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Indo-American Psychiatric News

Hearty Greetings from the IAPA Editorial board! This has indeed been a fantastic year for Indo-American Psychiatric Association (IAPA). As IAPA has expanded its chapters and membership, there was a felt need for a newsletter that would focus on issues related to Indian-American psychiatry, would facilitate the exchange of news/ideas and help keep us up-to-date on the latest in psychiatric treatment. To this end the Indo-American Psychiatric News was conceived and strives to fulfill these goals. In this edition of the newsletter, Lily Arora discusses the concepts of acculturation and ethnic identity as it relates to first-generation and second-generation Indian-Americans (pages 3-5); Harvinder Singh gives as a brief overview of the newer antipsychotics in the first of a two-part series (pages 5-8); Shirshendu Sinha discusses the novel orexin-receptor antagonist, Suvorexant (pages 8-12); and Vasudev Makhija introduces us to his fabulous work at SAMHIN (South Asian Mental Health Initiative and Network) (pages 13-14). Happy reading!

Message from IAPA President

It is with pride and joy that I announce the release of IAPA's electronic newsletter. I applaud the publication of the electronic newsletter.

My congratulation to Dr. Rajiv Radhakrishnan (PGY 3 resident at Yale School of Medicine) for leading the effort on this and to other members of the editorial board: Drs. Amit Chopra (Staff Psychiatrist at Allegheny General Hospital), Lily Arora (Clinical Assistant Professor at Rutgers-New Jersey Medical School) and Shirshendu Sinha (PGY 4 resident at University of Connecticut Health Center). It takes special dedication and perseverance to be involved in such a project and I truly appreciate their creative skills.

IAPA chapters and junior IAPA members are the pillars of our organization. I kindly urge them to continue to provide support and work with senior members to get IAPA on the international map.

Kindly take a few minutes to review the newsletter. If you have any comments or feedback, please contact Dr. Rajiv Radhakrishnan (rajiv.radhakrishnan@yale.edu) or me (vrao@jhmi.edu).

Sincerely,
Vani Rao, MD
President, IAPA.

Lily Arora, MD.

Acculturation and Identity Transformation.

Immigration from one country to another is a process involving significant psychological adjustment. This is a topic that has been written about extensively. In most literature, Indian immigrants are grouped together with all other Asian immigrants. There are sufficient differences in the culture of Indian immigrants which makes it worthwhile to consider issues of psychological adjustment of Indian immigrants separately.

Psychological adaptation to immigration takes place through the processes of acculturation and identity transformation. Acculturation is the gradual process of the immigrant becoming more familiar with the conventional ways of behavior in his new homeland (Akhtar, 2009). Membership in a group, as well as one's values and emotional significance attached to this membership, are important parts of one's self-concept and form the basis of ethnic identity. This is subject to transformation upon immigration to a new country.

It is useful to understand Berry's model of acculturation prior to delving into the factors affecting the adaptation process in Indian-Americans. According to Berry, there are four ways in which an individual can associate with his or her host culture. The first is assimilation in which all ties with the individual's own culture are severed. The second is marginalization, in which ties to both the individual's and host culture are severed. Third is separation in which the individual rejects the host culture and identification is primarily with the individual's own culture. Finally, the healthiest is integration in which the individual selectively acquires traits of the host culture while maintaining characteristics of his own.

The factors affecting the acculturation of first and second generation Indian-Americans differ significantly enough to consider them separately. First generation Indians are defined as those who were born in India and migrated to the US. Second generation refers to their children, who are born in the US.

The First Generation

Factors affecting the processes of acculturation and identity formation in the first generation include: circumstances and motivation for migration, age at migration and gender.

Circumstances and motivation for migration: Was migration temporary or permanent? Was it voluntary or resulting from sudden exile? Are there opportunities to visit the country of origin? The answers to these questions determine what psychological events will follow. Psychological adaptation is easier if migration is temporary, voluntary, with opportunities to visit the

country of origin, and there is the possibility to live in an ethnic enclave (with the opportunity to be close to others of the same ethnicity and participate in cultural activities).

