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Indo-American Psychiatric News

Editor's Greeting:

Hello Everyone. Welcome to the September edition of the IAPA newsletter. We think you'll find this edition's articles to be of particular interest. We had two great events for our communities in Pennsylvania and New Jersey. You'll find articles summarizing each. The other district chapters should feel encouraged to host such events and it will be our special pleasure to publish summaries of those as well.

Mary Ganguli, MD, MPH, FRCP(C) gives us a discussion of how the DSM-V treats neurocognitive disorders. Psychiatry resident, Kamalika Roy, lets us know about the newest of the new anti-depressants, vortioxetine.

Finally, Sudhakar Madaksira, MD, DLFAPA presents his personal challenges regarding the mystery of reincarnation. This is an unusual topic, and we hope you'll be intrigued.

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. And of course we welcome Ashwin Patkar, MD, the new president of the IAPA.

Ashwin Patkar, MD

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

Inter-Generational Complexities in Immigrant South Asians

By Rama Rao Gogineni, MD and April E Fallon,Ph.D.

The South Asian community in the United States includes individuals who trace their ancestry to Bangladesh, Bhutan, India, the Maldives, Nepal, Pakistan, and Sri Lanka. Over 3.4 million South Asians live in the United States. Indians comprise the largest segment of the South Asian community, making up over 80% of the total population, followed by Pakistanis, Bangladeshis, Nepalese, Sri Lankans, Bhutanese, and Maldivians. In addition, it is estimated that at least 66,000 Indo-Caribbean's live in the United States. Twenty-seven percent of the Asian population in the U.S. can be categorized as second generation immigrants. Immigration presents unique generational and intergenerational challenges to affected communities. While both first and second generation immigrants are susceptible to extremely stressful and traumatic experiences related to immigration, the manifestations of these vulnerabilities vary by generation. For example, middle-aged first generation immigrants are more likely to realize limitations and experience distresses brought on by separation from family and friendships. Second-generation immigrants face high parental expectations and restrictions on their autonomy. Additionally, they often are exposed to prejudice and discrimination, which makes them have to defend their American identity. Moreover, children of immigrants often feel caught between two cultures, and therefore face struggles at school, socially, and culturally within their home. In contrast, for South Asian Americans over the age of 65, the fastest growing segment of the population, cultural influences undeniably play a role in advanced care and the end-of-life decision-making process.

With this backdrop, the IAPA TriState area held an all day conference titled "Generational and Inter-Generational Complexities in Immigrant South Asians." The conference took place on Saturday, May 30th, 2015 at Drexel University

College of Medicine, in Philadelphia, Pennsylvania. The objectives of the conference were to:

1. Explore how the psychosocial factors, which include resiliency, vulnerability, protective and coping mechanisms, affect first generation youth and second generation adolescents and young adults.
2. Describe specifically how the Diaspora handles and negotiates intergenerational strain brought on by immigration.
3. Understand the ways that aging immigrants face advanced care planning and the role of culture and religion in end-of-life decision making.

Keynote speaker Salman Akhtar, MD in his presentation "Immigration and its Discontents: Impact upon the next generation" described acculturation struggles and discontents pertinent to 2nd generation Indians and their parents. He also discussed culture gap, vicissitudes of separation and identity struggles, illustrating with several examples from himself, friends, and their children, which gave the talk a special and sentimental touch. He encouraged both generations to understand, accept, and compromise with each other.

In "Developmental Aspects: New immigrant, Seasoned and 2nd generation" Dr. Shivkumar Hatti focused on the 3rd individuation struggles of Indian immigrants with entry into Erikson's 7th and 8th stages and Maslow/Bandura's self actualization phases of life. Dr. Parna Prajapati pointed out that any unfavorable or unpredictable experience could potentially serve as a "microtraumatic" experience, and eventual accumulation of these micro-traumatic experiences greatly define the way an immigrant perceives the new world. The role of family members, friends, and acquaintances in the host country cannot be stressed enough. They form a "holding environment" which supports the new immigrant and plays a pivotal role in modulating his/her perception of the new experiences. Furthermore, stress-provoking situations like derailment in the visa process or

documentation, poor financial background to begin with, inability to communicate clearly in the foreign land, and inadequate 'holding environment' all together can have significant impact on acculturation of first generation immigrant . Dr. Kimia Pourrezaei concentrated on the unique dynamics and challenges of 2nd generation youth raised in the era of emerging internet technology and the impact of this experience on individuation and identity formation. She discussed the notion of feeling like an outsider amongst Iranians, Americans, and Iranian-Americans alike. Rather than conform to various cultural expectations, she gravitated toward the cultural underground of film, music, art, and activism. She used her position as "the other" to think critically about racism, ethnocentricity, homophobia, gender inequality, and social constructs which aim to disempower and limit human potential".Dr. Tanuja Gandhi focused her comments on how her "conservative, religious, familial, and cultural background" shaped her professional and individual identity formation. She expressed how by working through these struggles with the assistance from IAPA, APA Training program, colleagues, and mentors, she is able to establish an "independent Identity".

