L1. ADULT ATTENTION DEFICIT HYPERACTIVITY DISORDER

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Attention Deficit Hyperactivity Disorder (ADHD) is a common psychiatric disorder with childhood onset. The core clinical features of ADHD are hyperactivity, inattentiveness and impulsivity. The disorder may persist till adulthood and follow a chronic course. As the age increases, the symptoms of hyperactivity decreases, but impulsivity and inattentiveness may persist, which causes significant impairment in real world functioning. Co-morbidities like mood disorders, substance use disorders and anxiety disorders are commonly reported in patients with adult ADHD. ADHD in adults frequently goes undiagnosed. A recent epidemiological data suggest that 80% of patients with adult ADHD go undiagnosed. In most clinical scenarios, the co-morbidities associated with ADHD being the reason for consultation and ADHD gets diagnosed accidentally. The major reasons for missing the diagnosis of adult ADHD in routine clinical scenario are – lack of formal guideline for diagnosis & treatment, lack of awareness & adequate training on adult ADHD and age dependent change in clinical presentation.

Proper evaluation, adequate treatment of adult ADHD and associated co-morbidities will improve the outcome. The goal of management of ADHD in adults is to reduce symptoms of inattentiveness, impulsiveness, reduce disruption in social, academic & occupational functioning. Treatment need to be continued as long as improvement in symptoms is sustained. Psychopharmacological therapy may be needed indefinitely. Medications found to be useful in the treatment of childhood ADHD have generally been shown to be effective in adults. Methylphenidate, Atomoxetine, Clonidine, Modafinil and Bupropion are found to be effective in adults with ADHD. In addition to pharmacotherapy, non-pharmacological modalities like – Psychoeducation, Supportive problem-directed therapy, Behavioral interventions and Cognitive remediation are also effective. This presentation focuses on the understanding regarding clinical presentation, co-morbidities, assessment and management of adult ADHD.

L2. AUTISM IN BANGLADESH: ISSUES AND CONCERNS

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1. Professor of Psychiatry, President, Bangladesh Association of Psychiatrists (BAP), Chairperson, Neurodevelopmental Disability Protection Trust, Bangladesh
2. Assistant Professor, Child Adolescent & Family Psychiatry, National Institute of Mental Health (NIMH), Dhaka, Bangladesh.

Topic: Few years ago autism was a little-known issue in Bangladesh. Now, autism has drawn more attention due to its' ever-growing prevalence and burden concern. In several studies the prevalence of autism in Bangladesh has found 20-84/1000 Children.

Objectives: Objectives of this paper is to discuss the achievements, challenges and future prospects of the service delivery for the children with autism in Bangladesh.

Methods: Discuss the few the studies on autism in Bangladesh as well as the policy framework regarding the autism and other neurodevelopmental disabilities.

Results: In spite of several limitations like lack of skilled manpower in this sector and limited infrastructures Bangladesh have tremendous achievements in service delivery and policy making on autism. Established Center for Neurodevelopment and Autism in Children (CNAC) in 2010, a community based survey on childhood mental illness conducted on 2009, hosted the first *Regional Conference on Autism Spectrum Disorders and Development Disabilities in Bangladesh and South Asia* in 2011, unanimously adopted the *Dhaka Declaration for Autism and Developmental Disabilities in 2011,* Passed *Neurodevelopmental disability protection trust act 2013* and *Disability rights and protection act 2013* in National Parliament of Bangladesh, and played as an initiator of the resolution on autism "Comprehensive and Coordinated Efforts for the Management of Autism Spectrum Disorders" (ASD) 2014 World health assembly are the mile stones in the achievement path of autism in Bangladesh.

Conclusions: Developed effective training manuals, collaborative studies on this issue, conducted nationwide broad based survey, enhance the public and professional awareness, and integrated the e-health services for the children with autism are the future plans for Bangladesh.