Age at Migration: Parents may immigrate voluntarily, but children are always exiles. They have no choice in the matter. It is thus very important for parents to be well adjusted in order to provide the ego support required in order to prevent adverse psychological consequences in children of immigrants. Adolescents are burdened with the loss of cultural familiarity in addition to the drive for autonomy from their parents. This renders them more prone to confusion regarding their identity. In context of receiving adequate support from their friends and community, they are able to integrate in a healthy manner. Adults are the ones who have an opportunity to adjust according to Berry's model of acculturation. Their adaptation depends on their mode of adjustment. This is impacted by personality traits, previous modes of coping and attitude. The elderly are put in a difficult position as they are uprooted after a lifetime of being socially established in their home country. Alongside loss of well established rituals, former friends, limits on independence and having to learn a new language, comes potential alienation from the acculturation of their younger generation.

Gender: For Indian men, the purpose of migration has been for bettering their educational and financial situation. Women are imbued with the responsibility of maintaining traditions and passing them on to the next generation. This accounts for a model of acculturation specific to first generation Indians in which family values, religion and cultural cuisine are maintained at home. In the workplace, dress, etiquette and interactions are "Americanized."

The Second Generation

The psychological adaptation of the second generation relies on the difficult task of meeting parents' cultural expectations in addition to adjusting to the conventions of the host country. Challenges faced by this population include overcoming shame in regards to having culturally different parents, expectations of parents of children that differ from societal norms and prejudice.

Cultural Differences from Parents: Children of first generation Indian Americans often serve as their parents' "cultural brokers." They are depended upon to help their parents with legal, financial and medical matters. Such a role can put them in the difficult position of being parentified and thereby causing adverse consequences in the development of a healthy sense of self.

Family Values: As discussed above (under *Gender*) , the expectation of Indian women is to carry on traditional values to future generations. This places great pressure on Indian daughters to refrain from dating due to concerns about exogamy and premarital pregnancy leading to experiencing guilt after lying to their parents about their whereabouts or avoidance of sexuality due to internal conflicts. Great expectations in terms of fulfilling the parents' "American dream" are often placed on children. Failure to meet academic standards set by par-

ents may be viewed with disdain by the community enhancing acculturative stress.

Prejudice: Physical differences and overt neurotic habits (e.g. shyness), increase the chances that a child will be treated with prejudice by peers. If the parents have become well integrated into the host country, the presence of sustained love under such circumstances is beneficial to the creation of psychic solidity and resilience in the child.

In conclusion, there are many factors specific to the Indian American population to consider in terms of acculturation in the process of psychological adaptation to immigration to the US. These factors not only are specific to this sect of the Asian population but also vary in terms of whether the immigrants are first or second generation.

Disclosure: The author reports no financial conflict of interest.

Lily Arora MD is a Clinical Assistant Professor at Rutgers-New Jersey Medical School.

REFERENCES

Akhtar, S. (2011). Immigration and Acculturation. Plymouth: Rowman and Littlefield Publishers Inc.

Akhtar, S. (2009). Comprehensive Dictionary of Psychoanalysis. London: Karnac Books Ltd.

Akhtar, S. (1999). Immigration and Identity. Oxford: Rowman and Littlefield Publishers Inc.

Berry, J. (2005). Acculturation: Living successfully in two cultures. International Journal of Intercultural Relations. 29:697-712.

Dasgupta, S.D. (1998). Gender Roles and Cultural Continuity in the Asian Indian Immigrant Community in the U.S. Sex Roles. 38:11/12

Kankipati, V. "Acculturation of Asian Indian Women in the United States" (2012). Theses and Dissertations--Family Sciences. Paper 4.

Harvinder Singh, MD
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What's New in Psychopharmacology.
Part I: Arrival of New Antipsychotics.

The introduction of chlorpromazine in 1950s marked the introduction of first medication known to significantly reduce the symptoms of psychosis. Antipsychotic medications, previously referred to as major tranquilizers or neuroleptics, can be classified into first generation (conventional or typical) antipsychotics and second generation (atypical) antipsychotics. Typical antipsychotics therapeutic benefit is related to dopamine type 2 (D2) receptor antagonism, whereas dual 5-HT2 receptor–dopamine type 2 (D2) receptor antagonism is responsible for second generation antipsychotics favorable efficacy and side

effect profile over first generation antipsychotics. This first section of article is focused on individual discussion of recently introduced newer antipsychotics.

Four newer antipsychotics recently introduced in the market include Paliperidone (Invega), Iloperidone (Fanapt), Asenapine (Saphris) and Lurasidone (Latuda). These medications will be compared and summarized in following tables.

