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Indo-American Psychiatric **News**

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Editor's Greeting:

Happy New Year!

Welcome to the January edition of the IAPA newsletter. Our publication is evolving with the addition of several new sections. The first section starts off with topics of interest in psychiatry. Our second section contains information about events held by our state chapters. This is followed by publications by our members. Our fourth section features the outstanding achievements of our community members who are the recipients of distinguished awards. Finally, with great sadness, we announce the death of one of our esteemed members.

We would like all of you to feel free to provide us with your views and reactions. We're hoping for materials to allow us to publish letters to the editors.

Sincerely,

Lily Arora, MD

Disclaimer: The views expressed in the different articles are solely those of the authors based on literature review and their clinical experience and not necessarily those of the Indo-American Psychiatric Association.

Evidence Based Treatment of Behavioral and Psychological Symptoms of Dementia

Rajesh R. Tampi, M.D., MS, DFAPA

Behavioral and Psychological Symptoms of Dementia (BPSD) are a group of non-cognitive symptoms and behaviors that are commonly seen in individuals with dementia [1]. BPSD can be defined as a heterogeneous range of psychological reactions, psychiatric symptoms and behaviors that are unsafe, disruptive and impair the care of the patient in a given environment [1].

BPSD are noted in approximately one-third of community-dwelling individuals with dementia [1]. Their prevalence tends to rise to over 80% in those individuals with dementia who reside at skilled nursing facilities [1]. Unlike cognitive symptoms of dementia which decline over the course of the illness, BPSD tends to fluctuate with psychomotor-agitation being the most persistent symptom [1].

BPSD can be grouped into different symptom clusters [2]. These include the psychotic cluster (delusions and hallucinations); mood disorders cluster (depression and anxiety; apathy-indifference), aberrant motor behavior cluster (pacing, wandering, and other purposeless behaviors) and the inappropriate behavior cluster (disinhibition and euphoria). Apathy has been noted to be the most common behavioral symptom in dementia with a prevalence rate ranging from 48% to 92% [3].

Current data indicates that BPSD occurs due to a complex interplay between the various neurobiological changes associated with dementia, psychological traits and the genetic make-up of the individual with dementia [1, 4]. Neurobiological changes include pathological and functional changes within the frontal, parietal and temporal cortices and also the basal ganglia. High levels of neuroticism tend to predispose individuals to BPSD. Genetics of BPSD include among other factors the presence of APOE3/4 genotype and the polymorphisms of the serotonin and dopamine receptors [1].

The presence of BPSD is associated with significantly higher social and economic burden of care for these individuals [1]. BPSD also increases the risk for institutionalization for these individuals. In addition, BPSD is associated with a faster cognitive and functional decline and a worse quality of life for individuals with dementia. They also add to the direct and indirect costs of care for these individuals [1].

Assessment of individuals with BPSD should include a thorough medical and psychiatric history [5]. Common reversible conditions including metabolic, infectious and neurovascular disorders must be identified and treated. The effect of medications on the development of these symptoms must be evaluated. The use of standardized rating scales help in qualifying and quantifying these behaviors and also aid in monitoring their progress during treatment [6].

Current evidence indicates efficacy for both non-pharmacological and pharmacological treatments for BPSD [7]. Pharmacotherapy is mainly reserved for those individuals who have had an incomplete response to non-pharmacological interventions and is often used in combination with the non-pharmacological management strategies [7].

A systematic review of evidence indicates that caregiver and residential care staff education and possibly cognitive stimulation for individuals with dementia appear to have lasting effects in the management of BPSD [8]. Behavioral management techniques centered on an individual's behavior are most successful in mitigating these behaviors. Availability of support systems for the individuals with dementia and their caregivers with greater 'time for self' and providing education and training to the caregivers reduce caregiver burden [7]. Additionally, they have a positive impact on the individual's behaviors and thus delay institutionalization.

Meta-analytic data indicate that atypical antipsychotic medications; Risperidone and Aripiprazole have modest effects on the treatment of BPSD [9]. Available data also indicates limited benefit for olanzapine and quetiapine for the treatment of these behaviors [7]. The use of these medications is limited by their side-effect profile and their associated direct and indirect costs. Current data does not indicate significant benefit for these medications in reducing the financial costs and the burden of care for individuals with BPSD [7].

The data on the use of anticonvulsants in the treatment of BPSD is limited with benefit noted only for carbamazepine from controlled studies [10]. Antidepressants especially selective serotonin reuptake inhibitors have shown some benefit in treating the mood disorder cluster of symptoms but again this data is limited [11]. Benzodiazepines have minimal role in the treatment of BPSD given the lack of data on their efficacy and significant adverse effects [12]. Cholinesterase inhibitors and Memantine have limited data on treating BPSD although they may delay the emergence of these symptoms by slowing the cognitive decline [7].

