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event will raise awareness about the distinct nature of FTD and importance of connecting patients and families with systems of support.

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Poster Number: EI 39

The Elephant in the Room: Race Matters

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Introduction: There is increasing ethnic and cultural diversity among both the aging population and healthcare providers in the United States. For older adults in particular, ethnicity, race, and culture may influence the relationship between patient and clinician, which is an important aspect of treatment outcome. The ACMGE requires residents to be competent in evaluation and treatment of patients from diverse backgrounds. However, examination of the clinician's own race, ethnicity and cultural background and its influence on treatment is underemphasized in residency training. As these changes in the demographics of the United States continue, issues around cultural competency in clinical education will grow in salience, with a particular emphasis on how they affect treatment of older adults.
Methods: A series of case vignettes demonstrate the perspective of a South-Asian psychiatry resident on the impact of addressing cultural interactions and biases between both the patient and clinician in a predominantly rural, Caucasian, geriatric patient population. The goal was to strengthen the therapeutic alliance between the clinician and patient and provide effective psychotherapeutic interventions. Identifying how personal factors of race and ethnicity, along with cultural biases, influenced the therapeutic alliance and therapeutic interventions are reviewed.
Results: Examining the patient's perspective towards the clinician helped facilitate a discussion of patients' biases and fears and helped improve treatment outcome. Addressing the potential influence of a clinician's background is key to strengthening the therapeutic alliance and trust between clinician and patient. Rather than focusing on cultural formulation for the patient alone, it is important for clinicians to be aware of and utilize an approach that strongly considers unconscious biases related to culture and ethnicity.
Conclusions: Residency training should include well-defined approaches emphasizing both patient and clinician awareness of how each of their cultural background and biases can influence and guide treatment. As the aging population continues to expand, there must be more focus on how to implement and discuss strategies to address this. More open discussions regarding both a patient and clinician's background can maximize the therapeutic alliance and improve treatment outcomes, particularly for older adults.

Poster Number: EI 40

The Impact of Social Support and Spirituality on the Association between Stressful Life Events and Resilience among Older Hispanics and Non-Hispanic Whites

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Introduction: Hispanics/Latinos/as (hereafter referred to as Hispanics) are the fastest growing ethnic group among the older adult population in the U.S. Several studies have revealed a phenomenon known as the "Hispanic Paradox," which describes the trend of Hispanics showing equal or better health outcomes and increased life expectancy compared to non-Hispanic Whites despite facing a number of disadvantages.
While historically, the field of psychiatry has focused on mental illness, recently there has been increased interest in investigating positive mental health, including resilience and its correlates. The experience of stressful life events has been linked to resilience among older adults, yet research among older Hispanics in this area is scarce. The link between stressful life

events and resilience may be influenced by many potential factors. Among them, social support and spirituality are both increased among Hispanics, with prior findings suggesting that these factors may buffer the negative effect of stress on resilience among older adults.

The present study examined (1) the association between stressful life events and resilience among older Hispanics and non-Hispanic Whites; and (2) the impact of social support and daily spirituality on this association by ethnic group. We hypothesized that (1) increased stressful life events would be associated with lower resilience among both ethnic groups, but that the association would be weaker among Hispanics; and (2) social support and spirituality would buffer against the negative impact of life events on resilience among Hispanics, among whom both factors are increased.

Methods: Participants included 240 community-dwelling older adults from the Successful AGing Evaluation (SAGE) study at the University of California, San Diego (UCSD) Stein Institute for Research on Aging. For the present analyses, we selected all SAGE study participants who were Hispanic and aged 50 years or older (n=120). We then randomly selected the same number of non-Hispanic White study participants with similar age, gender, and years of education. Participants were mailed a self-report survey of successful aging, which included measures of resilience (10-item Connor-Davidson Resilience Scale), stressful life events over the past year and level of associated distress (Life Events Scale), spirituality (Brief Multi-Dimensional Measure of Religiousness/Spirituality-Daily Spiritual Experiences subscale) and social support (Duke Social Support Index—Social Interaction subscale).

Results: Hispanics reported significantly higher stress associated with recent life events and higher spirituality than non-Hispanic Whites, with no significant ethnic differences on income, marital status, resilience or social support (Table 1). A multivariable linear regression analysis showed that Hispanics and non-Hispanic Whites had comparable associations between stressful life events and resilience; across the entire sample, higher degree of stress associated with life events was significantly associated with lower resilience (p=.004). Separate multivariable models by ethnic group showed that among Hispanics, there was a significant interaction between life events and both spirituality and social support on resilience. Specifically, among Hispanics with low social support or low spirituality, stressful life events were associated with decreased resilience, but among Hispanics with high spirituality or high social support, stressful life events and resilience exhibited no significant association (Figure 1a). Non-Hispanic Whites showed a similar pattern of performance on spirituality, but there was no significant interaction between social support and life events on resilience (Figure 1b).

Table 1. Cohort Characteristics by Ethnic Group.