Table 1: Newer Antipsychotics

Medication	Approval Date	Manufacturer	FDA Approved Indications	Dosing Instructions
Paliperidone	December 19, 2006	Janssen Pharmaceuticals , Inc	- Schizophrenia (age ≥ 12) - Schizoaffective disorder as monotherapy and as an adjunct to mood stabilizers and/or antidepressants.	Once daily: do not chew or divide the tablet
Iloperidone	May 6, 2009	Novartis Pharmaceuticals Corp	- Schizophrenia (Adults)	Twice daily and titrated slowly to avoid orthostasis and sedation
Asenapine	August 13, 2009	Merck & Co, Inc	- Schizophrenia (Adults) - Bipolar I disorder (manic/mixed episodes): acute treatment as monotherapy or adjunctive therapy	Sublingual: eating and drinking should be avoided for 10 minutes after administration
Lurasidone	October 28, 2010	Sunovion Pharmaceuticals , Inc	- Schizophrenia (Adults) - Bipolar I disorder (depression): as monotherapy or adjunctive therapy	Once daily with food

Many side effects of antipsychotic drugs can be understood in terms of the their receptor blocking properties. First generation antipsychotics are known for extra pyramidal symptoms (EPS), whereas second generation antipsychotics carries the metabolic syndrome burden. Table 2 compares the four new medications side effects profiles with each other, with 1+ stands for least and 4 + signifies highest risk of side effect “compared” to each other. This is based on a multiple-treatments meta-analysis published in Lancet comparing the efficacy and tolerability of 15 antipsychotic medications in schizophrenia (Leucht et al, 2013).

Table 2: Side-effect profile of newer antipsychotics

Medication	Weight Gain	EPS	QTc prolongation	Prolactin Increase	Sedation
Paliperidone	3+	3+	2+	**4+**	1+
Iloperidone	**4+**	1+	**4+**	2+	2+
Asenapine	2+	2+	3+	1+	**4+**
Lurasidone	1+	**4+**	1+	3+	3+

Table 3: Use of newer antipsychotics in special populations.

Medication	Renal Impairment	Hepatic Impairment	Adolescents	Elderly	Pregnancy	Smoking
Paliperidone	Reduced in moderate or severe renal impairment	No dose adjustment	No dose adjustment	No dose adjustment	Category C	No dose adjustment
Iloperidone	No dose adjustment	No dose adjustment	Safety not established	Safety not established	Category C	No dose adjustment
Asenapine	No dose adjustment	Not recommended in severe hepatic impairment	Safety not established	No dose adjustment	Category C	No dose adjustment
Lurasidone	Reduced in moderate or severe renal impairment	Reduced in moderate or severe hepatic impairment	Safety not established	Safety not established	Category B	No dose adjustment

The task for the prescriber is to decide if these new medications result in better patient outcomes and efficacy for not only positive but also negative and cognitive symptoms of schizophrenia. Patient outcomes may be improved by early treatment with medications that are better tolerated. While we are still a long way from ideal treatment, the introduction of new antipsychotic medications has narrowed the gap between current best practice and optimal practice.

Disclosure: The authors report no financial conflict of interest.

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REFERENCES:

Leucht S, Cipriani A, Spineli L, Mavridis D, Orey D, Richter F, Samara M, Barbui C, Engel RR, Geddes JR, Kissling W, Stapf MP, Lässig B, Salanti G, Davis JM. Comparative efficacy and tolerability of 15 antipsychotic drugs in schizophrenia: a multiple-treatments meta-analysis. Lancet. 2013 Sep 14;382(9896):951-62.

Invega [Package Insertt]. Janssen Pharmaceuticals, Inc. Titusville, NJ

Fanapt [Package Insert]. Novartis Pharmaceuticals Corporation East Hanover, NJ

Saphris [Package Insert]. Merck and Co, IncKenilworth, NJ

Latuda [Package Insert]. Sunovion Pharmaceuticals Inc. Fort Lee, NJ

Shirshendu Sinha, MBBS

Suvorexant: A Novel Therapy for Insomnia

Introduction: Insomnia is a common condition, reported to occur in one third of the adult population (1). Chronic insomnia (> 6 months) is often associated with a reduced quality of life , impaired daytime functioning , increased loss of time from work and higher health costs . Chronic insomnia is also associated with an increased risk of depression and chronic use of hypnotic medications (1).