There are major concerns with the use of psychotropic medications in the treatment of BPSD especially the increased risk of cerebrovascular adverse events and death with the use of antipsychotics [13]. Available evidence indicates that the risk is not significantly different for the various antipsychotics [14]. The risk for these adverse effects appears to be greatest within the first month of treatment initiation and the risk remains elevated for up-to two years [13].

Available data indicates that the assessment and treatment of BPSD needs a standardized approach. A thorough medical evaluation will aid in the diagnosis and treatment of medical conditions that can cause or worsen BPSD [1]. Additionally, a medical evaluation and treatment of underlying medical illness can prevent the unnecessary use of psychotropic medications. The use of standardized assessment scales can qualify and quantify these behaviors. They can also assist with the assessment of severity or the stage of dementia. Education of the staff and caregivers along with cognitive stimulation in the individuals with dementia can reduce the frequency and severity of BPSD [7].

For behaviors that are resistant to non-pharmacological interventions, pharmacotherapy can be initiated [7]. Careful clustering of symptoms, identifying target symptoms, using medications that have best evidence in treating these target symptoms, close monitoring for symptom improvement with frequent assessment for adverse effects of medications can maximize treatment outcomes. The combination of non-pharmacological and pharmacological treatment modalities appear to have a synergistic effect and should be the norm and not the exception for the treatment of more severe symptoms. As new research data emerges for the assessment and treatment of BPSD, this data should be included to the treatment algorithms to optimize outcomes for individuals with BPSD.

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Conflicts of interest: None

Addiction : Brain disease or a lack of willpower

Surita Rao M.D.

Addiction is one of the most hard wired brain diseases in existence yet people routinely ascribe it to weakness or a lack of willpower. Complicating the issue is the fact that many of the consequences are social such as legal issues, financial problems or the impact of the addictive illness on a person's relationships with friends and family. Patients suffering from alcohol or drug dependence may appear to be rational but when it comes to picking up whether to use or not, or whether to tell the truth about what they are doing and how to go about it, they generally forgo rationality.

The Mesolimbic pathway of the brain is responsible for "drive" behaviors such as food and sex. The former is necessary to keep the organism alive and the latter to keep the species alive. It is one of the most phylogenetically old pathways in our brain. It is one we share in common with animals who are far simpler than us such as lizards. In fact you can think of it as the " lizard brain " , a part of the brain which is wired to work almost purely on instinct. The disease of addiction hijacks this pathway. It tricks the brain into thinking that the drug , including alcohol is more important than food or anything else in life, perhaps even more important than staying alive.

In addiction treatment the addict is taught to use their brain's higher centers, those responsible for rational thought and inhibition, such as the frontal lobe or the cortex to override the " lizard brain " when a craving occurs. The craving may be set off by external triggers or romanticized memories of drug or alcohol use. This is why in the therapies most often used to treat addiction such as relapse prevention there is emphasis simple easy to remember techniques and rules which are explained and practiced in a repetitive manner. One example is learning to avoid " people places and things" that are associated with the drug use. This may sound simple but can be a complex socially involved process that can eliminate a person's entire social life and routines and replace them with new ones.

Many people in society believe that addiction is a disease of choice rather than something that happens to us such as clinical depression. While the patient does have to make a choice to get better, enter treatment or go to 12- step meetings, these choices are not as simple as turning down an invitation to a party, choosing not to buy something or deciding not to have a second drink might be for most of us. The closest those of us who do not suffer from addiction can come to experiencing what it would be like to renounce drugs and alcohol completely would be for us to give up all sugar and refined carbohydrates. No one can argue that sugar and refined carbohydrates are necessary foods yet we eat them everyday even though we know they are not good for us. What if you could never eat them again? Imagine having to give up cake, cookies, donuts, bagels, white rice, pasta or bread that is not one hundred percent whole grain. How many of us could really do that for the rest of our lives without slipping up in a world where these foods are everywhere?

In many ways having an addictive illness is like having heart disease. It is a combination of genetics and lifestyle choices. Getting better from a heart attack involves medication, maybe surgery but also exercise, eating right and reducing stress. One can go into remission but constant monitoring is needed to ensure health. Entering and staying in recovery from an addictive illness can be similar. The patient often enters treatment, either in "rehab" (residential level of care) where they go away to a program and immerse themselves in treatment and recovery or to an outpatient program where they attend group therapy while living at home whilst working and engaging in everyday activities.

