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PSYCHIATRIC NEWS

The First and Last Word in Psychiatry

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David Hathcox

APA President Dilip Jeste, M.D., tells attendees at APA's 2013 annual meeting that one of the highlights of his presidential year was overseeing the review, approval, and publication of *DSM-5*. See story below. Additional coverage of the annual meeting appears throughout this issue and continues in the next.

Jeste Looks to a 'Positive Psychiatry' For an Aging Population

The outgoing APA president hails the publication of *DSM-5* and the accomplishments of retiring APA Medical Director James H. Scully Jr., M.D.

BY MARK MORAN

"Positive psychiatry"—promoting resilience, wisdom, and optimism, as opposed to merely treating symptoms—is the psychiatry of the future.

That's what outgoing APA President Dilip Jeste, M.D., said in his presidential address at the Opening Session of APA's 2013 annual meeting last month in San Francisco.

Jeste reflected on events of his presidential year, including most prominently the publication of *DSM-5*. He hailed *DSM-5* Task Force Chair David Kupfer, M.D., and Co-chair Darrel Regier, M.D., and noted that the revised manual involved years of work involving hundreds of individuals.

"We hope that *DSM-5* will lead to more accurate diagnoses, better access to mental health services, and improved patient outcomes," he said. "Of course, with scientific advances, it will need revisions. Science should never be stagnant, and neither should medicine."

Jeste also remarked on the accomplishments of outgoing Medical Director James H. Scully Jr., M.D., noting that he "leaves APA in a much stronger position than when he [became medical director]." And he welcomed incoming medical director Saul Levin, M.D., saying his expertise in electronic health information exchanges and implementation of the

see **Jeste** *on page 35*

Brain Imaging, Other Advances Reveal Drugs' Effects on Brain

New understanding of how drugs of abuse affect dopamine reward circuitry is providing insights into potential new therapies.

BY AARON LEVIN

"The universe of a person who is addicted is narrowed to the drug, and that is the challenge and the incredible opportunity we have as psychiatrists to help these individuals," said Nora Volkow, M.D., director of the National Institute on Drug Abuse, at APA's 2013 annual meeting in San Francisco last month.

Research in recent years using brain imaging techniques has provided new insights into the mechanism of addiction while simultaneously unsettling elements of what once was the common wisdom, she said.

All drugs of abuse increase dopamine, which is crucial for their effect, she said. They also trigger neuroplasticity changes that result in addiction, but more dopamine does not explain addiction.

Among both lab animals and humans, voluntary initiation of drug use leads to a subsequent loss of control and development of addiction among about 10 percent of subjects. The lab rats and mice are useful for refuting old stereotypes.

Some people still consider addiction moral turpitude, she said. "But how can you develop the same phenotype in a rat,

see **Volkow** *on page 26*

PERIODICALS: TIME SENSITIVE MATERIALS

INSIDE

Schizophrenia can tear patients apart

For the treatment of schizophrenia

LATUDA can help put your patients back together

- Symptom improvement was established in several pivotal trials[1]
- The safety and tolerability of LATUDA were evaluated in pivotal trials and multiple studies up to 52 weeks[1]
- The recommended starting dose, 40 mg/day, is an effective dose with no initial dose titration required. The maximum recommended dose is 160 mg/day[1]
  - LATUDA should be taken with food (at least 350 calories)
  - Dose adjustment is recommended in moderate and severe renal and hepatic impairment patients. The recommended starting dose is 20 mg. The dose in moderate and severe renal impairment patients and in moderate hepatic impairment patients should not exceed 80 mg/day. The dose in severe hepatic impairment patients should not exceed 40 mg/day
  - LATUDA should not be used in combination with strong CYP3A4 inhibitors such as ketoconazole or strong CYP3A4 inducers such as rifampin. When coadministered with a moderate CYP3A4 inhibitor such as diltiazem, the recommended starting dose of LATUDA is 20 mg/day and the maximum recommended dose is 80 mg/day

INDICATIONS AND USAGE

LATUDA is an atypical antipsychotic indicated for the treatment of patients with schizophrenia. Efficacy was established in five 6-week controlled studies of adult patients with schizophrenia. The effectiveness of LATUDA for longer-term use, that is, for more than 6 weeks, has not been established in controlled studies. Therefore, the physician who elects to use LATUDA for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient.

IMPORTANT SAFETY INFORMATION FOR LATUDA

WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS

See full prescribing information for complete boxed warning.

- **Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death.**
- **LATUDA is not approved for the treatment of patients with dementia-related psychosis.**

Please see additional Important Safety Information, including **Boxed Warning**, and Brief Summary of Prescribing Information on adjacent pages.

SUNOVION

Latuda®
(lurasidone HCl) tablets
20mg | 40mg | 80mg | 120mg

INDICATIONS AND USAGE

LATUDA is an atypical antipsychotic agent indicated for the treatment of patients with schizophrenia. Efficacy was established in five 6-week controlled studies of adult patients with schizophrenia. The effectiveness of LATUDA for longer-term use, that is, for more than 6 weeks, has not been established in controlled studies. Therefore, the physician who elects to use LATUDA for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient.

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WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS

See full prescribing information for complete boxed warning.

- **Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death.**
- **LATUDA is not approved for the treatment of patients with dementia-related psychosis.**

CONTRAINDICATIONS

LATUDA is contraindicated in the following:

- Any patient with a known hypersensitivity to lurasidone HCl or any components in the formulation. Angioedema has been observed with lurasidone.
- Concomitant use with strong CYP3A4 inhibitors (e.g., ketoconazole).
- Concomitant use with strong CYP3A4 inducers (e.g., rifampin).

WARNINGS AND PRECAUTIONS

Cerebrovascular Adverse Reactions, Including Stroke: LATUDA is not approved for the treatment of patients with dementia-related psychosis.

Neuroleptic Malignant Syndrome (NMS): NMS, a potentially fatal symptom complex, has been reported with administration of antipsychotic drugs, including LATUDA. NMS can cause hyperpyrexia, muscle rigidity, altered mental status and evidence of autonomic instability (irregular pulse or blood pressure, tachycardia, diaphoresis, and cardiac dysrhythmia). Additional signs may include elevated creatine phosphokinase, myoglobinuria (rhabdomyolysis), and acute renal failure. The management of NMS should include: 1) immediate discontinuation of antipsychotic drugs and other drugs not essential to concurrent therapy; 2) intensive symptomatic treatment and medical monitoring; and 3) treatment of any concomitant serious medical problems for which specific treatments are available.

Tardive Dyskinesia (TD): The risk of developing TD and the likelihood that it will become irreversible are believed to increase as the duration of treatment and the total cumulative dose of antipsychotic drugs administered to the patient increase. However, the syndrome can develop, although much less commonly, after relatively brief treatment periods at low doses. Given these considerations, LATUDA should be prescribed in a manner that is most likely to minimize the occurrence of TD. If signs and symptoms appear in a patient on LATUDA, drug discontinuation should be considered.