A variety of treatment options are available for insomnia. The most common pharmacological interventions are benzodiazepines (BZDs) and the non-BZD gamma-amino-butyric acid (GABA) – acting hypnotics such as zolpidem (Ambien,Sanofi), eszopiclone (Lunesta, Sunovion), and zaleplon (Sonata, Pfizer) (2). Other less frequently prescribed agents include sedating antidepressants, melatonin agonists, and antihistamines (1). Diminished efficacy and negative side effects limit the use of these treatment options for many patients.

On August 13, 2014 FDA has approved Suvorexant (Belsomra), marketed by Merck, for adults with insomnia who have difficulty falling or staying asleep. Suvorexant, a drug with a novel mechanism of action as an orexin receptor antagonist (ORA), is the first in a new class of drugs is approved for insomnia.

Chemical structure: Suvorexant is described chemically as: [(7R)-4-(5-chloro-2-benzoxazolyl)hexahydro-7-methyl-1H-1,4-diazepin-1-yl][5-methyl-2-(2H-1,2,3-triazol-2-yl)phenyl]methanone (4). Its empirical formula is C23H23ClN6O2 and the molecular weight is 450.92. Its structural formula is shown in Figure 1:

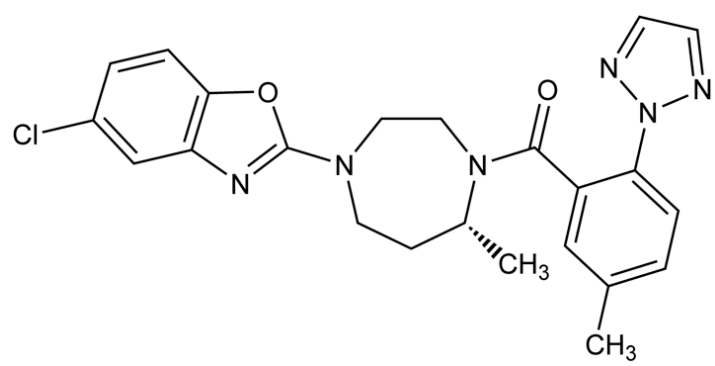


Figure 1 Structure of suvorexant

Mechanism of action: Chronic insomnia can be better explained by a deeper understanding of the neural pathways that regulate sleep and wakefulness. Wake promoting signals arise from neurons in the brain stem, hypothalamus, and basal forebrain that activate the cerebral cortex and other parts of the forebrain. (5).These neurons use acetylcholine and monoamine neurotransmitters such as norepinephrine (locus ceruleus), dopamine (ventral tegmental area), histamine (tuberomammilary nucleus) , serotonin (dorsal raphe), and acethycholine (basal forebrain and lateral dorsal and pedunculopontine tegmental nuclei) that promote wakefulness and sedation is common with many monoamine antagonists and anticholinergics (e.g. haloperidol, doxepin and diphenhydramine) (7). Neurons producing orexins are another key element of the wake promoting system (6, 7). Orexin A and Orexin B are peptide neurotransmitters produced by a small cluster of neurons in the lateral hypothalamus (6, 7). The orexin peptides A and B bind selectively to the orexin 1 (OX1R) and orexin 2 (OXR2), which are both G protein coupled receptors with 7 transmembrane domains (6, 7). OXR1 binds Orexin A with high affinity and Orexin B with low affinity (6, 7). Orexin peptides are excitatory and promote wakefulness, antagonists that block orexin receptors inhibit excitatory inputs to other arousal systems and create conditions for sleep to occur, rather than imposing sedations like GABAergic drugs (2). Genetic mutations in the orexin system in animal result in hereditary narcolepsy; loss of orexin neurons has been reported in humans with narcolepsy and a low CSF level of orexin A has become a diagnostic criterion for narcolepsy- cataplexy according to the International Classification of the sleep disorders, second edition (8).

Clinical Efficacy: In three clinical trials involving more than 500 participants, suvorexant 15 or 20 mg was found to be superior to placebo ($p< 0.05$) for both sleep latency and sleep maintenance as assessed both objectively by polysomnography and subjectively by patients' estimated sleep latency and sleep maintenance. In a one month crossover with non–elderly population, suvorexant 10 and 20 mg were superior to placebo for sleep latency and sleep maintenance, as assessed objectively by polysomnography (4).