There are medications available for the treatment of substance use disorders. They may be long acting opiates themselves such as Methadone or Suboxone (buprenorphine). Anti-craving and maintenance of recovery medications such as Campral (acamprosate), Naltrexone and Antabuse (disulfuram). All three are used for alcohol cravings and Naltrexone can also be used for opiate cravings. They form only a small yet a significant part of the treatment of addictive illness. Psychosocial treatments constitute the mainstay of therapy. These should be done in a specialized treatment program or with a therapist who is experienced and trained in the treatment of addictive disorders.

In either case, long term aftercare is often crucial to sustained recovery, as is active involvement in a 12-step program such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). It is not enough to attend 12-step meetings. The person must also obtain a sponsor; a peer who has long term recovery and helps others and works with the addict through the twelve steps in a personalized manner. AA and NA are free, anonymous, available almost everywhere in the United States and in other parts of the world. They provide enormous support for the person with an addictive illness to enter into and maintain recovery.

Sometimes medical students or resident doctors express that they are uncomfortable asking their patients to attend AA or NA if the patient believes it is too religious. Twelve step programs are spiritual programs but not religious programs at heart. I have had patients who are atheists or agnostics enjoy actively participating in 12-step programs. I sometimes question the hesitant medical student or resident if they would be so conflicted in making the recommendation if there was a free, widely available means of bringing a different life-threatening illness, such as cancer for example, into remission.

Addiction is a life threatening and life-long illness. However, there is significant hope for an addict to enter into recovery for life if he has the discipline to do all the things required to go into remission. Making these healthy choices may not be as easy for a person with an addicted brain as it may seem to be for the rest of the world.



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Conflicts of interest: None

Flibanserin: A Newly-Approved Treatment for Hypoactive Sexual Desire

Kriti D. Gandhi, M.D.

Introduction:

For females the DSM –IV diagnosis of hypoactive sexual desire disorder (HSDD) has merged with female sexual arousal disorder and is now female sexual interest/arousal disorder (FSIAD) in the DSM-5. This new diagnosis is defined as an absence or significant reduction in sexual interest/arousal for at least 6 months that causes clinically significant distress and is not explained better by another cause. On August 18th, 2015, the FDA approved flibanserin as the first treatment of HSDD/FSIAD [1]. Flibanserin was initially developed as an antidepressant; however, during trials this drug was found to have greater efficacy than placebo in self-reported strength of a woman's sex drive.

Mechanism of action:

In terms of its pharmacology, flibanserin acts primarily at the serotonin 5-HT_{1A} and 5-HT_{2A} receptors at clinical doses. It is a postsynaptic agonist at 5-HT_{1A} and an antagonist at 5-HT_{2A}. For unclear reasons, this drug appears to have regionally selective activity in the brain. In the prefrontal cortex (PFC), nucleus accumbens, and hypothalamus, flibanserin's dual agonism at 5-HT_{1A} and antagonism at 5-HT_{2A} results in inhibition of serotonin release by pyramidal neurons in these regions. However, flibanserin has a less potent effect on pyramidal neurons other regions such as the hippocampus. [2]. It is unknown how this relates to flibanserin's impact on sexual desire.

Clinical trials/efficacy:

Before resubmission to the FDA, three randomized controlled trials studied the efficacy of flibanserin. Flibanserin 100 mg at bedtime was associated with a statistically significant increase in satisfying sexual events and decrease in sexual distress as measured by the Female Sexual Function Index and the Female Sexual Distress Scale-Revised. Treatment length for these trials was 24 weeks [3,4,5]. These trials were all completed in premenopausal women.

Adverse reactions:

The most commonly reported adverse events in trials were somnolence, dizziness, fatigue, nausea, insomnia and dry mouth. [3,5, 6].

Precautions:

Flibanserin use has been associated with hypotension and syncope; due to this, the medication is available only through a Risk Evaluation and Mitigation Strategy (REMS) program [6].

Contraindications:

Contraindications to flibanserin are related to the risk of hypotension and syncope. Flibanserin is contraindicated with use of alcohol. Use of flibanserin with moderate or strong CYP3A4 inhibitors is also contraindicated, as these medications can result in increased concentrations of flibanserin. The third contraindication is in patients with hepatic impairment, again due to increased flibanserin concentrations [6].

Special populations:

Flibanserin use is not recommended in nursing mothers, geriatric patients or pediatric patients. Flibanserin may pose a higher risk of hypotension, syncope and CNS depression in CYP2C19 poor metabolizers due to increased exposure to the drug [6].

Flibanserin increases digoxin concentration; therefore, increased monitoring of digoxin levels is recommended[6].