L3. PRESCRIBING PSYCHOTROPIC MEDICINES TO CHILDREN AND ADOLESCENTS IN CONTEXT OF SAARC COUNTRIES

Devashish Konar, M.D., Mental Health Care Centre, Kolkata, West Bengal, India

Just being scared to use Psychotropic medicines in children does not help them. It is good to be cautious lest we do any harm but withholding available medicines out of scare may actually harm many more.

In a scenario when it has been recognized that many of the serious mental illnesses start at an early age and have serious consequences if not treated early, organizing treatment for them has become an important public health issue.

Psychological methods though better for children often need to be augmented with pharmacotherapy to get optimum result. In countries like ours where trained people in psychological therapies are really scarce and you have better number of doctors who can use Psychotropic medicines with little orientation and training, taking up issue of prescribing Psychotropic medicines to children and adolescent is one of the priorities that needs to be addressed urgently. We need to understand available database and develop successful delivery models suitable for our part of the world.

L4. CURRENT SCENARIO, ACHIEVEMENT, AND CHALLENGES OF CHILD PSYCHIATRY IN BANGLADESH

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5. *Chairman, Dept. of Psychiatry, Bangabandhu Sheikh Mujib Medical University, Dhaka, Bangladesh*
6. *Professor, Child Adolescent & Family Psychiatry, National Institute of Mental Health, Dhaka, Bangladesh.*

Topic: In the arena of clinical services, research and education in child psychiatry has started its formal journey just two decades back in Bangladesh.
Objectives: To describe the current scenario, achievements and challenges of child psychiatry services in Bangladesh.
Methods: Review the path of journey of child psychiatry and little discussion on community based researches on child mental health.
Results: Capacity building through human resource development, organized the services by institutional model and relevant researches are the turning point of the development of child psychiatry in Bangladesh. The prevalence of child mental disorders found 18.4% in a community based survey. By the efforts of few visionary psychiatrists the wing of child psychiatry has established in Bangabandhu Sheikh Mujib Medical University (BSMMU) and separate department named 'Child Adolescent and Family Psychiatry' has formed in National Institute of Mental Health (NIMH), Dhaka. Center for Neurodevelopment and Autism in Children (CNAC) also established in BSMMU with the mission to serve the children with neurodevelopmental disabilities, to increase awareness and to train the professionals. Bangladesh Association for Child & Adolescent Mental Health (BACAMH) also formed in 2008 to promote the child mental health through training, services, research, advocacy, prevention, peer support, and collaboration.
Conclusions: Current trends suggest that the future prospect of child psychiatry in Bangladesh is promising. In spite of very limited number of specialists and lack of logistic supports, the child psychiatry is going ahead to set an example for other developing countries in the context of service delivery, research and awareness build up.

L5. SAHYA AND AHIMSA COMMUNICATION: ASIAN PERSPECTIVES FOR GLOBAL PEACE

L. Sam S. Manickam,
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Conflicts whether it be interpersonal or between nations are inevitable. Though conflicts cannot be eradicated, efforts can be made to eliminate some of the sources of conflict, thereby reducing its incidence and strive towards peace. Lessons learned from the Asian perspectives on achieving peace is gaining momentum with more and more programs on Nonviolence communication is being launched. In this paper, some of the Asian psychological concepts in reducing the sources of conflict that helps achieve global peace are delineated. One such concept is sahya, a quality, which makes one endure and at the same time strive to overcome the adversaries, in one's pursuit of attaining oneness with Brahman or Truth" (Manickam, 2005) and is not only an individual quality but also gets manifested as a group quality in the Asian region. Training in Ahimsa communication, (Manickam, 2012) which essentially comprises of the qualities of sahya, kshama (forgiving), empathy and tapasya (self-suffering) to different groups, especially to the adolescents who are drawn towards home grown terrorism can reduce the conflicts. The Asian concepts appears to have relative power in achieving global peace, which are yet to be explored experimentally.