Dosage and administration: Suvorexant was approved in four different strengths 5, 10, 15 and 20 milligrams. The higher doses were found to have similar efficacy to lower doses, but significantly more adverse reactions were noted with higher doses (4). The lowest effective dose should be used for the patient (4). The total dosage should not exceed 20 mg once a night, taken within 30 minutes of going to bed and at least seven hours before the planned waking time (4).

Contraindications: Suvorexant is contraindicated in patients with narcolepsy (4).

Safety profile: Adverse Reactions: Drowsiness was the most common adverse event in clinical trials (4).

Warnings and Precautions: Central nervous system (CNS) depressant effects and daytime impairment. Suvorexant is a CNS depressant that can impair daytime wake-

fulness even when used as prescribed. Prescribers should monitor for somnolence and CNS depressant effects, but impairment can occur without symptoms and may not be detected by an ordinary clinical exam. Suvorexant can impair driving skills and may increase the risk of falling asleep while driving. Discontinue or decrease the dose in patients who drive if daytime somnolence develops. The risk of next-day impairment, including impaired driving, increases if suvorexant is taken with less than a full night of sleep remaining, taken at a higher-than-recommended dose, co-administered with other CNS depressants, or co-administered with other drugs that increase blood levels of suvorexant (4).

Need to evaluate for comorbid diagnoses. Because sleep disturbances may be the presenting manifestation of a physical and/or psychiatric disorder, treatment of insomnia should be initiated only after careful evaluation of the patient. The failure of insomnia to remit after seven to 10 days of treatment may indicate the presence of a primary psychiatric and/or medical illness. Worsening of insomnia or the emergence of new cognitive or behavioral abnormalities may result from an unrecognized underlying psychiatric or physical disorder, and can emerge during treatment with hypnotic drugs such as suvorexant (4).

Abnormal thinking and behavioral changes. Cognitive and behavioral changes (e.g., amnesia, anxiety, hallucinations, and other neuropsychiatric symptoms) have been associated with the use of hypnotics. Complex behaviors such as “sleep-driving” (driving while not fully awake), preparing and eating food, making phone calls, or engaging in sexual activity, with amnesia after the event, have been associated with the use of hypnotics in hypnotic-naïve and hypnotic-experienced persons. The use of alcohol and other CNS depressants may increase the risk of such behaviors. Discontinuation of suvorexant should be strongly considered for patients who report any complex sleep behavior (4).

Worsening of depression/ suicidal ideation. In clinical studies, a dose-dependent increase in suicidal ideation was observed in patients taking suvorexant as assessed by questionnaire.Immediately evaluate patients with suicidal ideation or any new behavioral sign or symptom. In primarily depressed patients treated with sedative-hypnotics, worsening of depression and suicidal thoughts and actions (including completed suicides) have been reported. Suicidal tendencies may be present in such patients, and protective measures may be required.Intentional overdose is more common among these patients; therefore, the lowest number of tablets that is feasible should be prescribed for the patient at any one time. The emergence of any new behavioral sign or symptom of concern requires careful and immediate evaluation (4).

Patients with compromised respiratory function. Suvorexant’s effect on respiratory function should be considered if the drug is prescribed to patients with compromised respiratory function. Suvorexant has not been studied in patients with severe obstructive sleep apnea or severe chronic obstructive pulmonary disease (4).

Sleep paralysis, hypnagogic/hypnopompic hallucinations, and cataplexy-like symptoms. Sleep paralysis (an inability to move or speak for up to several minutes during sleep–wake transitions) and hypnagogic/hypnopompic hallucinations (including vivid and disturbing perceptions by the patient) can occur with suvorexant use. Prescribers should explain the nature of these events to patients when prescribing the medication. Symptoms similar to mild cataplexy can occur, with risk increasing with the dose of suvorexant. Such symptoms can include periods of leg weakness lasting from seconds to a few minutes, can occur both at night and during the day and may not be associated with an identified triggering event (4).

Metabolism and drug interactions: Metabolism by CYP3A4 is the major elimination pathway for suvorexant (4). Suvorexant is not recommended in patients with severe hepatic impairment or those taking a strong CYP3A4 inhibitor such as fluconazole (Diflucan, Pfizer) which would increase the plasma concentration, placing patients well above the desired therapeutic response. The recommended dose of Suvorexant is 5 mg in patients receiving moderate CYP3A4 inhibitors (4). Digoxin level should be monitored closely as slight increases were seen with co administration with suvorexant (4).

Special populations: Pregnancy: Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. Suvorexant should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus (4).