Flibanserin has not been studied in pregnant women. Animal studies have noted fetotoxicity only at levels of the drug that caused significant maternal toxicity[6].

Dosage and administration:

The recommended dosage of flibanserin is 100 mg by mouth at bedtime.

Controversy:

Controversy has surrounded the FDA's approval of flibanserin. Criticisms include the fact that after the drug's second rejection, an advocacy group named 'Even The Score' was created; this group received funding from Sprout pharmaceuticals which had bought the drug. Even The Score conducted advocacy efforts in support of flibanserin, including social media campaigns. Other criticisms include the use of a patient-reported outcome and its likely use off-label by a population that do not meet criteria for HSDD and who likely have concomitant conditions that make the risk of adverse events more likely [7]. Others argue that the criticisms are outweighed by the benefit of having another option for the treatment of a complicated condition that may require a multifactorial approach to fully treat [8].

Conclusion:

Flibanserin is a 5-HT_{1A} agonist and 5-HT_{2A} antagonist recently approved by the FDA for FSIAD/HSDD; it is the only first and only FDA-approved treatment for this disorder. Its mechanism of action in increasing sexual desire is unknown. The approval of this drug has been the subject of controversy; in particular with relation to the effect consumer advocacy may have had over its approval.

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Conflicts of interest: None

Chapter Meetings

Domestic Violence: Destroying a Demon and Building Hope at IAPA (Boston)

Deepika Shaligram MD

The week of Diwali this year saw IAPA (Boston) set to destroy yet another demon – Domestic Violence. On November 13th, 2015 the Boston Chapter of the Indo-American Psychiatric Association led by **Drs. Matcheri Keshavan** and **Rohit Chandra** convened a meeting on the problem of domestic violence at the Massachusetts Mental Health Center in Boston.

About thirty thoughtful mental health professionals comprising psychologists, social workers, psychiatrists, researchers and community leaders from Massachusetts, New Hampshire and Rhode Island gathered to hear **Dr. Gouri Banerjee** and **Dr. Priya Sehgal** speak about the issue of domestic violence in our community. Dr. Banerjee is co-founder and president of Saheli and Emeritus Associate Professor at Emmanuel College, Boston. Dr. Sehgal is a final year psychiatry resident at Cambridge Health Alliance/Harvard Medical School.

Dr. Banerjee spoke passionately about her work at Saheli, a 501 (C)3 non-profit organization dedicated to enabling South Asian women and families lead safe and healthy lives regardless of religion, ethnicity, age, gender or sexual orientation. She described the services offered to survivors of domestic violence through their 24- hour crisis help lines and community resources. These include physical/ mental health referrals, legal and immigration consultations, vocational training and economic support. All are free of cost. Saheli has remarkably provided services to 300 families in need in the past year alone (Email: info@saheliboston.org and helpline 1-866-4 SAHELI). It was encouraging to hear that the profile of recent immigrants is changing to include older, better educated women who are undeterred by stigma and open to seeking help.

Dr. Sehgal eloquently described the scope of the problem of domestic violence in the world with a particular focus on South Asian Americans. She noted that about 1 in 3 women around the world experience physical and or sexual violence. South East Asia has the highest world prevalence at 37.7%. She quoted a study by Raj and Silverman in 2002 that demonstrated approximately 40% of Asian Indian women in the Boston Area report being victims of domestic violence in comparison to an estimated national prevalence of 35%. She explained how gender norms, family structure and value systems contribute to domestic violence in our community. Risk factors for perpetrators include low education levels, witnessing domestic violence

between parents and substance abuse. Furthermore, women who are financially dependent and importantly, those without immediate family in the U.S. are three times more likely to be physically injured. She commended the work done by Saheli in reaching out to these victims.

[Democratic](#) member of the [New Hampshire House of Representatives](#), **Dr. Latha Mangipudi**, a practicing speech and language pathologist and a PhD in Behavioral NeuroScience graced the occasion and shared her vision of advocacy and prevention from the policymaker's perspective. It is noteworthy that she worked tirelessly to help pass a bill in 2014 that prohibits employers from discriminating against victims of domestic violence. **Dr. Sukanya Ray**, Associate Professor of Psychology at Suffolk University, formerly of the Asian Mental Health Clinic at Cambridge Health Alliance, contributed significantly to the discourse drawing from her expertise on Asian Perspectives on Health and Work.