L6. GLOBALIZATION AND SOUTH ASIA: IMPLICATIONS FOR MENTAL HEALTH

Mohan Isaac
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Do political and societal changes influence population mental health? If so, how? Can the consequences of societal change – both positive and negative – on population mental health be assessed or measured? If so, how? During the past one to two decades, many European countries such as Greece, Spain, Italy etc. have reported negative mental health consequences of the Global Financial Crisis (GFC). Following the collapse of the Soviet Union, major health and mental health consequences were reported in many of the newly independent / formed Eastern European countries, during the next decades.
Most countries in South Asia have witnessed significant political and socioeconomic changes during the past two to three decades. One of the major drivers of social change in some of the countries of South Asia has been "globalization". The presentation will examine the phenomenon of globalization from a South Asian perspective and explore how globalization is influencing one of the large countries in South Asia, India, with specific reference to the mental health consequences. Based on the presenter's past experience of assisting the Government of Karnataka, in India, on the issue of "farmers' suicides", the presentation will critically review and discuss the pattern and possible solutions for the continuing problem of suicide by farmers in India.

L7. DEVELOPMENT OF SOCIO-EMOTIONAL COGNITION AND HEALTHY MIND

Prof. Sabita Malhotra

Neuro-biology of developing brain, unraveling the mysteries of the mind and its various functions, is the most exciting advancement in contemporary research, and is likely to dominate the field in the twenty first century. Most critical insights and understanding of development of healthy mind and psychiatric disorders seen in the childhood and adults have emerged from developmental neuroscience of social and emotional cognition, revolutionizing the theory and practice of psychiatry. Importance of knowing and steering the development of healthy brain and mind during the developmental phases of life is highlighted.

L8. MBSR IN PHYSICIANS: THE PRINCE EDWARD ISLAND, CANADA STUDY

Dr Shabbir Amanullah,
Adjunct Professor, University of Western Ontario, Canada

Introduction: That physicians' work under a lot of stress is abundantly clear. Many studies out of UK, Canada and the US have shown stress as an issue that needs to be addressed. Mental health morbidity amongst physicians results in difficulties for the physician, his/her family, the patient load, hospital and community at large. Prince Edward Island is the smallest province in Canada with a population of about 140,000.

The prevalence of depression, insomnia and other mental health conditions were not studied formally but seemed to reflect statistics from other English speaking white populations. There were no statistics for other races that were available for comparison.

Given the smallness of the province, privacy was a concern but also, the ability to choose who they wanted for a therapist was limited. It was proposed that an emphasis on preventive strategies may be of benefit

Aims:

1. Baseline assessment on Maslach Burnout Inventory and QOL on all physicians willing to complete it at the QEH Charlottetown, PEI
2. To study the effects of an 8-week mindfulness program* for physicians on perceived efficiency, work enthusiasm, on reported medical errors and general sense of wellbeing*.
3. To determine if a Mindfulness Program would have the* positive benefit* of improving one's ability to cope* with stress

Methods: A brief study done in 2009 on physician perception of stress and the stigma of mental illness showed that there was a need for a more detailed study in the area. A questionnaire was circulated prior to a lecture during Grand Rounds* on well-being and its importance. The Maslach Burnout Inventory and Quality of life questionnaires were circulated. On completion of the lecture on stress and its impact, a session on mindfulness was conducted by FM,and JM. Physicians were then asked for post session feedback and, if they were interested, in registering for an 8 week course that was to be conducted in the hospital.

The sessions on MBSR were conducted by Mr. Frank MacAulay, certified in the MBSR program The authors discussed the study every 2 weeks and feedback was obtained by the main author over the telephone on the progress of the sessions.

The primary reason to engage with a non-psychiatrist was to address the issue of stress reduction as a 'non-illness'-based initiative, but at the same time have a physician plan, initiate and implement it in partnership.

Results: Initial interest was high but final participation was much smaller. The sub-speciality breakdown showed interesting findings and challenge existing assumptions.

Conclusions: It also showed that there could be many varied activities that could potentially serve to be stress interventions but local studies are needed to ensure suitability.

L9. IMAGING IN CHILDREN WITH INTELLECTUAL DISABILITY

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Children with intellectual disability / global development delay {GDD} come to psychiatrist or pediatricians with complaints of developmental or language delays, school failures, or suspected intellectual disability with or without apparent physical abnormalities.