Metabolic Changes

Hyperglycemia and Diabetes Mellitus: Hyperglycemia, in some cases extreme and associated with ketoacidosis or hyperosmolar coma or death, has been reported in patients treated with atypical antipsychotics. Patients with risk factors for diabetes mellitus (e.g., obesity, family history of diabetes) who are starting treatment with atypical antipsychotics should undergo fasting blood glucose testing at the beginning of and periodically during treatment. Any patient treated with atypical antipsychotics should be monitored for symptoms of hyperglycemia including polydipsia, polyuria, polyphagia, and weakness. Patients who develop symptoms of hyperglycemia during treatment with atypical antipsychotics should undergo fasting blood glucose testing. In some cases, hyperglycemia has resolved when the atypical antipsychotic was discontinued; however, some patients required continuation of anti-diabetic treatment despite discontinuation of the suspect drug.

Dyslipidemia: Undesirable alterations in lipids have been observed in patients treated with atypical antipsychotics.

Weight Gain: Weight gain has been observed with atypical antipsychotic use. Clinical monitoring of weight is recommended.

Hyperprolactinemia: As with other drugs that antagonize dopamine D2 receptors, LATUDA elevates prolactin levels. Galactorrhea, amenorrhea, gynecomastia, and impotence have been reported in patients receiving prolactin-elevating compounds.

Leukopenia, Neutropenia, and Agranulocytosis: Leukopenia/neutropenia has been reported during treatment with antipsychotic agents. Agranulocytosis (including fatal cases) has been reported with other agents in the class. Patients with a preexisting low white blood cell count (WBC) or a history of drug induced leukopenia/neutropenia should have their complete blood count (CBC) monitored frequently during the first few months of therapy, and LATUDA should be discontinued at the first sign of a decline in WBC in the absence of other causative factors.

Orthostatic Hypotension and Syncope: LATUDA may cause orthostatic hypotension. Orthostatic vital signs should be monitored in patients who are vulnerable to hypotension and in patients with known cardiovascular disease or cerebrovascular disease.

Seizures: LATUDA should be used cautiously in patients with a history of seizures or with conditions that lower seizure threshold (e.g., Alzheimer's dementia).

Potential for Cognitive and Motor Impairment: In short-term, placebo-controlled trials, somnolence was reported in 17.0% (256/1508) of patients treated with LATUDA compared to 7.1% (50/708) of placebo patients, respectively. Patients should be cautioned about operating hazardous machinery, including motor vehicles, until they are reasonably certain that therapy with LATUDA does not affect them adversely.

Body Temperature Regulation: Disruption of the body's ability to reduce core body temperature has been attributed to antipsychotic agents. Appropriate care is advised when prescribing LATUDA for patients who will be experiencing conditions that may contribute to an elevation in core body temperature, e.g., exercising strenuously, exposure to extreme heat, receiving concomitant medication with anticholinergic activity, or being subject to dehydration.

Suicide: The possibility of suicide attempt is inherent in psychotic illness and close supervision of high-risk patients should accompany drug therapy. Prescriptions for LATUDA should be written for the smallest quantity of tablets consistent with good patient management in order to reduce the risk of overdose.

Dysphagia: Esophageal dysmotility and aspiration have been associated with antipsychotic drug use. Aspiration pneumonia is a common cause of morbidity and mortality in elderly patients, in particular those with advanced Alzheimer's dementia. LATUDA and other antipsychotic drugs should be used cautiously in patients at risk for aspiration pneumonia.

ADVERSE REACTIONS

Commonly Observed Adverse Reactions (incidence ≥5% and at least twice the rate of placebo) in patients treated with LATUDA were somnolence, akathisia, nausea and parkinsonism.

Please see brief summary of prescribing information on adjacent pages, including **Boxed Warning**.

Reference: 1. LATUDA prescribing information. Sunovion Pharmaceuticals Inc. December 2012.

FOR MORE INFORMATION, PLEASE CALL 1-888-394-7377 OR VISIT **www.LatudaHCP.com**.

Brief Summary (for Full Prescribing Information, see package insert)

WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS

- **Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death *[see Warnings and Precautions (5.1)]*.**
- **LATUDA is not approved for use in patients with dementia-related psychosis *[see Warnings and Precautions (5.1)]*.**

1. INDICATIONS AND USAGE

LATUDA is indicated for the treatment of patients with schizophrenia.

The efficacy of LATUDA in schizophrenia was established in five 6-week controlled studies of adult patients with schizophrenia *[see Clinical Studies (14.1)]*.

The effectiveness of LATUDA for longer-term use, that is, for more than 6 weeks, has not been established in controlled studies. Therefore, the physician who elects to use LATUDA for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient *[see Dosage and Administration (2)]*.

4. CONTRAINDICATIONS

LATUDA is contraindicated in the following:

- Any patient with a known hypersensitivity to lurasidone HCl or any components in the formulation. Angioedema has been observed with lurasidone *[see Adverse Reactions (6.1)]*.
- Concomitant use with strong CYP3A4 inhibitors (e.g., ketoconazole) *[see Drug Interactions (7.1)]*.
- Concomitant use with strong CYP3A4 inducers (e.g., rifampin) *[see Drug Interactions (7.1)]*.

5. WARNINGS AND PRECAUTIONS

5.1. Increased Mortality in Elderly Patients with Dementia-Related Psychosis

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of 17 placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of between 1.6- to 1.7-times the risk of death in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. Observational studies suggest that, similar to atypical antipsychotic drugs, treatment with conventional antipsychotic drugs may increase mortality. The extent to which the findings of increased mortality in observational studies may be attributed to the antipsychotic drug as opposed to some characteristic(s) of the patients is not clear. LATUDA is not approved for the treatment of patients with dementia-related psychosis *[see Boxed Warning]*.

5.2. Cerebrovascular Adverse Reactions, Including Stroke in Elderly Patients with Dementia-Related Psychosis

In placebo-controlled trials with risperidone, aripiprazole, and olanzapine in elderly subjects with dementia, there was a higher incidence of cerebrovascular adverse reactions (cerebrovascular accidents and transient ischemic attacks), including fatalities, compared to placebo-treated subjects. LATUDA is not approved for the treatment of patients with dementia-related psychosis *[see also Boxed Warning and Warnings and Precautions (5.1)]*.

5.3. Neuroleptic Malignant Syndrome

A potentially fatal symptom complex sometimes referred to as Neuroleptic Malignant Syndrome (NMS) has been reported in association with administration of antipsychotic drugs, including LATUDA.

Clinical manifestations of NMS are hyperpyrexia, muscle rigidity, altered mental status, and evidence of autonomic instability (irregular pulse or blood pressure, tachycardia, diaphoresis, and cardiac dysrhythmia). Additional signs may include elevated creatinine phosphokinase, myoglobinuria (rhabdomyolysis), and acute renal failure.

The diagnostic evaluation of patients with this syndrome is complicated. It is important to exclude cases where the clinical presentation includes both serious medical illness (e.g., pneumonia, systemic infection) and untreated or inadequately treated extrapyramidal signs and symptoms (EPS). Other important considerations in the differential diagnosis include central anticholinergic toxicity, heat stroke, drug fever, and primary central nervous system pathology.

The management of NMS should include: 1) immediate discontinuation of antipsychotic drugs and other drugs not essential to concurrent therapy; 2) intensive symptomatic treatment and medical monitoring; and 3) treatment of any concomitant serious medical problems for which specific treatments are available. There is no general agreement about specific pharmacological treatment regimens for NMS.

If a patient requires antipsychotic drug treatment after recovery from NMS, the potential reintroduction of drug therapy should be carefully considered. If reintroduced, the patient should be carefully monitored, since recurrences of NMS have been reported.