	Hispanic (*n=120*)	Non-Hispanic White (*n=120*)	t/X^2	p^a
Age, *M (SD)*	73.08 (9.92)	73.02 (10.45)	–	–
Gender, *n* (%) male	68 (56.7%)	68 (56.7%)	–	–
Education, *n* (%)				
HS or less	41 (34.2%)	41 (34.2%)	–	–
Some college to Bachelor	56 (46.7%)	56 (46.7%)	–	–
Post-graduate	23 (19.2%)	23 (19.2%)	–	–
Marital Status, *n* (%)			0.37	.88
Married	73 (60.8%)	78 (65.0%)		
Single	4 (3.3%)	3 (2.5%)		
Divorced/separated	23 (19.2%)	20 (16.7%)		
Widowed	20 (16.7%)	20 (16.7%)		
Personal yearly income, *n* (%)			4.25	.12
Less than $35,000	68 (58.6%)	48 (45.3%)		
$35,000 - $74,999	29 (25.0%)	38 (35.9%)		
$75,000+	19 (16.4%)	20 (18.9%)		
Resilience	30.23 (6.69)	31.09 (6.68)	0.99	.32
Stressful life events	0.39 (0.38)	0.27 (0.29)	−2.55	.01
Social Support	8.50 (1.39)	8.72 (1.63)	1.13	.26
Low social support (%)[b]	57 (49.1%)	48 (40.3%)	1.84	.17
Daily spiritual experiences	16.00 (7.83)	21.79 (8.79)	5.22	<.001
Low spirituality (%)[b]	39 (34.5%)	69 (61.1%)	16.16	<.001

[a]Based on independent samples t-tests or Chi-Square tests.
[b]Indicates percent of participants scoring below the median of the overall sample on this measure.

Conclusions: Contrary to our primary hypothesis, higher degree of stress associated with life events was similarly associated with decreased resilience in both ethnic groups. In regards to our second aim, we found that while both social support and spirituality appeared to buffer the potential detrimental impact of stressful life events on resilience among Hispanics, only spirituality did among non-Hispanic Whites. Findings from this study lend support to the practice of encouraging the use of social supports and spirituality to help older adults, particularly Hispanics, cope with stressful life experiences. For researchers, present findings highlight the importance of considering social support and spirituality when developing interventions aimed at promoting resilience among older persons, particularly Hispanics. There are likely to be other major determinants of resilience among older persons, but these two factors are particularly prominent among Hispanics and appear to have powerful protective effects on resilience in this group. Thus, considering these factors might be key for the development of targeted culturally relevant interventions.

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Poster Number: EI 41

Treatment Issues in an Elderly Female with Repeat Inpatient Psychiatric Admissions

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Introduction: Ms. S., is a seventy year old African American widowed female, living alone, with a previous psychiatric history of schizoaffective disorder and a past medical history of uncontrolled diabetes mellitus. She has had over thirty inpatient lifetime psychiatric admissions and a longstanding history of noncompliance. She has been followed by an Assertive Community Treatment (ACT) team for the last two years. In spite of ACT Team follow up, she has had numerous admissions which on many occasions were back to back admissions. Her inpatient stays were characterized by extended periods, some of which were up to sixty days. On one occasion, she was readmitted within twelve hours of discharge. On this occasion, she was admitted for manic and aggressive behavior in the context of medication noncompliance within days of discharge from a different hospital. On our unit, the patient refused medications consistently and was uncooperative with vital signs and fingerstick glucose monitoring. She was observed to demonstrate extreme mood swings, quickly escalating to violent and aggressive behavior towards staff and other patients and then becoming calm. This poster explores difficulties in management and discharge of patient. At times, she required intramuscular injections of Haloperidol and Lorazepam to calm her. She refused psychiatric, diabetic, and hypertensive medications, so a forced medication order was obtained through the local mental hygiene court. She showed clinical improvement on a regimen of Aripiprazole titrated to a dose of twenty milligrams per day orally and Sodium Valproate one thousand milligrams per day orally. She was extremely inconsistent on Sodium Valproate so it was discontinued. She was eventually discharged on four hundred milligrams of intramuscular long acting Aripiprazole. Multiple meetings were held with her ACT team to ensure a safe discharge. Issues which emerged prior to discharge included obtaining her consent to make a duplicate key for her apartment, ensuring that her house was habitable, obtaining a referral for visiting nurse services for monitoring of her diabetes and hypertension, educating her on the importance of diabetic monitoring and compliance with her medication regimen, and obtaining home care services for an adequate amount of time. Unfortunately, she was ineligible for home care services as her personal income was in excess of the threshold required for eligibility. Also, the absence of a responsible family member who could provide adequate support made her discharge challenging. Eventually, she was discharged home with referral to visiting nurse services and ACT Team follow up. This case highlights the challenges in maintaining elderly psychiatric patients with comorbid medical issues who are only partially cooperative with their treatment regimen in the absence of community resources and social supports.
Methods: Continuous psychiatric assessment of the patient along with review of factors that affect discharge and recidivism.
Results: Identification of factors which impede safe discharge of elderly patients with medical comorbidities and poor social support with review of literature done.
Conclusions: Measures need to be taken upon admission to ensure that geriatric patients with multiple readmission rates, poor social supports, and history of treatment failure have the appropriate interventions set in place well before discharge to decrease repeat encounters for similar presentations. Some of these include access to appropriate housing, visiting nurse services, ACT team follow up, and education to encourage treatment compliance.