The conference concluded with a lively discussion that generated solutions ranging from prevention efforts to interventions to address the physical and mental health outcomes of domestic violence and its socioeconomic and legal ramifications. Awareness programs that target educational institutions, places of worship and spiritual instruction (e.g. Bala Vihar) and community outreach (e.g. through posters, pre-marital counseling, screening of documentary films) were discussed. The opportunities for mental health professionals in terms of prevention via community education (e.g. through talks and panel discussions on television), routine screening of patients at clinical encounters, and lastly treatment of resultant mental disorders was the thrust of the conversation. The need to identify and treat perpetrators so as to break the cycle of violence was underscored. In this regard, Dr. Rohit Chandra was applauded for his involvement with the Men against Violence initiative spearheaded by Saheli. **Dr. Deepika Shaligram**, child psychiatry faculty member at Cambridge Health Alliance/Harvard Medical School, co-led the discussion and shared her experiences of working with children suffering the mental health consequences of parental domestic violence. She highlighted the importance of providing support and services to these young and vulnerable witnesses of intrafamily violence. Lastly, the importance of joining hands with other local organizations and programs serving the larger Asian community was discussed.

The meeting was a resounding success. We were delighted with the positive responses to a post-meeting survey which was designed to assess the availability of clinicians accepting referrals of South Asian domestic violence victims and those who are willing to provide phone consultations to Saheli's advocates (who staff the domestic violence helpline) and/or serve as a resource for Saheli to facilitate appropriate mental health referrals. We anticipate holding the next meeting of the Boston chapter in March or April 2016.

For more information about Saheli, please visit <http://www.saheliboston.org/>

***Deepika Shaligram MD**, is currently Medical Director of the Mental Health Program at Jewish Family & Children's Services in Boston and teaching faculty in the Child Psychiatry Fellowship program at Cambridge Health Alliance/Harvard Medical School. She has been practicing psychiatry for 14 years and she has published professionally on topics ranging from the interface between medicine and psychiatry, women's mental health, psychotherapy in the medication visit and health care disparities. Her other interests include resilience through exercise and meditation, immigrant issues, parenting dilemmas, advocacy and research. She is the recipient of many honors including the Luke Clack Young Investigator Award while at the National Institute of Mental Health and Neurosciences (NIMHANS), India and the Anne Alonso Memorial Award of the American Association of Directors of Psychiatric Residency Training (AADPRT) during her Child Psychiatry Fellowship training at Cambridge Health Alliance/Harvard Medical School. She has no financial conflicts.*



Florida Chapter Meeting

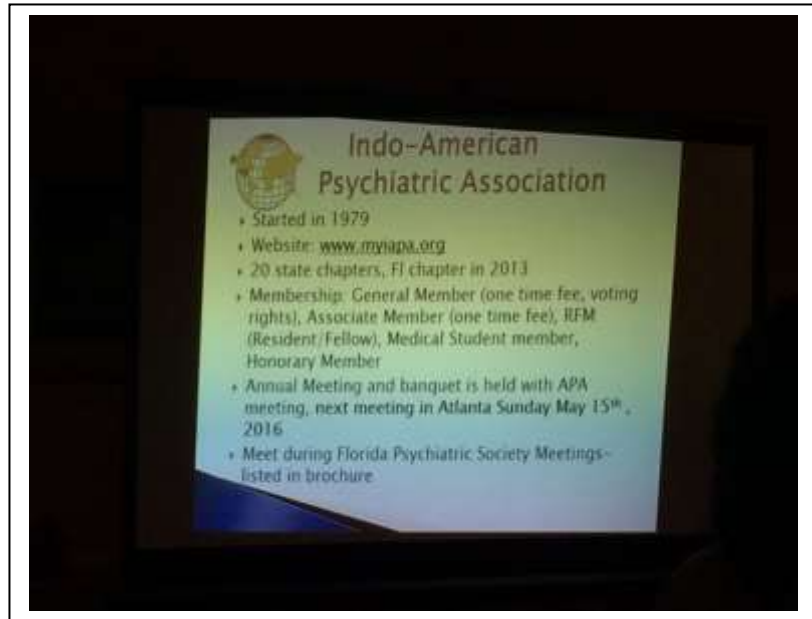
Bhagirathy Sahasranaman, MD

The Florida Chapter of the Indo-American Psychiatric Association (IAPA) held a dinner meeting on Nov 5th, 2015 at the Palace Indian Restaurant in Davie, Florida. The attendees included 37 physicians and nurse practitioners from the counties of Palm Beach, Broward and Dade. The meeting was sponsored by the Florida Medicaid Drug Therapy Management program, and the topic was “A discussion on the Florida Best Practice Psychotherapeutic Medication Guidelines for Adults, 2015, with an emphasis on the newly added guidelines for treatment of Mood Disorders in pregnancy”. Dr. B.Sahasranaman, Medical Director of Henderson Behavioral Health and President of the Florida IAPA chapter presented on the topic and led the discussion. Scrumptious appetizers and a delicious dinner was the highlight of the evening. It was a great time to learn about the guidelines (more information on the guidelines can be obtained at <http://medicaidmentalhealth.org>) and to network with other practitioners in the tri-county area. Information about the Indo-American Psychiatric Association was also provided to the attendees!