In "Inter-generational Dialogue: Bringing up children in US, Leaving Home, Generational culture gap" Dr. Anthony Fernandez highlighted dynamics/struggles, culture gap (perceived and real) between his teenage children and himself as the father. Dr. Nidhi Tewari described her silent suffering of growing up as a "brown skinned, minority child" in a middleclass town and how this influences the parenting of her children. She expressed gratitude that the social milieu is changing to encourage the recognition of diversity, helping Indian children feel "proud to be Indian." Dr. Cherian Varghese presented his personal challenges in caring for his aging parents, and dealing with his father's death and mother's Alzheimer's. He highlighted struggles with loyalty, responsibility and guilt as he stressed the need to work through "guilt about our parents, and the sense of loss about our children". He expressed his gratitude to his church and his community in supporting him and his family in this venture. Dr. Chand Nair focused on how his growing up as a minority in India, how his family's

misfortunes and resilience, shaped and prepared him for who he has become and his identity as a father, colleague, friend, mentor and Indo-American psychiatrist. Dr. Priya Musunuri shared how ethnocentrism and unique familial triangulations influenced her personal and family life in bringing up children. She also discussed how an "induced sense of betrayal"contributes distress if one needs to go through an "unacceptable" divorce.

The audience, which included, first and second generation immigrants, psychiatric residents, medical school faculty, religious clergy, community activists, and other interested individuals actively participated in the discussion. Also in attendance was Dr.Ranga Ram, an IAPA national officer, and Ranna Parekh, Director, Division of Diversity and Health Equity,American Psychiatric Association. Dr.Chand Nair, President of the Tri State IAPA conveyed special thanks to sponsors Dr.Jennifer Bonovitz, and Brook Glen and its CEO Mr. Neil Callahan for partially underwriting the event. The conference concluded with Dr.Romani George thanking all for their contributions.

Disclosure: The author reports no financial conflict of interest.

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Event Photos:

Harish Malhotra, MD, DLFAPA

Bridging the Gap: Opening Communication within South Asian Communities…One Conversation at a Time

SAMHIN, South Asian Mental Health Initiative and Network hosted its first-panel discussion on June 13, 2015, at the TV Asia studios in Edison, NJ. It addressed the issue of the communication gap that exists within the South Asian community in the USA.

Dr. Vasudev Makhija, Founder & President of SAMHIN (www.samhin.org), made his opening remarks. He described how the South Asian community has achieved success in all fields, ranging from medicine to business to sports to politics. South Asians take pride in these achievements. However, we turn our eyes away from sensitive issues. Mental illness, addiction and crime e.g. suicides, sexual assaults, and murders create uncomfortable media headlines. The stigma and shame of mental illness continue to be major hindrances to its medical care. One of the reasons that we turn away from these issues is that they poke holes in our myth of the model minority.

There are other barriers to access to care besides shame and stigma. There are gaps in the communication within and between families and between communities. SAMHIN's selective speakers consisted of Lily Arora, MD, FAPA, Sudha Wadhwani, Psy. D, Priti Shah Ph.D., and Tejas Shah, BA. SAMHIN recognizes a need for an ongoing dialogue about the Communication within South Asian Communities. The continuing dialogue becomes important because of the changing demographics and nature of issues of the South Asian community in this country.

Dr. Arora, an addiction psychiatrist and Clinical Assistant Professor at Rutgers, led the discussion with her talk on "Our Journey, Our Struggles." She explored the cultural roots of the South Asian community and explained acculturation from the perspective of immigrants. Dr. Arora then provided an overview of different types of acculturation and the profound psychological outcomes from adopting each type of acculturation as it affects children, adults, and the elderly who have emigrated from India. She also explored other factors affecting the psychological adjustment of immigrants. She eloquently highlighted adaptive vs. maladaptive styles of acculturation.

Dr. Sudha Wadhwani and Dr. Priti Shah have extensively worked with South Asian youth in outreach and community intervention in addition to university mental health. They gave a presentation entitled "Opening Communication within South Asian Families." They described generational, gender, acculturation and communication gaps. They stressed the importance of identity development at various stages of life for the South Asians in this country. They emphasized the role of validation and support. They educated attendees on the importance of developing the bicultural family identity that values and respects all cultures and generations in the home. They touched on issues of dating and marriage. They talked about gender roles and issues of gender inequality. Importance of open and non-judgmental communication and specific communication skills in a variety of situations were discussed.