5.4. Tardive Dyskinesia

Tardive dyskinesia is a syndrome consisting of potentially irreversible, involuntary, dyskinetic movements that can develop in patients treated with antipsychotic drugs. Although the prevalence of the syndrome appears to be highest among the elderly, especially elderly women, it is impossible to rely upon prevalence estimates to predict, at the inception of antipsychotic treatment, which patients are likely to develop the syndrome. Whether antipsychotic drug products differ in their potential to cause tardive dyskinesia is unknown.

The risk of developing tardive dyskinesia and the likelihood that it will become irreversible are believed to increase as the duration of treatment and the total cumulative dose of antipsychotic drugs administered to the patient increase. However, the syndrome can develop, although much less commonly, after relatively brief treatment periods at low doses.

There is no known treatment for established cases of tardive dyskinesia, although the syndrome may remit, partially or completely, if antipsychotic treatment is withdrawn. Antipsychotic treatment, itself, however, may suppress (or partially suppress) the signs and symptoms of the syndrome and thereby may possibly mask the underlying process. The effect that symptomatic suppression has upon the long-term course of the syndrome is unknown.

Given these considerations, LATUDA should be prescribed in a manner that is most likely to minimize the occurrence of tardive dyskinesia. Chronic antipsychotic treatment should generally be reserved for patients who suffer from a chronic illness that (1) is known to respond to antipsychotic drugs, and (2) for whom alternative, equally effective, but potentially less harmful treatments are not available or appropriate. In patients who do require chronic treatment, the smallest dose and the shortest duration of treatment producing a satisfactory clinical response should be sought. The need for continued treatment should be reassessed periodically.

If signs and symptoms of tardive dyskinesia appear in a patient on LATUDA, drug discontinuation should be considered. However, some patients may require treatment with LATUDA despite the presence of the syndrome.

5.5. Metabolic Changes

Atypical antipsychotic drugs have been associated with metabolic changes that may increase cardiovascular/cerebrovascular risk. These metabolic changes include hyperglycemia, dyslipidemia, and body weight gain. While all of the drugs in the class have been shown to produce some metabolic changes, each drug has its own specific risk profile.

Hyperglycemia and Diabetes Mellitus

Hyperglycemia, in some cases extreme and associated with ketoacidosis or hyperosmolar coma or death, has been reported in patients treated with atypical antipsychotics. Assessment of the relationship between atypical antipsychotic use and glucose abnormalities is complicated by the possibility of an increased background risk of diabetes mellitus in patients with schizophrenia and the increasing incidence of diabetes mellitus in the general population. Given these confounders, the relationship between atypical antipsychotic use and hyperglycemia-related adverse events is not completely understood. However, epidemiological studies suggest an increased risk of treatment-emergent hyperglycemia-related adverse events in patients treated with the atypical antipsychotics. Because LATUDA was not marketed at the time these studies were performed, it is not known if LATUDA is associated with this increased risk.

Patients with an established diagnosis of diabetes mellitus who are started on atypical antipsychotics should be monitored regularly for worsening of glucose control. Patients with risk factors for diabetes mellitus (e.g., obesity, family history of diabetes) who are starting treatment with atypical antipsychotics should undergo fasting blood glucose testing at the beginning of treatment and periodically during treatment. Any patient treated with atypical antipsychotics should be monitored for symptoms of hyperglycemia including polydipsia, polyuria, polyphagia, and weakness. Patients who develop symptoms of hyperglycemia during treatment with atypical antipsychotics should undergo fasting blood glucose testing. In some cases, hyperglycemia has resolved when the atypical antipsychotic was discontinued; however, some patients required continuation of anti-diabetic treatment despite discontinuation of the suspect drug.

Pooled data from short-term, placebo-controlled studies are presented in Table 2.

Table 2: Change in Fasting Glucose

		LATUDA				
	Placebo	**20 mg/day**	**40 mg/day**	**80 mg/day**	**120 mg/day**	**160 mg/day**
Mean Change from Baseline (mg/dL)						
	n=680	**n=71**	**n=478**	**n=508**	**n=283**	**n=113**
Serum Glucose	–0.0	–0.6	2.6	–0.4	2.5	2.5
Proportion of Patients with Shifts to ≥ 126 mg/dL						
Serum Glucose (≥ 126 mg/dL)	8.3% (52/628)	11.7% (7/60)	12.7% (57/449)	6.8% (32/472)	10.0% (26/260)	5.6% (6/108)

In the uncontrolled, longer-term studies (primarily open-label extension studies), LATUDA was associated with a mean change in glucose of +1.8 mg/dL at week 24 (n=355), +0.8 mg/dL at week 36 (n=299) and +2.3 mg/dL at week 52 (n=307).

Dyslipidemia

Undesirable alterations in lipids have been observed in patients treated with atypical antipsychotics. Pooled data from short-term, placebo-controlled studies are presented in Table 3.

Table 3: Change in Fasting Lipids

		LATUDA				
	Placebo	**20 mg/day**	**40 mg/day**	**80 mg/day**	**120 mg/day**	**160 mg/day**
Mean Change from Baseline (mg/dL)						
	n=660	**n=71**	**n=466**	**n=499**	**n=268**	**n=115**
Total Cholesterol	–5.8	–12.3	–5.7	–6.2	–3.8	–6.9
Triglycerides	–13.4	–29.1	–5.1	–13.0	–3.1	–10.6
Proportion of Patients with Shifts						
Total Cholesterol (≥ 240 mg/dL)	5.3% (30/571)	13.8% (8/58)	6.2% (25/402)	5.3% (23/434)	3.8% (9/238)	4.0% (4/101)
Triglycerides (≥ 200 mg/dL)	10.1% (53/526)	14.3% (7/49)	10.8% (41/379)	6.3% (25/400)	10.5% (22/209)	7.0% (7/100)

In the uncontrolled, longer-term studies (primarily open-label extension studies), LATUDA was associated with a mean change in total cholesterol and triglycerides of -3.8 (n=356) and -15.1 (n=357) mg/dL at week 24, -3.1 (n=303) and -4.8 (n=303) mg/dL at week 36 and -2.5 (n=307) and -6.9 (n=307) mg/dL at week 52, respectively.

Weight Gain

Weight gain has been observed with atypical antipsychotic use. Clinical monitoring of weight is recommended.

Pooled data from short-term, placebo-controlled studies are presented in Table 4. The mean weight gain was 0.43 kg for LATUDA-treated patients compared to -0.02 kg for placebo-treated patients. Change in weight from baseline for olanzapine was 4.15 kg and for quetiapine extended-release was 2.09 kg in Studies 3 and 5 *[see Clinical Studies (14.1)]*, respectively. The proportion of patients with a ≥ 7% increase in body weight (at Endpoint) was 4.8% for LATUDA-treated patients versus 3.3% for placebo-treated patients.

Table 4: Mean Change in Weight (kg) from Baseline

		LATUDA				
	Placebo (n=696)	**20 mg/day (n=71)**	**40 mg/day (n=484)**	**80 mg/day (n=526)**	**120 mg/day (n=291)**	**160 mg/day (n=114)**
All Patients	–0.02	–0.15	0.22	0.54	0.68	0.60

In the uncontrolled, longer-term studies (primarily open-label extension studies), LATUDA was associated with a mean change in weight of -0.69 kg at week 24 (n=755), -0.59 kg at week 36 (n=443) and -0.73 kg at week 52 (n=377).

