRIST

Tuğba Koca Laçin

Ankara Etlik City Hospital

Sleep disturbances during pregnancy affect a significant portion of expectant mothers and are closely linked to psychiatric well-being. Recent studies from 2023–2024 have shown that poor sleep quality in pregnancy frequently co-occurs with psychiatric conditions such as depression, anxiety, and a history of trauma. These sleep problems can lead to adverse outcomes for the mother and the baby. Therefore, healthcare professionals in the perinatal period must adopt a proactive approach to sleep issues.

Early screening can help identify at-risk pregnant individuals; for example, recognizing sleep disturbances early on and providing psychosocial support, or treatment when necessary, can help prevent the development of postpartum depression. A holistic approach is essential in managing sleep disorders during pregnancy: biological changes, emotional needs, and environmental factors must be considered.

A pregnant woman struggling with insomnia should receive education on sleep hygiene, have the opportunity to express her anxieties, and be referred to cognitive behavioral therapy (CBT) if needed. Concurrent medical problems such as pain, restless legs syndrome (RLS), or sleep apnea should be addressed in tandem. If pharmacologic treatment is necessary, the choice of agent must carefully balance maternal benefit with potential fetal risk.

It must be emphasized that good sleep during pregnancy is not a luxury—it is a necessity. A well-rested mother is more resilient both emotionally and physically, better equipped to handle the demands of pregnancy. Thus, evaluating and, when necessary, addressing sleep quality should be seen as an integral component of modern perinatal care aimed at ensuring the health of both mother and child.

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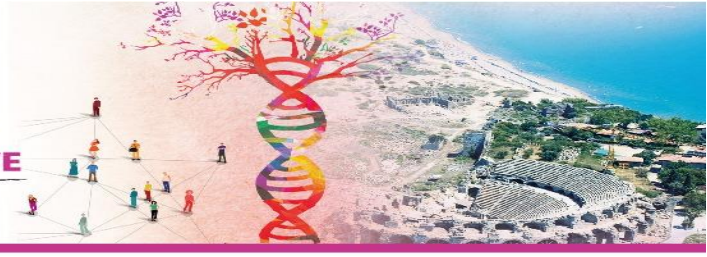

THE DREAM OF GENETIC CODES: PERSONALIZED TREATMENTS AND SCIENTIFIC APPROACHES TO SLEEP PATTERN

Tuğba Koca Laçin

Ankara Etlik City Hospital

Sleep is a highly regulated biological process with a strong genetic foundation. In 2024, major advances in genomics illuminated the intricate relationship between genetic variation and individual sleep patterns, paving the way for personalized treatment strategies. Genome-wide association studies (GWAS) revealed significant links between circadian rhythm genes—such as CLOCK, PER1/2/3, and CRY1/2—and traits like sleep duration, sleep quality, and chronotype. These findings support the notion that a person's genetic profile can influence both their sleep window and their responsiveness to treatment.

Furthermore, genetic variants associated with neuropsychiatric disorders such as ADHD, depression, and bipolar disorder were shown to contribute to disrupted sleep regulation. This growing body of evidence is reshaping how clinicians assess symptoms and tailor interventions. For example, individuals with specific PER3 polymorphisms were found to respond more robustly to melatonin-based therapies.

Pharmacogenetics has also emerged as a critical tool for optimizing treatment. Genetic polymorphisms affecting drug metabolism, particularly involving sedative-hypnotics and melatonin receptor agonists, are being used to guide drug selection and dosing. This approach reduces adverse effects and enhances therapeutic efficacy by aligning treatments with an individual's unique genetic makeup.

Additionally, polygenic risk scores (PRS) are being developed to estimate an individual's predisposition to various sleep disorders. These scores may enable early identification of at-risk individuals, potentially allowing for preventative strategies before the onset of clinical symptoms.

In conclusion, the integration of genetic data into sleep medicine marks a paradigm shift toward precision healthcare. By decoding the "genetic blueprint" of sleep, researchers and clinicians are now able to move beyond generalized protocols to deliver more accurate, biologically-informed interventions tailored to the individual.