Medical student, Tejas Shah, shared his experiences with friends dealing with substance abuse and addiction. In his talk " Having the First Conversation about Substance Abuse," Mr. Shah explained the addiction pathways in our brain. He brought to light the prevalence of drug abuse in our community, resulting in several tragic consequences. He stressed seeking treatment and care to reverse and overcome addiction. He reiterated how essential open communication between parents and children is in order to overcome addiction. He stressed the importance of dialogue on this issue.

Mansi Vira's hard work and dedication in helping organize and structure the event and introduce the speakers cannot be overemphasized.

An engaging and lively Q & A session followed the panel discussion. Audience members had the opportunity to ask the faculty questions. There were many great questions, and time could not do justice to the number of questions received. The sensitivity and depth of the questions asked were remarkable. SAMHIN's mission is to make communication transparent in the home and community and ultimately to bridge the communication gap. The gap inhibits access to mental health care.

SAMHIN is grateful to the Share and Care Foundation for their co-sponsorship including a sumptuous dinner and a great venue, with excellent support from staff at the TV Asia Studio auditorium.

We will stay tuned for more workshops in the future.

Disclosure: The author reports no financial conflict of interest.

Dr. Malhotra is psychiatrist practicing in Summit, N.J.

Mary Ganguli, MD, MPH, FRCP(C)

DSM-5 Neurocognitive Disorders: Myths, Misconceptions versus the Actual Facts.

Beginning a year prior to its publication, there was outrage that the DSM-V was doing away with the classification of dementia as a psychiatric condition. This was news to me and the other members of the long-suffering DSM-5 Work Group on Neurocognitive Disorders. Mysteriously, much of the outrage was coming from those who are not mental health clinicians in the United States and thus are not required to consult the DSM V. Now that the dust has settled, readers might appreciate an overview of the highlights of this new section.

Basic nomenclature: why "Neurocognitive?"

The new umbrella term "Neurocognitive Disorders" is less of a mouthful than the DSM-IV's "Dementia, Delirium, Amnestic, and Other Cognitive Disorders". The term "neurocognitive" has been challenged particularly by neurologists who argue that surely all cognition is neural. However, in psychiatry and psychology, "cognition" has a broader meaning, such as in the cognitive theory of depression. For us the term neurocognitive introduces a needed level of specificity.

What are the Neurocognitive Disorders included in this category?

The DSM-V section on Neurocognitive Disorders (NCD) includes 3 disorders: Delirium, Major Neurocognitive Disorder, and Mild Neurocognitive Disorder. The central/primary clinical feature of all 3 disorders is acquired cognitive decline. Further, all three are syndromes which are diagnosed with the expectation that the underlying etiological condition is known or knowable.

Delirium is a separate entity about which there is little confusion (pun intended) and will not be further discussed here.

Major NCD is a broad category which subsumes what was called “dementia” in DSM-IV but also includes other entities. As to what some readers perhaps consider the most important issue: DSM-5 has not done away with the term “dementia” but rather allows its continued use in the age groups (e.g., geriatric) and clinical entities (e.g., Alzheimer’s disease) where that is the standard term. More on this later.

Mild NCD is a second broad category and is a new entity. It refers to disorders in which the individual’s cognitive functioning is diminished beyond the normal/expected range but less severely than in Major NCD. The reason for the asymmetric use of the terms Major and Mild (rather than Major and Minor) was pushback from stakeholders who were concerned that the term “minor” trivialized the condition. It is worth noting that others opposed the very idea of diagnosing cognitive impairment at a mild level on the grounds that it would medicalize normal aging and be a boon to the pharmaceutical industry.

It must be understood that the Neurocognitive Disorders are not restricted to geriatric patients or populations. They can occur at any age, e.g. following encephalitis or head trauma in young adults or adolescents. In theory, they can also occur in young children, but that lands us in the territory of Neurodevelopmental Disorders, where a trauma or stroke might cause not cognitive decline but, rather, a bend in the trajectory of cognitive/intellectual development.

What are the "cognitive domains" included here?

A new feature in DSM-V is that the Neurocognitive Disorders chapter begins with a section on cognitive functioning and includes a table of six broad cognitive domains: complex attention, executive function, learning and memory, language, perceptual-motor (*aka* visuospatial or visuoconstructional) function, and social cognition. Although social cognition is a newly defined entity, it includes familiar elements such as judgment, which were in previous DSM editions. The table lays out the definitions of each of these domains and describes the manifestations of impairment in these domains at the "Mild" and "Major" levels. The table also provides suggestions for ways to assess these functions, without naming any specific proprietary neuropsychological tests.

It should also be emphasized that for any cognitive test to be used and interpreted, the clinician should have an understanding of how a given patient would be expected to perform on that test if the patient were cognitively intact. Elements impacting the patient's performance are his/her age, gender, educational level, cultural/linguistic background, etc. The patient's actual performance can be compared to the expected performance to determine the presence of impairment. There are published standardized normative values on these tests. These norms specify the mean and standard deviation (or equivalent percentile) of scores on those tests for the patient's peer group. The application of this principle can be seen below.