5.6. Hyperprolactinemia

As with other drugs that antagonize dopamine D_2 receptors, LATUDA elevates prolactin levels.

Hyperprolactinemia may suppress hypothalamic GnRH, resulting in reduced pituitary gonadotrophin secretion. This, in turn, may inhibit reproductive function by impairing gonadal steroidogenesis in both female and male patients. Galactorrhea, amenorrhea, gynecomastia, and impotence have been reported with prolactin-elevating compounds. Long-standing hyperprolactinemia, when associated with hypogonadism, may lead to decreased bone density in both female and male patients *[see Adverse Reactions (6)]*.

In short-term, placebo-controlled studies, the median change from baseline to endpoint in prolactin levels for LATUDA-treated patients was 0.4 ng/mL and was –1.9 ng/mL in the placebo-treated patients. The median change from baseline to endpoint for males was 0.5 ng/mL and for females was –0.2 ng/mL. Median changes for prolactin by dose are shown in Table 5.

Table 5: Median Change in Prolactin (ng/mL) from Baseline

		LATUDA				
	Placebo	**20 mg/day**	**40 mg/day**	**80 mg/day**	**120 mg/day**	**160 mg/day**
All Patients	–1.9 (n=672)	–1.1 (n=70)	–1.4 (n=476)	–0.2 (n=495)	3.3 (n=284)	3.3 (n=115)
Females	–5.1 (n=200)	–0.7 (n=19)	–4.0 (n=149)	–0.2 (n=150)	6.7 (n=70)	7.1 (n=36)
Males	–1.3 (n=472)	–1.2 (n=51)	–0.7 (n=327)	–0.2 (n=345)	3.1 (n=214)	2.4 (n=79)

The proportion of patients with prolactin elevations ≥ 5× upper limit of normal (ULN) was 2.8% for LATUDA-treated patients versus 1.0% for placebo-treated patients. The proportion of female patients with prolactin elevations ≥ 5x ULN was 5.7% for LATUDA-treated patients versus 2.0% for placebo-treated female patients. The proportion of male patients with prolactin elevations ≥ 5x ULN was 1.6% versus 0.6% for placebo-treated male patients.

In the uncontrolled longer-term studies (primarily open-label extension studies), LATUDA was associated with a median change in prolactin of –0.9 ng/mL at week 24 (n=357), –5.3 ng/mL at week 36 (n=190) and –2.2 ng/mL at week 52 (n=307).

Tissue culture experiments indicate that approximately one-third of human breast cancers are prolactin-dependent *in vitro*, a factor of potential importance if the prescription of these drugs is considered in a patient with previously detected breast cancer. As is common with compounds which increase prolactin release, an increase in mammary gland neoplasia was observed in a LATUDA carcinogenicity study conducted in rats and mice *[see Nonclinical Toxicology (13)]*. Neither clinical studies nor epidemiologic studies conducted to date have shown an association between chronic administration of this class of drugs and tumorigenesis in humans, but the available evidence is too limited to be conclusive.

5.7. Leukopenia, Neutropenia and Agranulocytosis

Leukopenia/neutropenia has been reported during treatment with antipsychotic agents. Agranulocytosis (including fatal cases) has been reported with other agents in the class.

Possible risk factors for leukopenia/neutropenia include pre-existing low white blood cell count (WBC) and history of drug-induced leukopenia/neutropenia. Patients with a pre-existing low WBC or a history of drug-induced leukopenia/neutropenia should have their complete blood count (CBC) monitored frequently during the first few months of therapy and LATUDA should be discontinued at the first sign of decline in WBC, in the absence of other causative factors.

Patients with neutropenia should be carefully monitored for fever or other symptoms or signs of infection and treated promptly if such symptoms or signs occur. Patients with severe neutropenia (absolute neutrophil count < 1000/mm^3) should discontinue LATUDA and have their WBC followed until recovery.

5.8. Orthostatic Hypotension and Syncope

LATUDA may cause orthostatic hypotension, perhaps due to its α1-adrenergic receptor antagonism. The incidence of orthostatic hypotension and syncope events from short-term, placebo-controlled studies was (LATUDA incidence, placebo incidence): orthostatic hypotension [0.3% (5/1508), 0.1% (1/708)] and syncope [0.1% (2/1508), 0% (0/708)]. Assessment of orthostatic hypotension was defined by vital sign changes (≥ 20 mm Hg decrease in systolic blood pressure and ≥ 10 bpm increase in pulse from sitting to standing or supine to standing positions). In short-term clinical trials, orthostatic hypotension occurred with a frequency of 0.8% with LATUDA 40 mg, 2.1% with LATUDA 80 mg, 1.7% with LATUDA 120 mg and 0.8% with LATUDA 160 mg compared to 0.7% with placebo.

Orthostatic vital signs should be monitored in patients who are vulnerable to hypotension (e.g., dehydration, hypovolemia, and treatment with antihypertensive medications), and in patients with known cardiovascular disease (e.g., heart failure, history of myocardial infarction, ischemia, or conduction abnormalities), or cerebrovascular disease.

5.9. Seizures

As with other antipsychotic drugs, LATUDA should be used cautiously in patients with a history of seizures or with conditions that lower the seizure threshold, e.g., Alzheimer's dementia. Conditions that lower the seizure threshold may be more prevalent in patients 65 years or older.

In short-term, placebo-controlled trials, seizures/convulsions occurred in 0.1% (2/1508) of patients treated with LATUDA compared to 0.1% (1/708) placebo-treated patients.

5.10. Potential for Cognitive and Motor Impairment

LATUDA, like other antipsychotics, has the potential to impair judgment, thinking or motor skills.

In short-term, placebo-controlled trials, somnolence was reported by 17.0% (256/1508) of patients treated with LATUDA (15.5% LATUDA 20 mg, 15.6% LATUDA 40 mg, 15.2% LATUDA 80 mg, 26.5% LATUDA 120 mg and 8.3% LATUDA 160 mg/day) compared to 7.1% (50/708) of placebo patients. In these short-term trials, somnolence included: hypersomnia, hypersomnolence, sedation and somnolence.

Patients should be cautioned about operating hazardous machinery, including motor vehicles, until they are reasonably certain that therapy with LATUDA does not affect them adversely.

5.11. Body Temperature Regulation

Disruption of the body's ability to reduce core body temperature has been attributed to antipsychotic agents. Appropriate care is advised when prescribing LATUDA for patients who will be experiencing conditions that may contribute to an elevation in core body temperature, e.g., exercising strenuously, exposure to extreme heat, receiving concomitant medication with anticholinergic activity, or being subject to dehydration *[see Patient Counseling Information (17.9)]*.

5.12. Suicide

The possibility of a suicide attempt is inherent in psychotic illness and close supervision of high-risk patients should accompany drug therapy. Prescriptions for LATUDA should be written for the smallest quantity of tablets consistent with good patient management in order to reduce the risk of overdose.

In short-term, placebo-controlled studies in patients with schizophrenia, the incidence of treatment-emergent suicidal ideation was 0.4% (6/1508) for LATUDA-treated patients compared to 0.8% (6/708) on placebo. No suicide attempts or completed suicides were reported in these studies.