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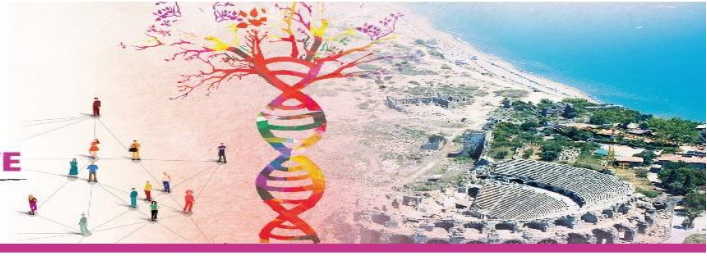


PHYSIOPATHOLOGY OF NEUROPSYCHIATRIC SYMPTOMS IN NEURODEGENERATIVE PROCESS AND THEIR IMPORTANCE IN CLINICAL PROCESS

Uğur Çıkrıkçılı

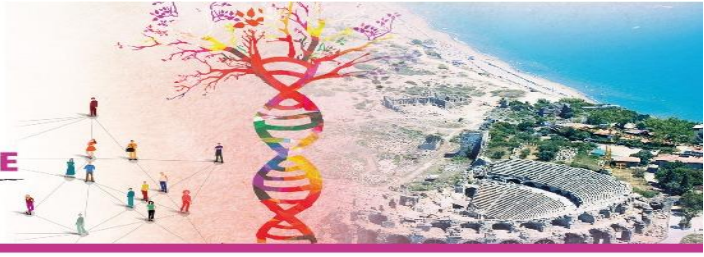
Institute of Behavioral Neurology and Dementia Research, Otto von Guericke University, Magdeburg, Germany

Neuropsychiatric symptoms (NPS) represent a core clinical component of dementia spectrum disorders and can be observed not only in the advanced stages of the disease but also during the prodromal and even preclinical phases. The first case described by Alois Alzheimer in 1906, Auguste D., presented with symptoms such as apathy, paranoid ideation, agitation, and anxiety—clearly illustrating the neuropsychiatric nature of dementia. Today, the concept of Mild Behavioral Impairment (MBI) enables a systematic evaluation of these symptoms by defining behavioral changes that emerge prior to cognitive decline and persist for at least six months, thereby facilitating the early recognition of neurodegenerative processes.

At the neuropathological level, tau protein accumulation, β-amyloid pathology, and reduced functional connectivity in structures such as the amygdala and medial temporal lobe constitute the underlying pathophysiology of NPS. Functional imaging studies have shown that symptoms like apathy and anxiety are particularly correlated with disruptions in the amygdala–hippocampus network. In this regard, NPS are not merely comorbid clinical features of dementia but are increasingly recognized as early biological markers of the disease. Within the scope of this presentation, special emphasis will be placed on the functional role of the amygdala, given the author's particular area of interest.

Therapeutic approaches require a multidisciplinary framework. Pharmacotherapeutic interventions include antidepressants, antipsychotics, and mood stabilizers, while psychosocial interventions such as cognitive-behavioral therapy, psychoeducational programs, support groups, and caregiver counseling should be integrated to create a comprehensive and individualized treatment plan.

Early diagnosis and management of neuropsychiatric symptoms not only help slow the progression of these manifestations but also play a pivotal role in enhancing the quality of life for both patients and their caregivers.



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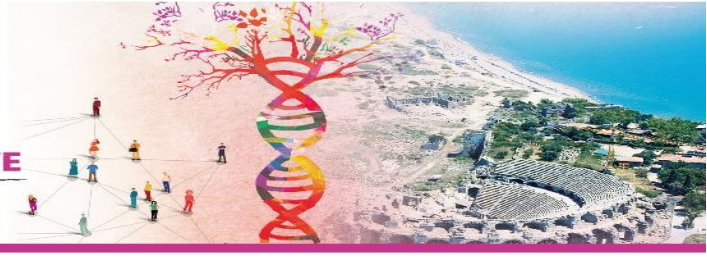

PHENOMENOLOGY OF DELUSIONS

Utku YAVUZ

Firat University Faculty of Medicine Department of Mental Health and Diseases

Delusion is a crucial concept in psychiatry and philosophy, characterized by highly implausible claims lacking evidence. The DSM-5 defines it as a false belief based on incorrect inference about external reality, firmly held despite contradictory evidence and not culturally accepted. However, this definition is considered problematic with several counterexamples. Philosophically, delusion can be viewed as an epistemically defective mental state or an expression of folk-epistemic bafflement.