Criteria for Major and Mild Neurocognitive Disorders

The diagnostic criteria for Major and Mild NCD follow a parallel structure. The core feature of both is evidence of decline, from a previously higher level in one or more cognitive domains based on both objective and subjective/ observational information. Subjectively and/or observationally in Major NCD, the impairment must interfere with independence in everyday activities. In Mild NCD, although the impairment does not interfere with independence in everyday activities, the individual is typically performs these activities slowly and/or with greater effort and difficulty than the norm. Objectively, based on appropriate norms, the individual's performance falls roughly between one and two standard deviations

below the mean for his peer group in Mild NCD and two standard deviations below the mean in Major NCD. In Mild NCD, impairment must be present in at least one of the cognitive domains. In Major NCD, impairment is usually present in two or more domains but occasionally (e.g. after a single large stroke or head trauma) the impairment in a single domain can be so severe that it causes substantial interference with everyday independence. It is important to note that for NCD syndrome there is no specific domain that is impaired. This is a departure from DSM-IV where memory had to be impaired to diagnose "dementia." As before, Major and Mild NCDs are not diagnosed if the observed impairments can be explained by delirium or another mental disorder. It is recognized that many psychiatric disorders, e.g. schizophrenia or major depression, have cognitive components; however, in those disorders, the cognitive impairment is not the central or primary feature.

Diagnosis of the NCDs does not stop with identifying the broad syndromes but proceeds to etiological diagnosis.

Etiological Subtypes

Detailed criteria are provided in DSM-V for Major and Mild NCD due to specific brain diseases: Alzheimer's disease, cerebrovascular disease, Parkinson's disease, Dementia with Lewy Bodies, Frontotemporal Lobar Degeneration (FTLD), Huntington's disease, HIV disease, Traumatic Brain Injury (TBI), Prion Disease, as well as NCD due to other medical conditions These disease-specific criteria were carefully developed to be consistent with extant expert consensus criteria and also set out in parallel format. This is a significant contribution in that there is no other document which lays out diagnostic criteria for multiple dementia subtypes, side-by-side, in an internally consistent format that facilitates differential diagnosis.

While this article cannot provide the criteria for all the etiological subtypes, the case of NCD due to Alzheimer's disease (AD) provides some useful illustrations. It was mentioned in the previous section that the Mild and Major NCD syndrome criteria do not specify any particular cognitive domain be impaired. However, for

Mild and Major NCD due to AD, the domain of memory must be impaired (DSM-V does refer to rare exceptions). In contrast, for NCD due to FTLD, memory may not be impaired but impairment is seen in executive functions, social cognition, and/or language. In NCD due to cerebrovascular disease, any domain can be impaired depending on where in the brain the vascular damage is located.
For NCD due to several of these disorders, DSM-V also provides a level of certainty of diagnosis, e.g. “Probable AD” and “Possible AD.” This approach is new to DSM and indeed, to much of psychiatry. However, it is standard in neurology and related fields, and reflects the current expert criteria for those diseases, such as the NIA-AA Work Group recommendations for the diagnosis of AD. “Probable AD” is diagnosed when the syndrome has certain very typical features and/or when there is a confirmed autosomal dominant inheritance otherwise, “Possible AD” is diagnosed. Biomarker-based diagnosis is the focus of intensive research at present but is not yet approved and standardized for clinical use. Therefore, although AD biomarkers are discussed in the text of DSM-V they are not included in the diagnostic criteria.

Summary

The Neurocognitive Disorders chapter of DSM-V has been the target of much discussion about basic nomenclature while several of its new and promising features are not widely known. Mental health clinicians are increasingly encountering patients with these disorders in their practices. They are strongly encouraged to read the chapter for themselves and familiarize themselves with the information it contains in order for them and their patients to reap the benefit of the labor of their colleagues who worked on DSM-V.

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Kamalika Roy, MD

Vortioxetine: The Novel Multi-modal Antidepressant

Vortioxetine is a novel multimodal antidepressant, which was approved, by Food and Drug Administration (FDA) in September 2013. As it is a new drug in the already crowded antidepressant armamentarium, it is necessary to review the mechanism, proposed advantages and the clinical implication of its multi-receptor mediated actions. The FDA review of the drug concludes that the other receptor mediated effects may have clinical relevance including treatment of cognitive impairment related to depression, and attenuated sexual side effects related to antidepressant treatment.

In Diagnostic and Statistical Manual-5 (DSM-5), cognitive impairment (i.e. reduced ability to think or concentrate or indecisiveness) has been included as a criterion of an episode of major depressive disorder. Cognitive impairment is an important undermining factor in functionality and workplace performance. Improvement of cognitive impairment is significantly associated with functional recovery. Persistence of residual cognitive impairment, even after adequate improvement in neurovegetative symptoms, has been a matter of concern in current practice with antidepressant treatment.