5.13. Dysphagia

Esophageal dysmotility and aspiration have been associated with antipsychotic drug use. Aspiration pneumonia is a common cause of morbidity and mortality in elderly patients, in particular those with advanced Alzheimer's dementia. LATUDA and other antipsychotic drugs should be used cautiously in patients at risk for aspiration pneumonia.

5.14. Use in Patients with Concomitant Illness

Clinical experience with LATUDA in patients with certain concomitant illnesses is limited *[see Clinical Pharmacology (12.3)]*.

Patients with Parkinson's Disease or Dementia with Lewy Bodies are reported to have an increased sensitivity to antipsychotic medication. Manifestations of this increased sensitivity include confusion, obtundation, postural instability with frequent falls, extrapyramidal symptoms, and clinical features consistent with the neuroleptic malignant syndrome.

LATUDA has not been evaluated or used to any appreciable extent in patients with a recent history of myocardial infarction or unstable heart disease. Patients with these diagnoses were excluded from premarketing clinical trials. Because of the risk of orthostatic hypotension with LATUDA, caution should be observed in patients with known cardiovascular disease *[see Warnings and Precautions (5.8)]*.

6. ADVERSE REACTIONS

The following adverse reactions are discussed in more detail in other sections of the labeling:

- Use in Elderly Patients with Dementia-Related Psychosis *[see Boxed Warning and Warnings and Precautions (5.1)]*
- Cerebrovascular Adverse Reactions, Including Stroke *[see Warnings and Precautions (5.2)]*
- Neuroleptic Malignant Syndrome *[see Warnings and Precautions (5.3)]*
- Tardive Dyskinesia *[see Warnings and Precautions (5.4)]*
- Hyperglycemia and Diabetes Mellitus *[see Warnings and Precautions (5.5)]*
- Hyperprolactinemia *[see Warnings and Precautions (5.6)]*
- Leukopenia, Neutropenia, and Agranulocytosis *[see Warnings and Precautions (5.7)]*
- Orthostatic Hypotension and Syncope *[see Warnings and Precautions (5.8)]*
- Seizures *[see Warnings and Precautions (5.9)]*
- Potential for Cognitive and Motor Impairment *[see Warnings and Precautions (5.10)]*
- Body Temperature Regulation *[see Warnings and Precautions (5.11)]*
- Suicide *[see Warnings and Precautions (5.12)]*
- Dysphagia *[see Warnings and Precautions (5.13)]*

6.1. Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in clinical practice.

The information below is derived from a clinical study database for LATUDA consisting of 2905 patients with schizophrenia exposed to one or more doses with a total experience of 985.3 patient-years. Of these patients, 1508 participated in short-term, placebo-controlled schizophrenia studies with doses of 20 mg, 40 mg, 80 mg, 120 mg or 160 mg once daily. A total of 769 LATUDA-treated patients had at least 24 weeks and 371 LATUDA-treated patients had at least 52 weeks of exposure.

Adverse events during exposure to study treatment were obtained by general inquiry and voluntarily reported adverse experiences, as well as results from physical examinations, vital signs, ECGs, weights and laboratory investigations. Adverse experiences were recorded by clinical investigators using their own terminology. In order to provide a meaningful estimate of the proportion of individuals experiencing adverse events, events were grouped in standardized categories using MedDRA terminology.

The following findings are based on the short-term, placebo-controlled premarketing studies for schizophrenia in which LATUDA was administered at daily doses ranging from 20 to 160 mg (n=1508).

Commonly Observed Adverse Reactions: The most common adverse reactions (incidence ≥ 5% and at least twice the rate of placebo) in patients treated with LATUDA were somnolence, akathisia, nausea and parkinsonism.

Adverse Reactions Associated with Discontinuation of Treatment: A total of 9.5% (143/1508) LATUDA-treated patients and 9.3% (66/708) of placebo-treated patients discontinued due to adverse reactions. There were no adverse reactions associated with discontinuation in subjects treated with LATUDA that were at least 2% and at least twice the placebo rate.

Adverse Reactions Occurring at an Incidence of 2% or More in LATUDA-Treated Patients: Adverse reactions associated with the use of LATUDA (incidence of 2% or greater, rounded to the nearest percent and LATUDA incidence greater than placebo) that occurred during acute therapy (up to 6 weeks in patients with schizophrenia) are shown in Table 6.

Table 6: Adverse Reactions in 2% or More of LATUDA-Treated Patients and That Occurred at Greater Incidence than in the Placebo-Treated Patients in Short-term Schizophrenia Studies

	Percentage of Patients Reporting Reaction	
Body System or Organ Class Dictionary-derived Term	**Placebo (N=708)**	**All LATUDA (N=1508)**
Gastrointestinal Disorders		
Nausea	5	10
Vomiting	6	8
Dyspepsia	5	6
Salivary Hypersecretion	<1	2
Musculoskeletal and Connective Tissue Disorders		
Back Pain	2	3
Nervous System Disorders		
Somnolence*	7	17
Akathisia	3	13
Parkinsonism**	5	10
Dizziness	2	4
Dystonia***	<1	4
Psychiatric Disorders		
Insomnia	8	10
Agitation	4	5
Anxiety	4	5
Restlessness	1	2

Note: Figures rounded to the nearest integer
*Somnolence includes adverse event terms: hypersomnia, hypersomnolence, sedation, and somnolence
**Parkinsonism includes adverse event terms: bradykinesia, cogwheel rigidity, drooling, extrapyramidal disorder, hypokinesia, muscle rigidity, parkinsonism, psychomotor retardation, and tremor
***Dystonia includes adverse event terms: dystonia, oculogyric crisis, oromandibular dystonia, tongue spasm, torticollis, and trismus

Dose-Related Adverse Reactions

In pooled data from the short-term, placebo-controlled, fixed-dose studies, there were no dose-related adverse reactions (greater than 5% incidence) in patients treated with LATUDA across the 20 mg/day to 160 mg/day dose range. However, the frequency of akathisia increased with dose up to 120 mg/day (5.6% LATUDA 20 mg, 10.7% LATUDA 40 mg, 12.3% LATUDA 80 mg, 22.0% LATUDA 120 mg); akathisia was reported by 7.4% (9/121) of patients receiving 160 mg/day. Akathisia occurred in 3.0% of subjects receiving placebo.

Extrapyramidal Symptoms

In the short-term, placebo-controlled schizophrenia studies, for LATUDA-treated patients, the incidence of reported events related to extrapyramidal symptoms (EPS), excluding akathisia and restlessness, was 13.5% versus 5.8% for placebo-treated patients. The incidence of akathisia for LATUDA-treated patients was 12.9% versus 3.0% for placebo-treated patients. Incidence of EPS by dose is provided in Table 7.