Nursing Mothers: It is not known whether this drug is secreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Suvorexant is administered to a nursing woman (4).

Pediatric Use: Safety and effectiveness in pediatric patients have not been established (4).

Geriatric Use: No clinically meaningful differences in safety or effectiveness were observed between these patients and younger patients at the recommended doses (4).

Patients with Hepatic Impairment: No dose adjustment is required in patients with mild and moderate hepatic impairment. Suvorexant has not been studied in patients with severe hepatic impairment and is not recommended for these patients (4).

Patients with Renal Impairment: No dose adjustment is required in patients with renal impairment (4).

Cost: The anticipated release date is late 2014 or early 2015, but information regarding pricing of this agent was not available at the time of writing (4).

Conclusions and future directions: Suvorexant is the first orexin receptor antagonist approved by FDA for insomnia. This new class of medication takes a novel approach to the treatment of insomnia. Traditional sleep aids have typically caused sleepiness by enhancing the inhibitory neurotransmitter in the brain. Orexins promote wakefulness and arousal and as a result orexin receptors antagonists promote

sleepiness. Based on neural inputs to orexin neurons, orexin antagonism could potentially have therapeutic effects on insomnia due to circadian rhythm disorders and on stress and anxiety related arousal in the setting of substance use disorders, although not FDA approved for these indications (7). Additionally orexin neurons and receptors are now being investigated as important new targets for clinical interventions in a variety of disorders including addictive and mood disorders as well as neurocognitive disorders (9).

Disclosure: Shirshendu Sinha has received research funding from Janssen.

Shirshendu Sinha MBBS is a PGY-4 resident and Education Chief Resident at University of Connecticut Health Center

REFERENCES:

1.Briefing Materials from Peripheral and Central Nervous System Advisory Committee. 2013. http://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/Drugs/PeripheralandCentralNervousSystemDrugsAdvisoryCommittee/UCM352969.pdf . Accessed December 6, 2014.

2. Dopp J, Phillips B. Sleep disorders. In: DiPiro J, Talbert R, Yee G, et al., eds.Pharmacotherapy: A Pathophysiologic Approach, 8th ed. New York: McGraw-Hill; 2011:621–623.

3. US Food and Drug Administration. FDA approves new type of sleep drug, Belsomra. http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm409950.htm Accessed December 6, 2014.

4. Merck Belsomra Package Insert.http://www.merck.com/product/usa/pi_circulars/b/belsomra/belsomra_pi.pdf Accessed December 6, 2014.

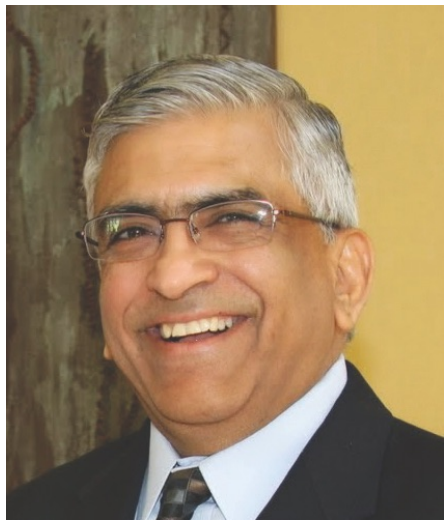
5. Saper CB, Scammell TE & Lu, J. Hypothalamic regulation of sleep and circadian rhythms. Nature (2005), 437 (7063) , 1257-1263.

6. de Lecea L. Hypocretins and the neurobiology of sleep-wake mechanisms. Progress in Brain Research. 2012; 198

7. Scammell TE, Winrow CJ.Orexin receptors: pharmacology and therapeutic opportunities. Annu Rev Pharmacol Toxicol. 2011; 51 (1); 243-266.

8. Tsujino N, Sakurai T. Orexin/Hypocretin: a neuropeptide at the interphase of sleep, energy homeostasis, and reward system. Pharmacol Rev. 2009; 61(2): 162-176.

9. Mahler SV, Smith RJ, Moorman DE, Sartor GC, Aston-Jones G.. Multiple roles for orexin/hypocretin in addiction. Prog.BrainRes. 2012;198:79–121.