Mechanism of Action:

Serotonin transporters (SERT) and receptors have long been implicated in depression, anxiety, learning, memory and also circadian rhythm. Vortioxetine has a number of effects beyond inhibition of SERT. It is a full agonist at 5HT-1A, partial agonist at 5HT-1B, antagonist at 5HT-1D, 5HT-3 and 5HT-7[1] (Figure)

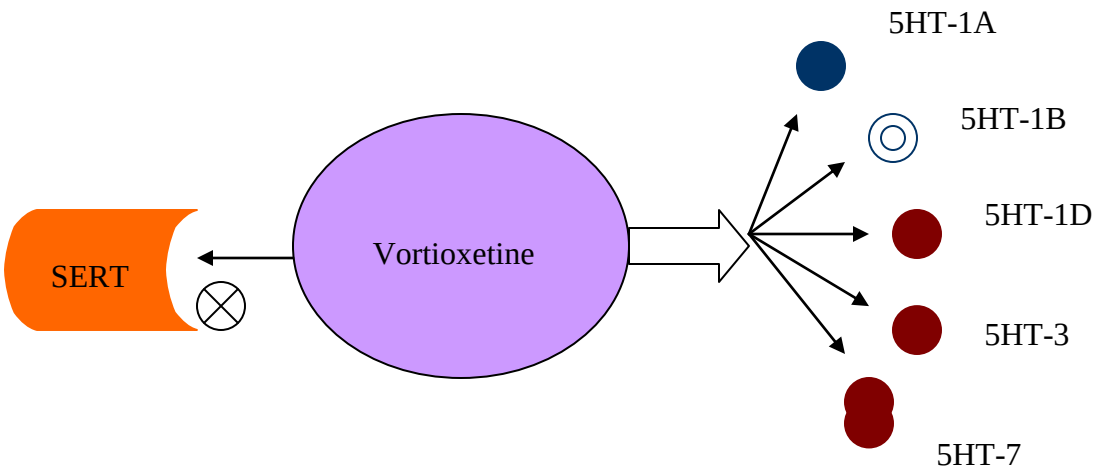

Figure: antagonist, agonist, : partial agonist, : inhibition

The clinical effects of this multi-modal antidepressant are described in the table below. The unique effect of improved cognition through the 5HT-7 receptor has been demonstrated in rat model. This effect will need to be documented in clinical practice.

Table: Useful and unwanted effects of multi-receptor affinity of vortioxetine

Receptor affinity	Useful effects	Unwanted effects
5HT-1A agonism	• Antidepressant and anxiolytic effect • Inhibits glutaminergic	• nausea and light headedness • Pre-synaptic

	cortico-striatal neurons and increases dopamine release in pre-frontal cortex • Increases dopamine release in striatum and reduces chance of extra pyramidal side effects	auto-receptor: proposed to be responsible for delay in antidepressant action
5HT-1B partial agonism and 5HT-1D antagonism	• Terminal auto-receptors: improve dopamine, acetylcholine and histamine release which is proposed to improve cognition	
5HT-3 antagonism	• It increases glutamate release from the pyramidal neurons in CA-1 area of hippocampus which is responsible for memory and cognition	• It also causes nausea, the most common side effect of vortioxetine
5HT-7 antagonism	• Associated with normalization of circadian rhythm and improved cognition	

Clinical trials, studies and effectiveness as antidepressant:

To describe FDA's perspective of this new antidepressant, some of the short term clinical trials are worth mentioning[2]. Most of them are of 6 to 8 weeks duration and used a dose range of 5mg/day to 20mg/day dose of vortioxetine. Clinically significant antidepressant action was shown only with 10mg/day or higher dose, when compared to placebo. There were two weeks' delay in having evident antidepressant effect, comparable to many other antidepressant of selective serotonin reuptake inhibitor (SSRI) group.

In a recurrence prevention or maintenance study[3], at the end of the maintenance period, the vortioxetine group had a lower relapse rate (13%) as compared to the placebo group (26%), where 75% subjects were on 10mg/day does of vortioxetine.

Possible effects on cognitive dysfunction

At the time of FDA review, there was a single double-blind, placebo-controlled duloxetine study referenced which showed superiority of vortioxetine in elderly depressed subjects with improved objective neuropsychological indicators like processing speed, verbal learning and memory[4]. However, the results of this study fell below FDA's threshold for superiority. At present there are at least two more studies showing a similar result. McIntyre et al. showed a subjective and objective improvement in cognitive function, independent of improving depressive symptoms, with vortioxetine, in adults with recurrent MDD[5]. Another similarly designed duloxetine study further strengthened this hypothesis. Patients who received Vortioxetine showed significant improvement in digit symbol substitution

and University of San Diego performance-based skill assessment tests as compared to duloxetine as an active reference[6].