Table 7: Incidence of EPS Compared to Placebo

		LATUDA				
Adverse Event Term	**Placebo (N=709) (%)**	**20 mg/day (N=71) (%)**	**40 mg/day (N=487) (%)**	**80 mg/day (N=538) (%)**	**120 mg/day (N=291) (%)**	**160 mg/day (N=121) (%)**
All EPS events	**9**	**10**	**21**	**23**	**39**	**20**
All EPS events, excluding Akathisia/ Restlessness	**6**	**6**	**11**	**12**	**22**	**13**
Akathisia	3	6	11	12	22	7
Dystonia*	<1	0	4	5	7	2
Parkinsonism**	5	6	9	8	17	11
Restlessness	1	1	3	1	3	2

Note: Figures rounded to the nearest integer
*Dystonia includes adverse event terms: dystonia, oculogyric crisis, oromandibular dystonia, tongue spasm, torticollis, and trismus
**Parkinsonism includes adverse event terms: bradykinesia, cogwheel rigidity, drooling, extrapyramidal disorder, hypokinesia, muscle rigidity, parkinsonism, psychomotor retardation, and tremor

In the short-term, placebo-controlled schizophrenia studies, data was objectively collected on the Simpson Angus Rating Scale for extrapyramidal symptoms (EPS), the Barnes Akathisia Scale (for akathisia) and the Abnormal Involuntary Movement Scale (for dyskinesias). The mean change from baseline for LATUDA-treated patients was comparable to placebo-treated patients, with the exception of the Barnes Akathisia Scale global score (LATUDA, 0.1; placebo, 0.0). The percentage of patients who shifted from normal to abnormal was greater in LATUDA-treated patients versus placebo for the BAS (LATUDA, 14.4%; placebo, 7.1%) and the SAS (LATUDA, 5.0%; placebo, 2.3%).

Dystonia

Class Effect: Symptoms of dystonia, prolonged abnormal contractions of muscle groups, may occur in susceptible individuals during the first few days of treatment. Dystonic symptoms include: spasm of the neck muscles, sometimes progressing to tightness of the throat, swallowing difficulty, difficulty breathing, and/or protrusion of the tongue. While these symptoms can occur at low doses, they occur more frequently and with greater severity with high potency and at higher doses of first-generation antipsychotic drugs. An elevated risk of acute dystonia is observed in males and younger age groups.

In the short-term, placebo-controlled clinical trials, dystonia occurred in 4.2% of LATUDA-treated subjects (0.0% LATUDA 20 mg, 3.5% LATUDA 40 mg, 4.5% LATUDA 80 mg, 6.5% LATUDA 120 mg and 2.5% LATUDA 160 mg) compared to 0.8% of subjects receiving placebo. Seven subjects (0.5%, 7/1508) discontinued clinical trials due to dystonic events – four were receiving LATUDA 80 mg/day and three were receiving LATUDA 120 mg/day.

Other Adverse Reactions Observed During the Premarketing Evaluation of LATUDA

Following is a list of adverse reactions reported by patients treated with LATUDA at multiple doses of ≥ 20 mg once daily during any phase of a study within the database of 2905 patients. The reactions listed are those that could be of clinical importance, as well as reactions that are plausibly drug-related on pharmacologic or other grounds. Reactions listed in Table 6 or those that appear elsewhere in the LATUDA label are not included. Although the reactions reported occurred during treatment with LATUDA, they were not necessarily caused by it.

Reactions are further categorized by organ class and listed in order of decreasing frequency according to the following definitions: those occurring in at least 1/100 patients (frequent) (only those not already listed in the tabulated results from placebo-controlled studies appear in this listing); those occurring in 1/100 to 1/1000 patients (infrequent); and those occurring in fewer than 1/1000 patients (rare).

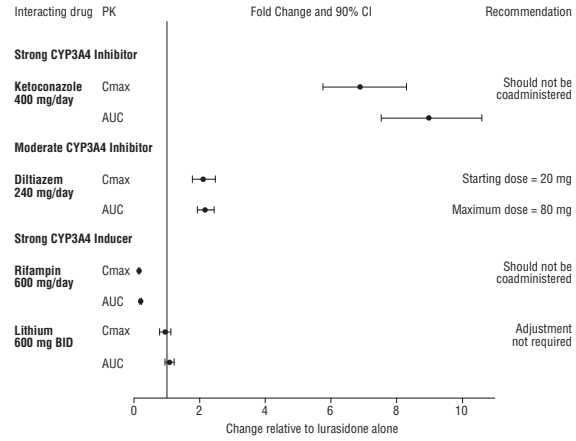
Blood and Lymphatic System Disorders: ***Infrequent:*** *anemia*
Cardiac Disorders: ***Frequent:*** *tachycardia;* ***Infrequent:*** *AV block 1st degree, angina pectoris, bradycardia*
Ear and Labyrinth Disorders: ***Infrequent:*** *vertigo*
Eye Disorders: ***Frequent:*** *blurred vision*
Gastrointestinal Disorders: ***Frequent:*** *abdominal pain, diarrhea;* ***Infrequent:*** *gastritis*
General Disorders and Administrative Site Conditions: ***Rare:*** *sudden death*
Investigations: ***Frequent:*** *CPK increased*
Metabolism and Nutritional System Disorders: ***Frequent:*** *decreased appetite*
Musculoskeletal and Connective Tissue Disorders: ***Rare:*** *rhabdomyolysis*
Nervous System Disorders: ***Infrequent:*** *cerebrovascular accident, dysarthria*
Psychiatric Disorders: ***Infrequent:*** *abnormal dreams, panic attack, sleep disorder*
Renal and Urinary Disorders: ***Infrequent:*** *dysuria;* ***Rare:*** *renal failure*
Reproductive System and Breast Disorders: ***Infrequent:*** *amenorrhea, dysmenorrhea;* ***Rare:*** *breast enlargement, breast pain, galactorrhea, erectile dysfunction*
Skin and Subcutaneous Tissue Disorders: ***Frequent:*** *rash, pruritus;* ***Rare:*** *angioedema*
Vascular Disorders: ***Frequent:*** *hypertension*

7. DRUG INTERACTIONS

7.1. Potential for Other Drugs to Affect LATUDA

LATUDA is predominantly metabolized by CYP3A4. LATUDA should not be used in combination with strong inhibitors or inducers of this enzyme *[see Contraindications (4)]* and dose should be limited when used in combination with moderate inhibitors of CYP3A4 *[see Dosage and Administration (2.4)]*. No dose adjustment is needed with concomitant use of lithium (see Figure 1).

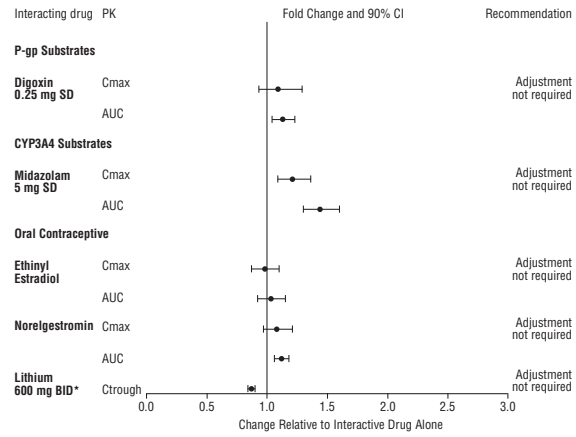
Figure 1: Impact of Other Drugs on LATUDA Pharmacokinetics



7.2. Potential for LATUDA to Affect Other Drugs

No adjustment is needed on the dose of lithium, or substrates of P-gp or CYP3A4 when coadministered with LATUDA (Figure 2).

Figure 2: Impact of LATUDA on Other Drugs



*Steady state lithium Ctrough on Day 4 vs Day 8 when lithium was coadministered with lurasidone at steady state

8. USE IN SPECIFIC POPULATIONS

8.1. Pregnancy

Teratogenic Effects

Pregnancy Category B

LATUDA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Non-teratogenic Effects

Neonates exposed to antipsychotic drugs during the third trimester of pregnancy are at risk for extrapyramidal and/or withdrawal symptoms following delivery. There have been reports of agitation, hypertonia, hypotonia, tremor, somnolence, respiratory distress and feeding disorder in these neonates. These complications have varied in severity; while in some cases symptoms have been self-limited, in other cases neonates have required intensive care unit support and prolonged hospitalization.