***Bhagi Sahasranaman MD** is the medical director of Henderson Behavioral Health, a CARF accredited behavioral health organization with a budget of over 38 million that serves over 28,000 individuals each year. She is also the child psychiatrist consultant for several organizations that provide care to children in child welfare such as Camelot Community Care, Children’s Harbor and Kids in Distress.*

Dr. Sahasranaman is Board certified in general psychiatry and in child and adolescent psychiatry and is a Distinguished Fellow of the American Psychiatric Association. She has served on various committees and panels in the district and state levels. She has been a member of the expert panel for the “Florida Medicaid Drug Therapy Management Program for Behavioral Health” that has developed Best Practice Medication guidelines for treatment of various Behavioral Health disorders in children and adults. She has provided numerous presentations, workshops, and trainings and has received several awards and recognitions. Dr. Sahasranaman is Clinical Assistant Professor, Department of Psychiatry, Nova Southeastern University College of Osteopathic Medicine and is also on the faculty of the Department of Psychiatry, Florida International University College of Medicine. Dr. Sahasranaman has no financial conflicts of interest.

Florida Chapter Meeting



Connecticut Chapter Meeting

The IAPA CT Chapter meeting was held on Oct 4, 2015. The program comprised of the following:

1. Welcome by Dr. Sanjay Banerjee.
2. Minutes from April 2015 - Approved. Proposed by Dr. Bansal and seconded by Dr. Kale.
3. Updates on APA Attendance and IAPA Banquet.
 - Indian Psychiatric Association meeting in Bhopal, India in January 2016.
4. We had very interesting lectures and stimulating discussion on the topics presented by our guest lecturer:
 - Dr. Joyce Kamanitz: Overview of the connection between Inflammation and CNS disorder.
 - Dr. Rajiv Radhakrishna: Review of designer drugs of abuse.
5. The next CT chapter meeting is scheduled for April 3, 2016



Indo-American Psychiatric Association's Annual Meeting in North Carolina

Anita Arora MD

- The Carolinas Chapter was initiated in September 2015.
- We have 15 Life members and some more who are planning on becoming life members soon.
- Our First Business meeting in September 2015 had more than 40 Attendees.
- We Hosted the National IAPA Fall meeting on October 24th, 2015, in Raleigh, North Carolina.
- With Amazing keynote speakers like Dr Meera Narasimhan and Dr. Ranna Parekh, over 65 attendees, the meeting was a great success.
- Our Goals are to consolidate Professional identity and address Professional, educational and social needs of the psychiatrists. We will be working with our colleagues in South Carolina to expand our chapter. Under the guidance of Dr. Ashwin Patkar (President, IAPA) and Dr. Haresh Tharwani (Chair of advisory board, Carolinas chapter), we believe that this chapter will be able to accomplish its Goals.

Anita Arora MD

President, Carolinas Chapter

No conflicts of interest.

Indo-American Psychiatric Association's Annual Meeting in North Carolina



PUBLICATIONS BY OUR MEMBERS

Understanding Schizophrenia: A Practical Guide for Patients, Families, and Health Care Professionals by Ravinder D. Reddy MD (Author), Matcheri S. Keshavan MD (Author)

(This article is from: <http://www.abc-clio.com/ABC-CLIOCorporate/product.aspx?pc=A4311C>)

Written by two physicians with decades of clinical and research experience in the field, this volume helps readers face schizophrenia by understanding what it is and how it is managed. Schizophrenia is a devastating illness that affects more than two million Americans. Written to help anyone who is faced with managing schizophrenia, whether as a patient, friend, or family member, this accessible book is an ideal first stop for practical, up-to-date information. It includes an overview of schizophrenic disorder and provides answers to common questions that arise at different phases of the illness. This brief and to-the-point guide focuses on dealing with many aspects of schizophrenia—complying with treatment, managing crises, being a caregiver, communicating with the care team, and coping skills. The book also provides practical approaches to common issues, such as financial support, housing, employment, interacting with the legal system, stress management, socialization, and negative emotions. Included are useful forms, lists, and a comprehensive collection of resources to access help and information. The goal of this book is to assist patients and their loved ones to effectively face schizophrenia, achieve maximal recovery, and enjoy a good quality of life.