Though FDA has been silent on the proposed effects on cognitive measures, more recent studies may show some more hopeful data in this regard.

Tolerability, safety and side effects:

Clinical trials suggest that vortioxetine has a good tolerability and safety profile with a discontinuation rate of 6% with a dose of 10mg/day[4], comparable to other SSRIs. The most commonly reported side effect has been nausea, which appears to be dose related and ranges from 14% to 20%.

In studies[4], self-reported treatment-related sexual side effects (using Arizona Sexual Experience Scale) have been slightly higher in the vortioxetine group. With the 20mg/day dose, 34% of females reported sexual side effects, compared to 20% in the placebo group. With the same dose, 29% of males reported sexual side effects as compared to 14% in the placebo group. According to FDA review, vortioxetine was not superior to duloxetine with respect to sexual side effects.

Vortioxetine had no significant effect on weight gain when compared to placebo group[4]. Insomnia, fatigue, and somnolence were described to be low with the new drug[5].

Metabolism and dose adjustments:

Vortioxetine is mainly metabolized through oxidation, primarily by the cytochrome P (CYP) 450 group, specifically by CYP2D6. Subsequently, it is conjugated with glucuronic acid and excreted through the kidneys. The

dose of vortioxetine should be reduced when prescribed with bupropion (a potent CYP2D6 inhibitor). There is no need to adjust the dose of vortioxetine in mild to moderate kidney or liver disease.

Though the labeling says that the drug can be discontinued abruptly, discontinuation syndrome has been documented in this situation, especially in patients on a higher dose.

The recommended starting dose is 10mg/day with gradual dose increment when it is well tolerated.

Antidepressant selection in clinical practice:

In limited clinical trials and maintenance studies, vortioxetine seems to have added benefit in improving cognition, sleep pattern and lesser sexual side effects. Considering the available data, it can potentially be used as a preferred agent for elderly depressed patients, patients with prominent cognitive dysfunction as a comorbidity of depression and patients with pseudodementia. Residual cognitive symptoms in treated depressed patients also might respond better to vortioxetine therapy. However the choice of antidepressant should be subject to the practitioner's clinical judgment.

As with many other antidepressants, more high quality, population representative studies are needed to appreciate its unique clinical benefits over other antidepressants in the long term. Some authors have not perceived much difference in the efficacy of vortioxetine compared with other agents[2]. The advantage of the multi-modal mechanism of action is yet to be documented as clinically relevant.

In a nutshell, the clinical judgment of weighing risk, benefits and customization according to patient's needs would be something to consider when prescribing a novel agent for treatment of depression.

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Sudhakar Madakasira, M.D., DLFAPA

Psychiatry and Reincarnation: Some Personal Ponderings

"Just as a man discards worn out clothes and puts on new clothes, the soul discards worn out bodies and wears new ones." - Bhagavad Gita (2:22)

When I was in middle school and later in high school, I remember reading English books, magazines and newspapers, whenever I had free time, and voraciously during holidays. During summer holidays, I would study and memorize Oxford English Dictionary starting alphabetically, but I never finished. I still chuckle at the English short stories and poems I wrote during that time and kept all these years. My parents were not happy that I made better grades in English than in Telugu, my mother tongue.

When I received a letter of acceptance and scholarship to nearby government medical college, I was proud, but not sure. I took the train to visit an uncle who was an English professor at a local university. I told him of my interest in studying English at the university. His laughter was quite bellicose. He said he loved the language but that it was difficult to make ends meet if not for the private lessons he gave. He thought I would be foolish not to study medicine, in view of the money and the prestige that came with the profession. He suggested I could pursue English as a hobby.

You are probably wondering "What does this have to do with psychiatry and reincarnation?" Please bear with me.

I joined the medical college and spent the first two years in a fugue state induced by busy schedules and classes, newly found freedoms and friendships, and foolishly romantic fantasies. I don't remember studying much and barely managed to pass, causing some suppressed embarrassment to my parents. The price I paid for this lack of discipline was the anxious dreams that haunted me until a few years ago, in which I would be late to the exam, not find the exam hall, not have the pencils, or run out of time. In other words, I made fine fodder for Freud.

In my third year of medical college, when clinical lectures and rotations started, the only ones that caught my fancy were by a Dr. R. Subramanyam,

the one and only psychiatry professor at the college. His first lecture was on Freud's theory of the mind in terms of id, ego and superego. There was no psychiatry rotation. I must have gone through my clinical rotations robotically because I don't remember much but managed to pass. During the mandatory internship at the same hospital, there was an option for a one-month elective, but as my luck would dictate, all slots were taken for my chosen month except psychiatry. So, I signed up. As it turned out, I was the only student from my class from my class and four classes before me to take this elective. I knew my classmates would laugh at me, so I wouldn't tell them until the last minute.