Safe use of LATUDA during pregnancy or lactation has not been established; therefore, use of LATUDA in pregnancy, in nursing mothers, or in women of childbearing potential requires that the benefits of treatment be weighed against the possible risks to mother and child.

Animal Data

No adverse developmental effects were seen in a study in which pregnant rats were given LATUDA during the period of organogenesis and continuing through weaning at doses up to 10 mg/kg/day; this dose is approximately half of the MRHD based on body surface area.

No teratogenic effects were seen in studies in which pregnant rats and rabbits were given LATUDA during the period of organogenesis at doses up to 25 and 50 mg/kg/day, respectively. These doses are 1.5- and 6-times, in rats and rabbits, respectively, the maximum recommended human dose (MRHD) of 160 mg/day based on body surface area.

8.3. Nursing Mothers

LATUDA was excreted in milk of rats during lactation. It is not known whether LATUDA or its metabolites are excreted in human milk. Because of the potential for serious adverse reactions in nursing infants, a decision should be made whether to discontinue nursing or to discontinue the drug, considering risk of drug discontinuation to the mother.

8.4. Pediatric Use

Safety and effectiveness in pediatric patients have not been established.

8.5. Geriatric Use

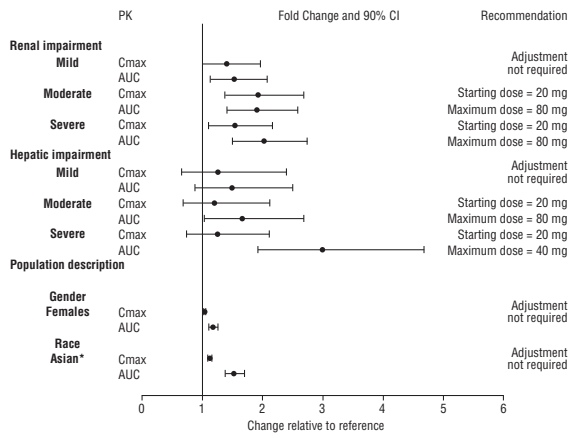
Clinical studies of LATUDA in the treatment of schizophrenia did not include sufficient numbers of patients aged 65 and older to determine whether or not they respond differently from younger patients. In elderly patients with psychosis (65 to 85), LATUDA concentrations (20 mg/day) were similar to those in young subjects *[see Clinical Pharmacology (12.3)]*. No dose adjustment is necessary in elderly patients (Figure 2).

Elderly patients with dementia-related psychosis treated with LATUDA are at an increased risk of death compared to placebo. LATUDA is not approved for the treatment of patients with dementia-related psychosis *[see Boxed Warning]*.

8.6. Other Patient Factors

The effect of intrinsic patient factors on the pharmacokinetics of LATUDA is presented in Figure 3.

Figure 3: Impact of Other Patient Factors on LATUDA Pharmacokinetics



*Compare to Caucasian

10. OVERDOSAGE

10.1. Human Experience

In premarketing clinical studies involving 2905 patients, accidental or intentional overdosage of LATUDA was identified in one patient who ingested an estimated 560 mg of LATUDA. This patient recovered without sequelae. This patient resumed LATUDA treatment for an additional two months.

10.2. Management of Overdosage

Consult a Certified Poison Control Center for up-to-date guidance and advice. There is no specific antidote to LATUDA, therefore, appropriate supportive measures should be instituted and close medical supervision and monitoring should continue until the patient recovers.

Cardiovascular monitoring should commence immediately, including continuous electrocardiographic monitoring for possible arrhythmias. If antiarrhythmic therapy is administered, disopyramide, procainamide, and quinidine carry a theoretical hazard of additive QT-prolonging effects when administered in patients with an acute overdose of LATUDA. Similarly, the alpha-blocking properties of bretylium might be additive to those of LATUDA, resulting in problematic hypotension.

Hypotension and circulatory collapse should be treated with appropriate measures. Epinephrine and dopamine should not be used, or other sympathomimetics with beta-agonist activity, since beta stimulation may worsen hypotension in the setting of LATUDA-induced alpha blockade. In case of severe extrapyramidal symptoms, anticholinergic medication should be administered.

Gastric lavage (after intubation if patient is unconscious) and administration of activated charcoal together with a laxative should be considered.

The possibility of obtundation, seizures, or dystonic reaction of the head and neck following overdose may create a risk of aspiration with induced emesis.

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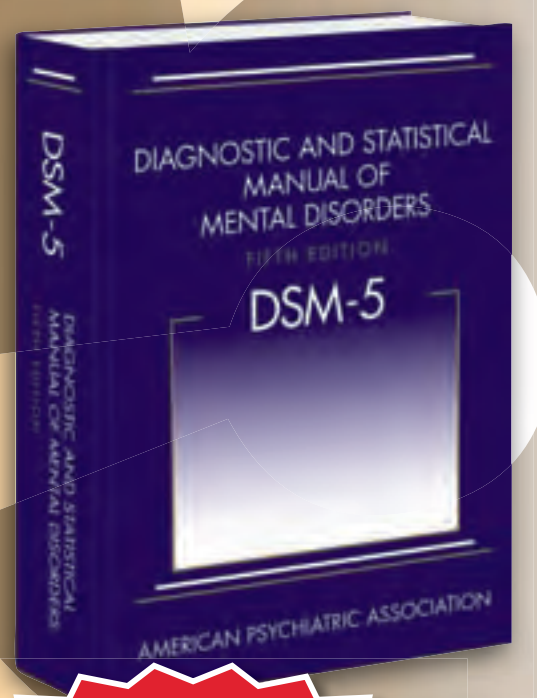

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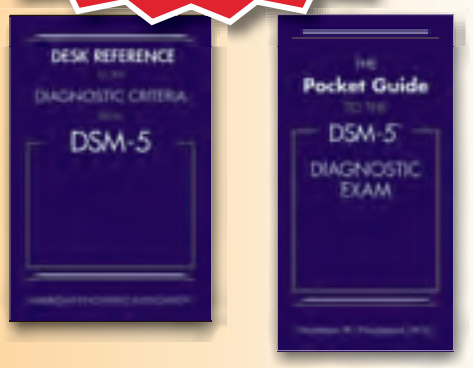

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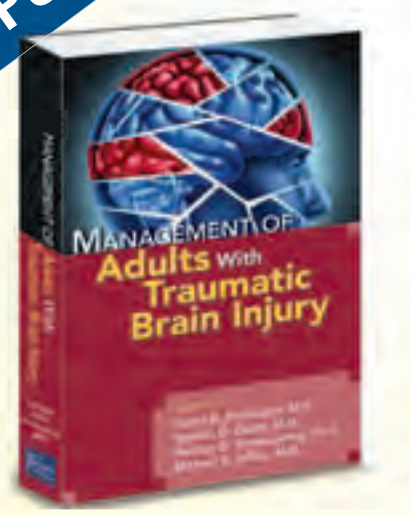

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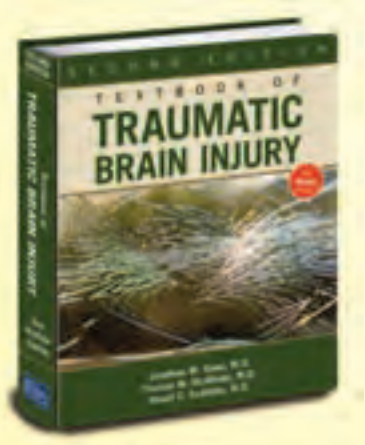

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ASSOCIATION NEWS

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Register Now for Institute!