Features

- Provides a succinct, introductory guide to getting started on the road to understanding schizophrenia
- Answers questions commonly asked at initial diagnosis and later, and explains facts and concepts using real-world examples and pictorial illustrations
- Offers practical, evidence-based, and up-to-date information
- Clarifies the nonmedical burdens of schizophrenia, such as loneliness, socialization, and coping with negative emotions
- Presents an authoritative, reliable alternative to Internet sources that contain biased or inaccurate information
- Helps those who are diagnosed with schizophrenia get the most out of their lives

Endorsements:

"For persons suffering from schizophrenia, knowledge of the disease and active participation in treatment are vital to achieve recovery. This book provides the solid groundwork necessary for understanding the many facets of schizophrenia. Complicated but important concepts are explained and made easy to grasp,

and the writing is engaging. This guide is a very useful resource that must be read by patients, their families, and the mental health professionals who work with them."—Bethany Yeiser, author of *Mind Estranged: My Journey from Schizophrenia and Homelessness to Recovery*

"The essential guide to schizophrenia for patients, their families, and care teams. Clear, concise, and thoroughly understandable information about what schizophrenia is, what it means, and what can be done about it. I wish I'd had it by my side years ago!" —Randye Kaye, author of *Ben Behind His Voices: One Family's Journey from the Chaos of Schizophrenia to Hope*

Available at Amazon: <http://amzn.com/1440831505>

The Authors

RAVINDER D. REDDY MD

*Ravinder Reddy, MD, formerly an Adjunct Professor of Psychiatry at the University of Pittsburgh School of Medicine Director, and specializes in the treatment, research, and particularly the teaching of schizophrenia. He received specialized training at the University of New Mexico and New York State Psychiatric Institute/Columbia University. He was the Psychiatry Residency Training Director at the University of Pittsburgh for many years, and trained over a hundred psychiatrists. He has over 25 years of clinical experience with schizophrenia, in inpatient and outpatient settings, as well as working with the homeless. He has been funded by the National Institute of Mental Health and NARASD to conduct research into the neurobiology of schizophrenia. He is the recipient of the Pittsburgh Schizophrenia Conference Award. He has previously published two books, *Schizophrenia: A Practical Primer* and *Fatty Acids and Oxidative Stress in Neuropsychiatric Disorders*, and ten book chapters on various topics in schizophrenia.*



MATCHERI KESHAVAN MD



Dr. Matcheri Keshavan is Stanley Cobb Professor and Vice- chair for Public Psychiatry at the Beth Israel deaconess medical center, Harvard Medical School, a position he has held since 2008. He graduated from medical school at the top of his class from Mysore University in 1977, and completed psychiatric training at the National Institute of Mental Health and Neurosciences (NIMHANS) in Bangalore (India), Vienna, London, and Detroit. He served as Professor of Psychiatry at the University of Pittsburgh and Wayne State University, Detroit till 2008. His research has resulted in over 500 publications to date, including over 350 peer-reviewed papers, four books, and 20 book chapters. He has received several awards including the Gaskell gold Medal of the Royal College of Psychiatrists (1985), Nancy Roschke Certificate for teaching excellence of the American Psychiatric Association in 1993, the Golden Apple Award for Teaching at the Department of Psychiatry in 1992, 1994 and 2004, the Research Scientist Development Award from NIMH and the 2003 NAMI (National Alliance for the Mentally Ill of Pennsylvania) Psychiatrist of the Year Award. Dr.Keshavan is the Editor in Chief of the Asian Journal of Psychiatry (Elsevier) In addition, Dr. Keshavan is often invited to speak at national and international conferences. He has several funded grants. His main areas of research include the neurodevelopmental basis of schizophrenia, neuroimaging and early intervention.

TBI Sleep Disturbances

Vani Rao, MD

Traumatic Brain Injury (TBI) is a leading cause of death and disability in adults and children in the United States and Canada. The annual incidence of TBI in the United States is approximately 1.7 million, and the total cost of caring for people with TBI was estimated at \$76.5 billion in 2010, and continues to increase. Thus, TBI is a significant public health problem and is often referred to as the 'signature wound' of the recent conflicts in Iraq and Afghanistan. Neuropsychiatric disturbances are the most common chronic sequelae after TBI. Among the neuropsychiatric disturbances, sleep disturbance ranks high with rates ranging from 30% to 80%. Common TBI sleep disturbances include insomnia, sleep apnea, hypersomnia and circadian rhythm abnormalities. Of those, insomnia is the most common type of sleep disturbance with rates that are three times higher than in the general population. TBI patients with insomnia experience numerous difficulties including vocational, behavioral, cognitive and communicative problems, and incur a greater risk for anxiety and depression. Further, it has been well documented that sleep disturbance can trigger or exacerbate other health problems, placing patients at increased risk for serious mental health problems, including suicide. Despite the known high prevalence of TBI-associated sleep disturbance, the problem is under-recognized and undertreated, largely due to low levels of awareness in the affected population and their providers.