What an amazing experience this elective was! One of my patients, diagnosed with schizophrenia, talked about being a CID agent assigned to protect Indira Gandhi. He received electro-convulsive therapy. No anesthesia was used in those days. While the ward attendants held his extremities my duty was to secure the tongue depressor in place. One of my outpatients, diagnosed with voyeurism for peeping through several neighbors' windows at night, received Largactil (chlorpromazine).

Now, thirty years into psychiatry in the US, I wake up every day looking forward to seeing my patients in a psychodynamic-oriented private practice. I also teach residents and other professionals about the Freudian approach. I enjoy and cherish this profession with a special interest in depression and prevention of suicide. I also love a glass of wine almost every night. My most cherished cap has a picture of four bottles of wine with a caption "GROUP THERAPY, Wine Is Life."

My parents tried to pressure me to marry an Indian girl. I would not have it, and after dating American girls, I fell in love with some and am now happily married to a beautiful girl from Mississippi.

Love for English, psychiatry, American women and wine. This is not a typical Hindu South Indian proclivity. What went wrong, or right, with me?

Some plausible explanations occurred to me five years ago after I visited a swami in a rural village near Chennai in the state of Tamil Nadu. He and an assistant performed Naadi Shastra, an ancient method of ascertaining a person's past, present and future, by comparing thumb prints (right one for men, left for women) with the characteristics and predictions described by Maharishi Agasthiya more than four thousand years ago. He systematically compared our thumb prints to copies of Sanskrit scrolls originally written on palm leaves. The appointment was made in someone else's name, so the swami had no knowledge whatsoever of me or my wife except the thumb prints. Yet, he was able to tell my first and last name, parents' names, my date and place of birth, my profession, and my future, even in terms of when and what I would die of.

As you can imagine, I was a skeptic throughout, thinking any smart Indian could make good guesses on another Indian after a few broad screening questions. I was totally aghast when the swami came out with accurate information about my wife who did not accompany me. He could not quite pronounce the American names but had the right syllables. He correctly told my wife's first name, date and place of birth, but also her American parents' first and last names. You are thinking he must have searched the internet but it is impossible to find such information without a last name or city of residence.

In my last life, the swami told me, I was an Englishman by the name Robert, who lived in the state of Kerala, that I was a doctor, a womanizer and an alcoholic and that I committed suicide at the age of forty. He could also tell

Robert’s parents' names and their occupations. I researched the internet for Robert and his parents in Kerala for mid-1900’s. I had no luck and and was not surprised either, as even Christians in South India were not known to keep death records in those days.

I still do not know what to make of my naadi shastra discoveries. My wife says bah humbug, but I am not sure. I wonder if there is some truth to these readings. The naadi shastra performers were authentic and forthright. They not only gave me a written description of my naadi shastra translated to Telugu, but also their audio recordings in Tamil.

I have been pondering ever since. Did my love for English occur because I was an Englishman in my previous life? Did I marry a Caucasian, not an Indian, for the same reason? Do I love wine because I was an alcoholic in my previous life? Is my fascination with psychiatry a compensation for mental anguish and suicide in my previous life?

If you believe in reincarnation, you will say yes and subscribe to these explanations. With a background in science and belief in evolution, I naturally question the concept of reincarnation. However, I also realize my knowledge is rudimentary. There is so much in our existence we do not know or understand. Who am I to question the wisdoms and powers of maharishis?

Finally, I move on to some practical questions. Will I get a different naadi shastra reading if I go to a different swami? Should I take precautions and atonements to prevent, delay or minimize the blood disease from which I’m supposed to diet?

I’ve pondered enough! I’ll just put this out of mind for now and live and enjoy life as it happens. I’ll try to not go back to the future. I’ll try to take it as it comes.

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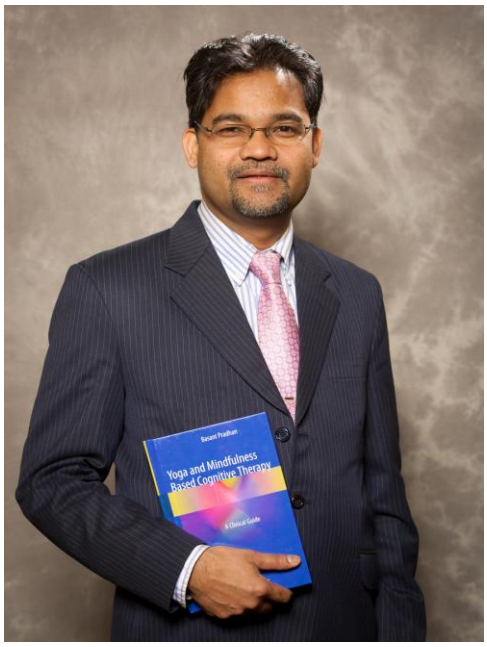
Sudhakar Madakasira, M.D.,DLFAPA is a clinical professor of psychiatry the University of Mississippi Medical Center and works as President and Medical Director of Psycamore Partial Hospital Programs. He is the 2013 recipient of the APA Assembly Profile of Courage Award for his fight against discrimination of the mentally ill by the City of Ocean Springs, Mississippi.