Clinically, delusions are diverse, appearing in psychotic disorders (often as paranoid systems), mood disorders (mood-congruent), and following brain injury (often monothematic like Capgras). Explanatory accounts vary, including bottom-up models where unusual experiences lead to delusions (e.g., Capgras), and top-down models where pre-existing beliefs influence experience. Other frameworks include explanationist versus endorsement models, and one-factor versus two-factor accounts addressing formation and maintenance. Tracking accounts explain misidentification delusions as neurological disruptions in individual tracking mechanisms.

A key philosophical debate questions whether delusions are genuine beliefs. Some argue that despite sincere assertion, delusions lack the functional roles of belief (e.g., guiding action and reasoning) and might be better understood as imaginings mistaken for beliefs. The nature and etiology of specific delusions influence this debate. Ultimately, defining and understanding delusion remains a complex challenge in both psychiatric diagnosis and philosophical inquir.As Murphy (2013) rightly says, we can even draw an illustrative parallel with the concept of knowledge: A delusion is a false belief, just as knowledge is true belief, but, as with knowledge, philosophers do not rest there. Knowledge is true belief plus something else. So too, philosophers try to and that extra property of the false belief that converts it from a mere false belief into a delusion.

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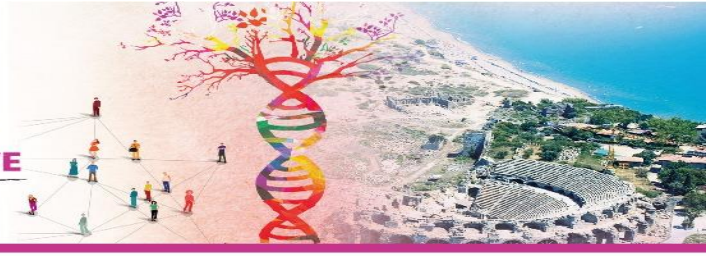


DIVERSE APPROACHES TO THE TREATMENT OF SUBSTANCE USE DISORDERS VIRTUAL REALITY APPLICATIONS IN THE TREATMENT OF SUBSTANCE USE DISORDERS

Yağmur Kır

Department of Psychiatry, Faculty of Medicine, Ankara University

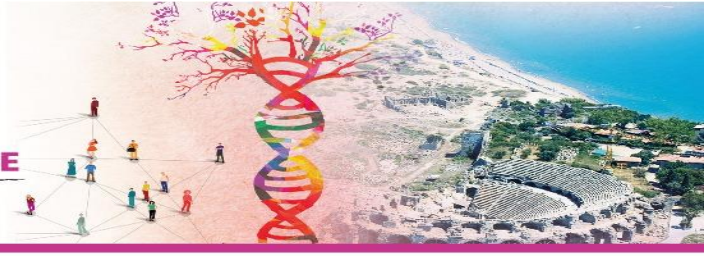
Today, technology offers innovative solutions in healthcare and is increasingly being incorporated into therapeutic practices. Approaches to mental health are also evolving beyond traditional methods, enabling more effective and personalised interventions. Substance use disorder (SUD) remains a significant public health concern due to its chronic nature and high relapse rates. Standard approaches often fail to achieve the desired outcomes in SUD treatment. Against this backdrop, virtual reality (VR) technology is emerging as a promising tool in the treatment of SUD.

VR applications place individuals in a controlled digital environment where they can be exposed to substance-related triggers similar to those encountered in real life. This controlled exposure enables individuals to recognise high-risk situations, develop coping strategies and strengthen self-regulation. For example, a user may find themselves in a simulated nightclub and be offered drugs. Their reactions and responses in this setting can then be observed and therapeutic interventions can be used to help them develop refusal skills and disengage from risky contexts. These exposure-based VR therapies can be integrated with traditional cognitive behavioural therapy (CBT). Furthermore, when combined with motivational approaches and desensitisation techniques, VR applications may also help to reduce cravings [1].

Immersive VR provides realistic synthetic experiences and has the potential to create therapeutic scenarios that would otherwise be impossible in real life. Facilitating future self-projection can promote continuity of self and enhance future-oriented thinking, which may help prevent relapse [2].

Emotional dysregulation and anxiety are commonly observed in individuals with SUD and are often associated with poorer treatment outcomes. VR appears to have beneficial effects on emotional regulation and anxiety management [3]. VR applications can enhance emotional awareness, manage stress responses, and support behavioural control. Furthermore, VR could be used as a motivational tool to encourage engagement in treatment. Such innovative approaches have the potential to boost interest in therapy. Including these technological tools in clinical practice introduces a new dimension to individual and group therapies.