Vasudev N Makhija, MD

SAMHIN, South Asian Mental Health Initiative and Network

In the past 3 decades psychiatrists of Indian origin have played an ever-increasing and even inspiring role in psychiatry in the United States. They have contributed in all areas of psychiatry – clinical, research, teaching, psychoanalysis, addiction, education etc. With my roots in India, I feel proud whenever I learn about a contribution by psychiatrist from Indian origin . We are all proud of Dr. Dilip Jeste serving as the president of American Psychiatric Association. I am not proud just because Dr. Jeste and others are of Indian origin in limelight, but because they have made significant contributions in the field of psychiatry.

As much as I am proud of these facts, gaps in access to quality psychiatric care for our community remains. The population of South Asians, including specifically Asian Indians in this country has grown tremendously in the past several decades.

The mental health literacy of our community remains much to be desired.

I have spoken to many psychiatrists to try to understand this. There are many causes of this gap in care. There are many roadblocks to the care. Many roadblocks originate with the our community members afflicted with mental illness and their families.. However, there are some roadblocks that we as psychiatrists may be responsible for.

There are some who take pride in saying that they do not treat Indian patients. They cite a variety reasons for this. Some psychiatrists disengage themselves from their roots. This short article is not about these and other roadblocks to access to care in our community. It is about how this led me to try to do something about it. Other organizations have also made some efforts. But it needs more. I decided that I want to make my small contribution to attempt to make a dent in this gap and hope for a better mental wellbeing of our community.

Over the years I discovered that hospitals and other health care facilities would often be at a loss where to refer a patient of Indian origin when a cultural or language issue may of significance. I began putting together database of psychiatrists and other mental health providers. This included information about languages, geographical locations, hours of practices, insurance information, special trainings, etc. My goal was to have this database available free of charge for anyone hoping to improve access to culturally competent care.

As I worked on this database I discovered many additional needs and gaps in mental health care of our community in this country. One thing led to another. And thus was born SAMHIN, South Asian Mental Health Initiative and Network in early 2014. SAMHIN is a 501 (c)(3) non-profit organization that envisions to address a broad

range of mental health needs of the growing South Asian community nationwide, beginning with New Jersey, including issues of stigma, access to care, spiritual/pastoral care, and developing a network of mental health providers to provide culturally competent psychiatric care.

This journey has not been easy. Many have supported and lent a helping hand in more than one-way. I am grateful for this. And, there are others who viewed my efforts with suspicion that this is for my personal and material gain. Fortunately such perceptions were in the minority although this contributed to roadblocks to building some alliances, which is critical to the success of this organization in achieving its mission.

The web team is working hard to get the website ready to have a variety of tools and resources including a network of mental health providers, available free for any one. One of SAMHIN's goals is to initiate a dialogue on mental health and illness and to decrease stigma and shame associated with metal illness. The tremendous need to maintain secrecy contributes to unnecessary and prolonged suffering. People with mental illness and their families find themselves in isolation when support is most needed.

Since the launch SAMHIN has used many means to do something about this. Educational and screening events have been held through collaborations with townships, various religious and community organizations. We have started using radio and television to educate our community.

Doing something about such difficult and deeply entrenched and inadequately understood issues is not easy. Many have joined hands with me in this journey. My hope is that many more will join me in this journey. I envision that this journey will lead to narrowing the gap between talents and contributions of a wide pool of psychiatrists of South Asian Indian origin and quality of mental health care of our community in this country.

Together, we can make great strides in the mental wellness of our community. After all who can dispute the importance of mental wellness?

Remember, Together We Can!!

www.samhin.org

www.linkedin.com/in/VNMakhija

https://www.facebook.com/SAMHINorg

Disclosure: The author reports no financial conflict of interest. SAMHIN is a registered non-profit organization.

Vasudev N Makhija, MD, DLFAPA is the Founder and President of SAMHIN, South Asian Mental Health Initiative and Network and the Immediate Past President of New Jersey Psychiatric Association.