AWARDS:



BRIEF SUMMARY OF AWARD:

A new study on refractory PTSD led by Basant Pradhan, MD and the trauma research team at the Department of Psychiatry, Cooper University Hospital, Camden, NJ in collaboration with the National Institute on Aging (NIA) is getting the prestigious NARSAD Young Investigator Grant (2015), awarded

by the Brain and Behavior Research Foundation. Dr Pradhan and team, in a landmark pilot study with the NIA, have developed new treatment for refractory PTSD (TIMBER psychotherapy and how it prolongs the action of ketamine for refractory PTSD. In addition they have established a plasma bio-marker which correlates with treatment response to ketamine and TIMBER in PTSD. This Grant award provides support for the most promising young scientists conducting neurobiological research in neuropsychiatry. Dr Pradhan and his team hope to use this grant for expanding our work further on TIMBER psychotherapy, ketamine & bio-marker(s) for refractory PTSD for which they already have generated pilot data.

More description about this foundation and this award can be found in https://bbrfoundation.org/yi

Brief Bio of Basant Pradhan, M.D.

Basant Pradhan, M.D. is an academic psychiatrist (for children, adolescents and adults), educator, researcher and author. Currently Pradhan serves as the founding director of the trans-cranial magnetic stimulation (TMS) treatment, and the Y-MBCT programs at the Cooper University Health System, Camden, NJ, USA. In addition, he serves as an Assistant Professor of Psychiatry and Pediatrics in the Cooper Medical School of Rowan University. Pradhan's clinical and translational research work since 1993 has revolved around his pioneering work on neuropsychological functioning of patients with first episode bipolar disorder as compared to those with multiple episodes and schizophrenia, epidemiology of child psychiatry, Yoga and mindfulness research, and development of new models of

treatments that combine cutting edge psychopharmacology with neuro-biologically informed models of psychotherapy. His current research project as a Principal Investigator involves a study with the National Institute on Aging (NIA/NIH) that examines the efficacy of *TIMBER*©, a translational mindfulness based psychotherapy designed by him that has been found effective for patients suffering from chronic and treatment refractory post-traumatic stress disorder (PTSD). Pradhan has pioneered in translational clinical research in the field of *Yoga and mindfulness based cognitive therapy* (Y-MBCT), has developed seven disorders specific Y-MBCT models that covers all major DSM psychiatric disorders and he and his colleagues have tested the efficacy and feasibility of these evidence based models in multi-cultural cohorts in India and the US consisting of more than 300 patients afflicted with various psychiatric conditions. As described in one of his books with the same title (2014, Springer), the Y-MBCT models integrate the concepts of cognitive neurosciences with principles of mindfulness based cognitive therapy (MBCT) and Yoga in evidence based manner. These models advocate for use of *Yoga in its entirety* (i.e. all eight limbs including meditation) rather than in piece meal, thus increasing the scope and utility of Yoga and mindfulness interventions both as adjunctive and sole modality of treatment. Dr. Pradhan has received numerous awards in his career, both in India and the US. He has authored or co-authored over 25 peer reviewed articles, editorials, books and book chapters.

FALL IAPA MEETING

The 2015 IAPA fall meeting will be held this year on Saturday, October 24th, 2015, in Raleigh, North Carolina. It will be hosted by the newly-formed Carolina's IAPA Chapter. We are anticipating the attendance of 25 Psychiatrists in IAPA leadership positions in addition to many local members. All members are invited to attend this joyous function.

We will have the pleasure of hearing keynote speaker, Meera Narasimhan, MD, Professor of Neuropsychiatry and Behavioral Science at the University of South Carolina reflect on her journey to becoming a Chair of Psychiatry.

Accommodations will be arranged at the location of the Fall meeting: Wingate Hotel, 6115 Corporate Ridge road, Raleigh, NC 2760 (tel: 866-455-2674 , Website:http://www.ncraleighhotel.com/). For further details please contact IAPA President, Ashwin Patkar at ashwin.patkar@duke.edu

We look forward to seeing all of you!

Vinay Saranga, MD

President Elect/Secretary–Carolina's Chapter

To submit articles to the Indo-American Psychiatric News or for queries, email Lily Arora, MD (lilyarora@gmail.com).