In conclusion, virtual reality is increasingly being recognised as a scientifically supported tool in the treatment of substance use disorders. As technology continues to advance, these interventions may become more accessible, effective and customisable in the near future.



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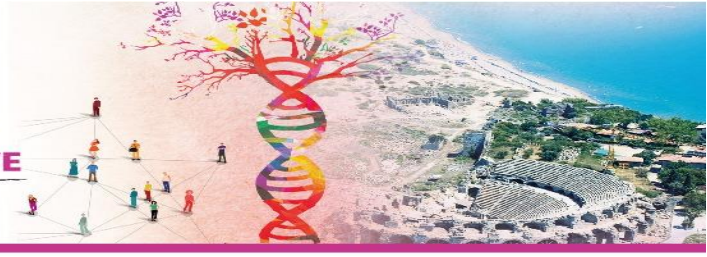


CAMOUFLAGİNG İN AUTİSM SPECTRUM DİSORDER: GENDER DİFFERENCES AND PSYCHİATRİC RİSKS

Yunus Akkeçili

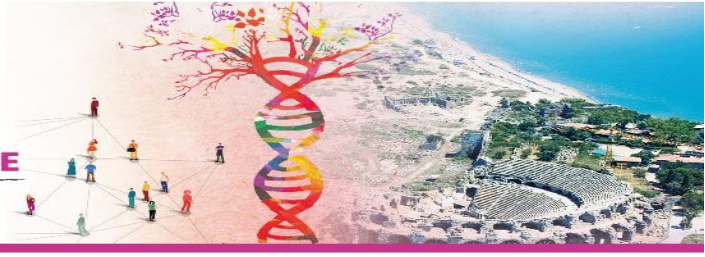
Dinar State Hospital,Dinar, Afyonkarahisar, Türkiye

Autism Spectrum Disorder (ASD) is a heterogeneous neurodevelopmental disorder characterized by difficulties in social communication and restricted/repetitive behaviors. In recent years, the concept of "camouflaging" has gained importance, especially in explaining the reasons behind the delayed or misdiagnosis of autism in women or high-functioning individuals. Camouflaging refers to an individual's conscious or automatic strategies to hide, reduce, or appear neurotypical in social settings. These strategies are categorized into three main types: "compensation," where social skill deficits are actively "masked" with strategies (e.g., creating scenarios to initiate conversations), "masking," which involves suppressing or concealing autistic traits (e.g., maintaining eye contact, using facial expressions), and "assimilation," where the individual attempts to adapt to uncomfortable social situations without allowing others to notice their distress.

Camouflaging behaviors have been suggested to be more frequently observed in women. The pressure on women to adapt to social expectations from an early age, along with their more advanced social imitation skills and linguistic advantages, may enable them to hide their autistic traits more effectively. This results in women exhibiting behaviors more aligned with neurotypical norms, which, in turn, may lead to a mismatch with the classic diagnostic criteria for autism. In this context, the lower rates of autism diagnosis in women, their later age at diagnosis, or the misdiagnosis with other conditions (such as personality disorders or eating disorders) may be linked to this camouflaging process.

However, some studies suggest that camouflaging behaviors are not exclusive to women or individuals with autism; they can also be observed in those with a broad autism phenotype or even in neurotypical individuals. Additionally, research exists indicating that there are no significant or consistent differences in the frequency of camouflaging between male and female autistic individuals. Therefore, assessing camouflaging solely through the female phenotype might be insufficient.

While camouflaging behaviors may improve short-term adaptation to social environments, they can lead to severe psychiatric outcomes in the long term. Specifically, consistently suppressing one's true self, acting according to others' expectations, and expending mental effort to conform to social norms can contribute to the development of psychological exhaustion (autistic burnout). Furthermore, these behaviors have been linked to significant mental health issues, such as anxiety, major depression, post-traumatic stress symptoms, eating disorders, and an increased risk of suicide. These psychiatric consequences may be more severe in women, particularly those whose diagnoses are delayed or who lack access to support systems.



Thus, camouflaging behaviors should be regarded not only as an adaptation strategy but also as a phenomenon that carries significant emotional burdens and psychiatric risks. Recognizing camouflaging during the diagnostic process can facilitate individuals' access to the correct diagnosis, enabling timely support and intervention mechanisms. This, in turn, can improve the individual's quality of life and prevent long-term psychiatric outcomes.