It is a disorder of varied etiology broadly classifiable as having prenatal, perinatal/neonatal, and post neonatal causes. Prenatal & neonatal causes predominate in children in India. Of these many are preventable. Studies from industrialized nations have consistently shown that prenatal & genetic causes predominate. Overall, etiological diagnosis is made in slightly over half the patients.

Given below is a list of some conditions leading to GDD/ and or intellectual disability

Prenatal causes: Chromosomal disorders, congenital malformations of brain, inherited genetic disorders, intrauterine infections

Perinatal / neonatal causes: Perinatal asphyxia- Low Apgar score of (3 or less at 5 minutes or beyond) at birth or need of resuscitation along with hypoxic ischemic encephalopathy, & low birth weight

Post neonatal causes: Illness or injury after the first month of life

Neuro- radiological investigations are performed in patients without an obvious diagnosis or in those with abnormal neurological findings, seizures, or microcephaly

In a study conducted in King George's Medical University on 114 children the following conditions were found (Prashant Johri, Raju Boggula, Anupama Bhave, Roli Bhargav, Chandrakanta Singh, Neera Kohli, Rajesh Yadav, Rashmi Kumar, Etiology of intellectual disability in pediatric outpatients in Northern India, Developmental Medicine and Child Neurology, 2010, 1- 6)

No.	Cause	No of patients
1.	Prenatal	17
a	Pachygyria	2
b	holoprosencephaly	1
c	schizencephaly	1
d	Hemimegalencephaly	1
e	Congenital rubella	1
f	Congenital cytomegalovirus infection (CMV)	1
g	Ataxia telangiectasia	1
h	Tuberous sclerosis	2
i	Leukodystrophy	1
j	Mucopolysaccharodosis	1
k	Congenital hypothyroidism	2
l	Down's syndrome	4
2	Perinatal/neonatal	38
a	Perinatal asphyxia	36
b	Neonatal meningitis/sepsis	1
c	kernicterus	1
3	Post neonatal	11
a	Central nervous system infection	11
	Total	66

Causes in Group 2 & 3 are preventable. With a little effort we can actually reduce the no of children presenting with intellectual disability/GDD

L10. UTILITARIAN CONCEPT OF MENTAL HEALTH

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SRM Medical College Hospital & Research Centre, Kattankulathur

Being the generation living in the 21st century, we occupy a special position in human history in that we have witnesses an unprecedented and unparalled growth in our understanding and knowledge of the world around us and the life on the planet. While we bask in the glory, let us not forget that there are some important questions that remain embarrassingly unanswered. Most conspicuous of those questions is one that is central to the field of Psychiatry, i..e., "What is the mind? What is mental Health?" Nevertheless, Psychiatrists have brazenly avoided or ignored this question due to a learned lack of enthusiasm. Given the historic inability to achieve a consensus about anything pertaining to the mind, not to mention the inevitable criticism and/or ostracism that relentlessly pursues anybody who takes a stand regarding this controversial issue. Psychiatrists did not ant to open that can of worms, we simply hoped that if you manage to keep the can closed, the worms would suffocate and die and we never have to face the uncomfortable question again.