Dr. Vani Rao's article in Psychiatric Times provides a comprehensive overview of the pathophysiology and management of sleep disturbances after TBI.

<http://www.psychiatrictimes.com/special-reports/sleep-disturbances-after-traumatic-brain-injury>

VANI RAO MD

Dr. Vani Rao is an Associate Professor in the division of Geriatric Psychiatry & Neuropsychiatry, Department of Psychiatry at Johns Hopkins School of Medicine. She is the Medical Director of the Brain Injury Program, Dept. of Psychiatry at Johns Hopkins Bayview Medical Center. She is also the Director of Neuropsychiatry fellowship program. Dr. Rao's research work focuses mainly on mood, sleep and behavioral problems associated with brain injury. Her publications are predominantly on the psychiatric aspects of traumatic brain injury. She currently has a grant from the Dept. of Defense (DoD) to conduct a clinical trial using Repetitive Transcranial Magnetic Stimulation (rTMS) for the Treatment of



Depression & Other Neuropsychiatric Symptoms after Traumatic Brain Injury (TBI). She is also co-investigator on two studies: TBI biomarkers; Cognitive behavioral therapy for TBI Insomnia. She has co-authored a book on the psychiatric aspects of TBI. The book published by Johns Hopkins press and titled. The Traumatized Brain: A Family Guide to Understanding Mood, Memory, and Behavior after Brain Injury will be released in November 2015.

AWARDS

SURINDER SUCHA NAND, M.D.



Dr. Surinder Nand is Clinical Professor of Psychiatry in the Department of Psychiatry at the University of Illinois at Chicago. She is the former Director of Mental Health Service Line at the Jesse Brown VA Medical Center. She integrated mental health services at two Veterans Administration Hospitals into one. As the Residency Training Director she combined three psychiatry residency training programs into one.

Dr. Nand is a Distinguished Fellow of the American Psychiatric Association (APA) and was elected President of the Illinois Psychiatric Society (IPS); a state branch of the APA. She is a life member of the Indo American Psychiatric Association (IAPA) and has served on the Executive Committee of the IAPA in various roles i.e. Treasurer, Secretary, President Elect and President. Currently, she serves as a trustee on the Board of Trustees of the IAPA.

Dr. Nand has served on the Board of Directors of Apna Ghar [Our Home], an organization that provides a variety of services for survivors of domestic violence for thirteen years. While serving as the Vice President of the Apna Ghar Board, she also functioned as the Interim Executive Director from February, 2008 to September, 2008. She has served Apna Ghar in a variety of other roles as well including volunteer, consultant, and mentor. She is a passionate ambassador for Apna Ghar and an advocate for prevention of domestic abuse. She has presented several workshops and has served on a number of panels at national professional meetings on issues related to domestic violence.

In addition to being honored for her clinical, administrative and teaching excellence and community service, Dr. Nand was awarded the Alexandra Symonds Award by the American Psychiatric Association in May, 2009. This award commemorates a lifetime of leadership. Dr. Nand is the first female psychiatrist of Indian origin to have received this award.

In May 2015, Dr. Nand received the President's Award from the Indo-American Psychiatric Association for her multi-pronged approach to fighting domestic violence. In September, 2015, she received the Outstanding Service Award in appreciation of her dedication and service to Apna Ghar from the Guest of Honor: the Nobel Laureate for Peace, Mr Muhammed Yunus at Apna Ghar's 25th Anniversary in Chicago. She has been honored by other organizations for her academic work as well as her community service.

"Serving our community" is Dr. Nand's motto. She provided service at the Milwaukee Sikh Temple in August, 2012 following the brutal killing of Sikh devotees. Dr. Nand has also served to mentor many men and women who are doing well in their respective careers.

Obituaries

Our heartfelt condolences to the family of Vivek Singh MD who passed away on Saturday October 31st, 2014. Dr. Singh served as the Chairman of the Department of Psychiatry at Texas Tech University Health Sciences Center in El Paso, Texas.

Please see <http://elpasoheraldpost.com/texas-texch-uhsc-el-paso-announces-death-of-of-dr-vivek-singh/>

**To submit articles to the Indo-American Psychiatric News or for queries,
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