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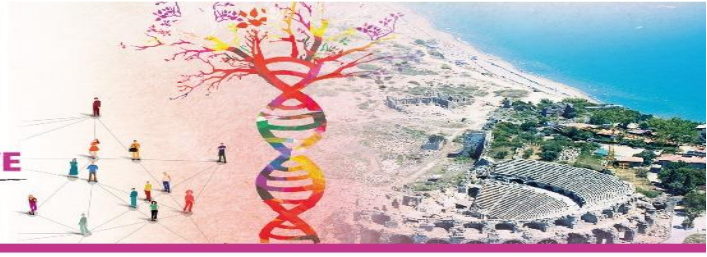


NEUROMODULATION IN THE TREATMENT OF SUBSTANCE USE DISORDERS

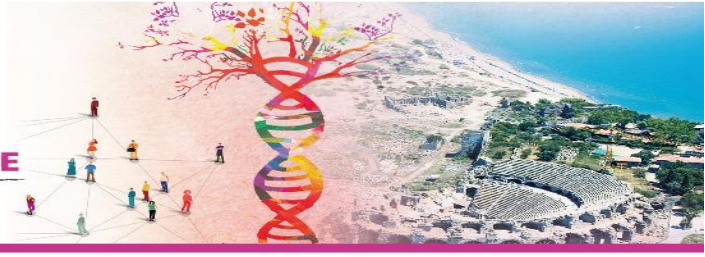
Zehra Uçar Hasanlı

Ankara Training and Research Hospital

Substance use disorders (SUDs) are chronic disorders with high relapse rates that seriously impair the biopsychosocial functioning of the individual. Although conventional treatment methods include psychoeducation, psychotherapy and pharmacotherapy, these approaches do not always provide adequate response; new intervention methods are needed, especially in individuals who experience intense craving or show a treatment-resistant course. In this context, in recent years, neuromodulation techniques have come to the fore as an alternative and complementary option in the treatment of SUD.

Neuromodulation is a treatment approach that aims to regulate neuronal activity through electrical or magnetic stimulation of specific brain regions. At the brain level, SUDs cause structural and functional changes, mainly consisting of increased activity in the mesolimbic-reward system and hypofunction of neural circuits involved in self-regulation, impulse control and decision-making. Non-invasive neuromodulation methods such as Transcranial Magnetic Stimulation (TMS) and Transcranial Direct Current Stimulation (TDCS) used in SUD-related studies often target the dorsolateral prefrontal cortex (DLPFC), which is known to be associated with impulse control, decision-making and craving processes; the insula, which is associated with craving and interoception; and the medial prefrontal cortex, which is associated with executive functions, behavioral control and drug seeking. In a recently published meta-analysis (Mehta et al. 2024), the effects of repetitive TMS (rTMS), deep TMS and high frequency (HF) stimulation were evaluated in alcohol use disorder and significant reductions in craving and alcohol consumption were found. Tobacco use was also found to decrease with TMS, and H4 coil TMS applications were approved by the FDA in smoking cessation treatment after the study by Zengen et al (2021). Positive effects of TMS were also found in opioid and methamphetamine use, and although no significant results were found in cocaine and cannabis use, decreasing trends were observed (Mehta et al. 2024). Although some of the studies in which TDCS was tried in alcohol use disorder yielded positive results, meta-analysis results were negative. The results of TDCS in tobacco, cannabis, cocaine and methamphetamine use disorder are also not consistent in general. In opioid use disorder, TDCS has been observed to reduce both craving and depressive symptoms (Mehta et al. 2024). Studies have also been conducted on the use of Deep Brain Stimulation (DBS), an invasive brain stimulation method, in SUD. In these studies, the nucleus accumbens, which is an important structure in the reward circuit, was targeted, and a decrease in craving and substance consumption was found in trials of DBS in alcohol, tobacco and opioid use disorders (Mehta et al. 2024).

Clinical studies reveal that neuromodulation techniques are promising in alleviating SUD symptoms and preventing relapse, but issues such as the continuity of their efficacy, target site selection and individual response variability are still under investigation. In the future, the efficacy of neuromodulation may be enhanced by targeting with neuroimaging and individualized treatment protocols. The integrated use of these techniques with pharmacological and



psychosocial treatments may lead to more comprehensive and effective results in the treatment of SUD.

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