We believed that just as we had avoided the definition of mental illness, we would be successful in evading the definition of the mind. However, in the last several decades, human life has transformed so much that we are faced with a relatively new concept- mental health, which also needs to be defined. The list keeps growing and our silence has been deafening. While our understanding of the human brain, behaviour and neurosciences has frown exponentially, the task of describing/defining the mind has been increasing. Our willful indifference and tactical retreat from this tough question is not helping us one bit. Increasingly, we are telling ourselves that any definition of mind or mental health is not even a possibility, let alone plausibility. Let me highlight the importance of this issue in my topic. In my experience as a clinical and teaching psychiatrist for the last 30 years the available definition and description of the mind and mental health are minimally beneficial in educating medical students, psychiatry residents and mental health professionals like nurses and paramedics. The definitions are too broad/loose for educating the mental health professionals who are often left without any working definition of the mind and mental health to understand psychiatric patients and approach them in a comprehensive manner. They are also unable to understand scientific literature and interpret it properly. Conversely, authorities of scientific manuscripts use the term interchangeably adding to the confusion. The existing definition gives room for much misunderstanding and misspeaking of terms.Inevitably,it allows personal bias to creep in leading to exploitation of the field by ideologists operating through non medical objectives. Psychiatrists also are unable to explain to the patients about mind or mental health. Worse, psychiatrists offer different/contrasting or rarely contradicting explanations leaving the public to assume that the psychiatrists do not know any more than the others about the mind. Such attitudes are widely prevalent and contribute to the pre existing stigma. This also stalls the progress in the attempt to increase mental health awareness.

In a sense, our delay in defining the core operational entity in our profession, the min or mental health has not been beneficial. Is it possible to identify sanity from insanity? Usually, psychiatrists conclude by continually asking themselves if the patient has Schizophrenia or depression and thereby arrive at a diagnosis of mental illness. Instead, if the psychiatrists ask themselves if the patient is mentally healthy or does hearing a voice make a patient mentally unhealthy, i.e the line of thinking rooted in identifying mental health and not mental illness. So, it is critically important that clinical evaluation, training and education in Psychiatry should start with mental health, moving to mental illness and not the other way around.

To define mental health, we have to first define mind which historically has been a daunting undertaking. Let us take a look at the history and development of the concept of mind which clearly says that it is very hard to define the mind and there has been no consensus. Why is this issue so controversial?

There are several reasons. So, what am I trying to conceptualize? Through centuries of indoctrination and linguistic idiosyncrasies, we are hard wired to think in a certain way when the words "mind" or "psyche" are used consciously or unconsciously. Therefore, I would like to deliberately avoid using the terms "mind" or "psyche"

Let me paraphrase my objectives. I am not trying to conceptualize the mind /psyche as the world has known it. I am trying to conceptualize the part of the human self that is the subject of interest in scientific study triggered by deviant human phenomena only for the purpose of producing medical relief to alleviate human suffering. I will baptize it by a term unused in contemporary Western literature in order to sever any connections/relations to what has already been philosophized for the mind/psyche and willfully exclude any pre existing assumptions about it. I choose the word "Manas" for this.

Psychiatrists also are unable to explain to the patients about mind or mental health. Worse, psychiatrists offer different explanations leaving the public to assume that the psychiatrists do not know any more than the others about the mind. Such attitudes are widely prevalent and contribute to the pre existing stigma. This also stalls the progress in the attempt to increase mental health awareness.

The usual way to define mental health is the absence of Mental illness. This is the easiest solution but is undoubtedly useless…The presence of Mental illness implies the absence of mental health but the absence of Mental illness does not imply the presence of mental health.

Based on this concept, I would like to propose the concept of Mental health which would be used only on individual people in clinical setting and uses the 2 dimensional approach.

The symposium will cover this in detail.

L11. A MODEL OF PSYCHOTHERAPY BASED ON ANCIENT INDIAN CONCEPTS

Dr. C. Shamasundar

This lecture traces the logical path by which certain holistic elements of ancient Indian wisdom lead to a model of psychotherapy that is compatible with different schools of psychotherapy. Ancient Indian concepts are capable of organization into an operational description of ideal state of mental health. This state is a product of an individual's adjustments in respect of attitudes and behavior to discharge one's responsibilities towards oneself, one's family and the society. This process of adjustment is what is called "coping-skills" in our current literature. Mental illness is a consequence

of failure in one's or one's family's coping. Psychotherapy is a process of restoring and strengthening the coping-skills of the individual and his family. This model deserves to be tested in clinical settings.