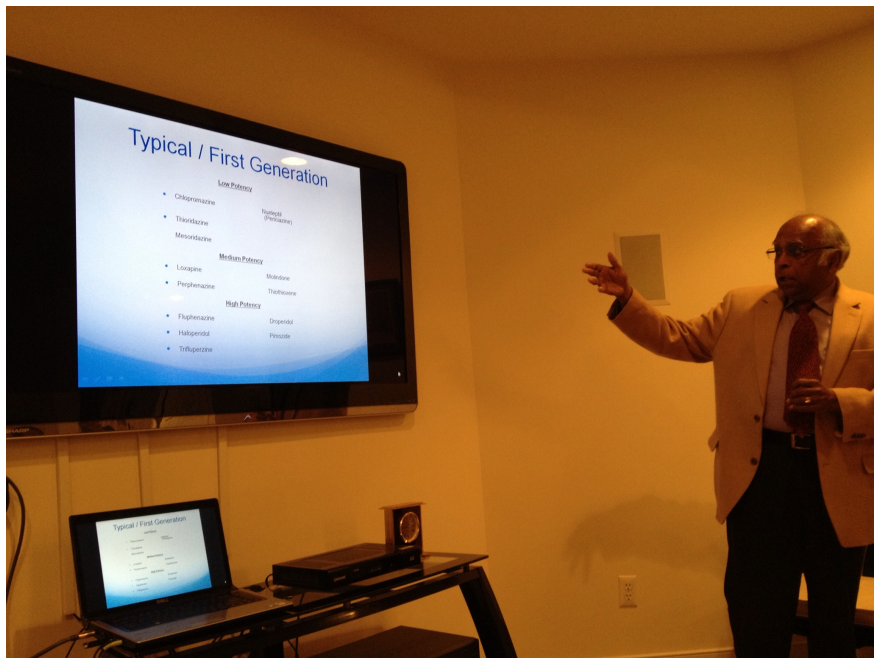
News Updates:

In June 2014, Tristate IAPA and the Psychoanalytic Society of Philadelphia organized a discussion and book release of Dr Salman Akhtar MD with discussion by Dr's Jennifer Bonovitz and Rajnish Mago. The event was held at Drexel School of Medicine in Philadelphia. The book titled “Sources Of Suffering”, discusses the emotions of fear, greed, guilt, deception , betrayal and revenge.

Dr. Subhash Chandra, an IAPA member and PGY-4 at SUNY Downstate was selected as one of the Rappeport fellows for the year 2014 at The American Academy of Psychiatry and Law's 27th Annual Rappeport Fellowship competition.

In November 2014, IAPA Tennessee Chapter held its 4th Annual Chapter Meeting. The chapter organized a symposium on "*Perspectives on Psychosis: Pearls for Practitioners*" followed by a panel discussion. The speaker panel included Dr. Rajiv Tandon, MD (University of Florida), Dr. Anand Pandya, MD (President Emeritus of NAMI), Dr. Stephen Heckers, MD (Chairman of Vanderbilt Psychiatry), Dr. William Petrie, MD (Director of Geriatric Psychiatry program at Vanderbilt and Dr. Todd Peters, MD (Child and Adolescent Psychiatrist from Vanderbilt).

IAPA Virginia Chapter held the following meetings in 2014: 1. Trauma and the developing brain-presented by Dr. Bela Sood; 2. Update on the newer atypical antipsychotics-presented by Dr. Prakash Ettigi; 3. Recent trends in substance abuse treatment-presented by Dr. Kanwar Sidhu



Upcoming Events:

1. IAPA Virginia Chapter has the following meetings lined up in the New Year
   i. Depression consultation-A review of the last 100 cases-by Dr. Anand Pandurangi. This will be in February 2015. Venue-TBA
   ii. The believing brain-by Dr. Innaiah Narisetti. This will be in March 2015. Venue-TBA
   For details, please contact Dr. T.G. Sriram (tsriram@msn.com).

2. IAPA Annual Conference will be held in Toronto on May 17th 2015. The theme for the scientific symposium is ''Promoting Mental Wellness: Pediatrics to Adulthood.

3. The 6th Indian Global Psychiatric Initiative (IGPI) 2015 meeting is scheduled to take place on the 6 & 7 January 2015 at the Westin Hotel in Hyderabad, India. (www.indianglobalpsychiatricinitiative.org).

4. The 67th Annual National Conference of the Indian Psychiatric Society (ANCIPS 2015) will be held from 8-11 January 2015 at Hyderabad International Convention Centre (HICC), Hyderabad, India.

5. DNA to Neighborhood: Relationship and Experience in Psychosis - An International Dialogue (WPA Co-Sponsored meeting). March 18- 22, 2015. Location: New York University, Manhattan. Website: www.isps2015nyc.org / www.isps.org / www.isps2015nyc.org

6. 7th International Together Against Stigma: Each Mind Matters. (WPA Co-Sponsored meeting). Feb 18-20, 2015. Location: San Francisco, USA. Email: heather.stuart@queensu.ca

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