L12. EVALUATION OF THE WHO MHGAP INTERVENTION GUIDE IN PEOPLE WITH INTELLECTUAL DISABILITY (PWID) – THE SRI LANKA EXPERIENCE

Sherva Cooray[1], Sabyasachi Bhaumik[1], Jayan Mendis[2], Rohit Gumber[1], Shweta Gangawati[1], Kiran Purandare[1], Chamila Abeywickrema[2]

1.International Links-ID, Faculty of Psychiatry of ID Royal College of Psychiatrists UK (RCPsych-UK)

2.National Institute of Mental Health (NIMH Sri Lanka

Objectives:

1. To adapt, pilot and develop the mhGAP (Mental health Gap programme) for use in PWID with support from the WHO, the International Links Group (Intellectual Disability)- RCPsych-UK and the NIMH, Sri Lanka
2. To explore the feasibility of its use in other LAMICs

Methodology: The five day modules incorporated didactic teaching, role-play with culturally appropriate case scenarios, audio-visual aids, and encouraged reflection on clinical practice. Trainees received comprehensive teaching materials at the outset. The course was evaluated by pre and post-test questionnaires and a feedback form on: relevance to clinical practice, educational needs, quality of teaching, group work and included a section for additional comments.

Results: The course averaged 85% satisfaction in all domains, and seen as relevant to clinical practice and educational needs with pragmatic suggestions for improvement. The trainees were dedicated and well motivated. The adaptation of a local toolkit for assessment of ID, resulted in the establishing a forum to progress this work. Additional topics suggested included counselling parents, sexual relationships and marriage, and childbearing for PWID.

Conclusions: The course is iterative – with each successive programme improving from lessons learnt. We are confident about the quality and relevance of training. We have modified the mhGAP-ID intervention guide within the context of the feedback and advice from the WHO. Combining mhGAP with mhGAP-ID training would enable efficient use of scarce resources.

L13. EXISTENTIAL PSYCHOLOGY AND BUDDHA PHILOSOPHY: ITS RELEVANCE IN NURTURING A HEALTHY MIND

Tapas Kumar Aich

The term "existentialism" have been coined by the French philosopher Gabriel Marcel in the mid-1940s and adopted by Jean-Paul Sartre. The label has been applied retrospectively to philosophers like Martin Heidegger, Karl Jaspers and Søren Kierkegaard and other 19th and 20th century philosophers who, despite profound doctrinal differences, generally held that the focus of philosophical thought should be to deal with the conditions of existence of the individual person and his or her emotions, actions, responsibilities, and thoughts.

The early 19th century philosopher Søren Kierkegaard, posthumously regarded as 'the father of existentialism', maintained that the individual solely has the responsibilities of giving one's own life meaning and living that life passionately and sincerely, in spite of many existential obstacles and distractions including despair, angst, absurdity, alienation, and boredom.

Over the last century, experts have written on many commonalities between Buddhism and various branches of modern western psychology like phenomenological psychology, psychoanalytical psychotherapy, humanistic psychology, cognitive psychology and existential psychology. In comparison to other branches of psychology, less have been studied and talked on the commonalities between Buddhist philosophy and modern existential psychology that have been propagated in the west.

Buddha said that the life is 'suffering'. Existential psychology speaks of *ontological anxiety* (dread, angst). Buddha said that 'suffering is due to attachment'. Existential psychology also has some similar concepts. We cling to things in the hopes that they will provide us with a certain benefit. Buddha said that 'suffering can be extinguished'. The Buddhist concept of nirvana is quite similar to the existentialists' *freedom*. Freedom has, in fact, been used in Buddhism in the context of freedom from rebirth or freedom from the effects of karma. For the existentialist, freedom is a fact of our being, one which we often ignore. Finally, Buddha says that 'there is a way to extinguish suffering'. For the existential psychologist, the therapist must take an assertive role in helping the client become aware of the reality of his or her suffering and its roots.

As a practising psychiatrist, clinician, therapist we often face patients with symptoms of depression where aetiology is not merely a reactive one, not an interpersonal conflict, not simply a cognitive distortion! Patients mainly present with some form of personal 'existential crisis'. Unless we understand and address these existential questions, we probably, will fail to alleviate the symptoms of depression, by merely prescribing drugs, in these patients!