G. Widman for GPTMC

APA's next major meeting—the Institute on Psychiatric Services—is being held October 10 to 13 in Philadelphia. The meeting is often referred to as APA's "little gem" because of its high quality and smaller size than the annual meeting. The theme of this year's institute is "Transforming Psychiatric Practice, Reforming Health Care Delivery." Advance registration is now open at www.psychiatry.org/ips. Housing information and reservations can also be accessed at that site.

Departments

FROM THE PRESIDENT

What It Means to Be President

BY JEFFREY LIEBERMAN, M.D.

At this year's annual meeting in San Francisco, I found myself moved by a normally routine ceremony over which the president-elect presides: administering the pledge to the new group of Distinguished Fellows. It's the one that begins: "I WILL FAITHFULLY DEDICATE MYSELF ABOVE ALL TO THE WELFARE OF MY PATIENTS; TO MAINTAIN THE DIGNITY OF MY PROFESSION AND THE PRACTICE OF MEDICINE…"

These words, which I and many other psychiatrists have spoken perfunctorily in the past, seemed especially resonant. This was partly because of the realization that I was about to actually take on the weighty responsibility of the APA presidency. But, mostly, it was that the words of the pledge reminded me about the current challenges facing the field of psychiatry. We live in a time of undelivered health care reform, continuing stigma, wanton criticism of psychiatry and APA, and an enormous burden of illness caused by mental illness and unmet clinical need for treatment. Under these circumstances, it is very hard to remind the public—and even ourselves—that we are living in a moment of unprecedented scientific progress and with an array of therapeutic interventions with extraordinary effectiveness.

It is easy to lose sight of these positive aspects of our discipline because of the trying times in which we find ourselves. The enduring effects of the economic recession continue to bludgeon mental health budgets and restrict reimbursement for services. Tragic civilian massacres have focused attention on mental illness and violence, but not, so far, in a constructive way. And *DSM-5* has been the target of criticism, aided and abetted by the media, and a lightning rod for antipsychiatry attacks.

These developments could not have been entirely foreseen by any of us. And they certainly were not what we signed up for when we decided to pursue a career in psychiatric medicine.

The reality is that the treatment of mental illness has been and remains a health care disparity despite the passage of the Mental Health Parity and Addiction Equity Act and the imminent implementation of the Patient Protection and Affordable Care Act. In addition, the stigma directed at mental illness and psychiatry continues to be perpetuated by the media disseminating exploitative and misleading information. For these and other reasons, now more than ever it is time for psychiatrists, and led by APA, to stand up for our patients and our field. We have the scientific momentum, public-health imperative, and moral high ground. We must not be defensive or even timid and must raise the awareness of the public and our colleagues in the medical profession about the true nature and inherent value of psychiatric treatment and mental health care.

So while on one hand I have a healthy dose of frustration and outrage, on the other hand I am very optimistic and bullish on our profession.

Consequently, on that day, at that moment, the words of the pledge that we recited had a clear and special meaning. I suddenly realized that the best strategy to respond to the challenges and criticisms that we faced was to rededicate ourselves to the principles and values that inspired our profession and that the pledge of Distinguished Fellowship beautifully articulated these precepts. Therefore, I ask that you reread the pledge below and join me in rededicating ourselves to trying to live up to its ideals.

"I WILL FAITHFULLY DEDICATE MYSELF ABOVE ALL TO THE WELFARE OF MY PATIENTS; TO MAINTAIN THE DIGNITY OF MY PROFESSION AND THE PRACTICE OF MEDICINE; TO SUPPLEMENT MY OWN JUDGMENT WITH THE WISDOM AND COUNSEL OF SPECIALISTS IN FIELDS OTHER THAN MY OWN; TO RENDER ASSISTANCE WILLINGLY TO MY OWN COLLEAGUES; TO BE GENEROUS IN GIVING PROFESSIONAL AID TO THE UNFORTUNATE; TO ENHANCE MY KNOWLEDGE BY CONTINUING STUDY, BY ATTENDANCE AT MEETINGS OF MY PROFESSIONAL COLLEAGUES, BY ASSOCIATION WITH PHYSICIANS OF EMINENCE, AND BY FREELY EXCHANGING EXPERIENCE AND OPINION WITH MY COLLEAGUES. I FURTHER PLEDGE TO AVOID COMMERCIALISM IN MY PROFESSIONAL LIFE; TO REFRAIN FROM SEEKING THE PUBLIC EYE FOR SELF AGGRANDIZEMENT; TO SET FEES COMMENSURATE WITH MY SERVICES AND ADJUST THEM TO THE CIRCUMSTANCES OF MY PATIENTS; AND TO AVOID ANY FINANCIAL PRACTICE WHATSOEVER THAT MIGHT DEBASE MY PROFESSION." PN

ASSOCIATION NEWS

Foundation Honors Programs On Minority Mental Health

At the APA annual meeting, the American Psychiatric Foundation hands out four awards recognizing outreach and care for minority communities.

BY AARON LEVIN

The American Psychiatric Foundation presented four $5,000 grants for advancing minority mental health at the foundation's annual benefit dinner in San Francisco during APA's 2013 APA annual meeting last month.

The event drew 200 guests who contributed a total of $45,000 toward the foundation's support of mental health research and community education.

Two of the awards went to organizations helping underserved populations, and two to individuals who have devoted substantial efforts to expanding access to mental health services for minority groups.

Psychiatrist Sarah Herbert, M.D., of Atlanta accepted on behalf of Gwen Davies, Ph.D., clinical director of the Latino Program at Positive Impact in Atlanta. The program is the only provider of Spanish-speaking mental health services for people with HIV in Atlanta. It operates at four primary care clinics and trains clinicians to recognize the need for such services.

"We hope this will become a model of mental health care for Latinos," said Davies in a letter read by Herbert. This is especially true when anti-immigration legislation often increases distrust among Latinos toward organizations offering services, added Davies.

The LGBT Affirmative Action Program of the South Beach Psychiatric Center in Brooklyn. N.Y., received a grant to further its work with low-income lesbian, gay, bisexual, and transgendered individuals with serious and persistent psychiatric disorders. The program provides community outreach, trains staff to provide LGBT-inclusive psychiatric services, and connects clients with peers.

"It's hard for LGBT individuals to identify with mainstream services," said co-founder Jack O'Brien, L.C.S.W., as he accepted the award. "Our patients are grateful to have our program available."

William Lawson, M.D., Ph.D., a professor of psychiatry at Howard University in Washington, D.C., was honored for a range of research and clinical work related to the mental health needs of African Americans.

"We have to ensure that we have the leadership to address the needs of this diverse patient population," Lawson told his fellow psychiatrists. He was specifically cited for his work with the Veterans Health Administration to overcome misdiagnosis of African-American veterans.

Finally, Benjamin Woo, M.D., was recognized for his work among the Chinese immigrant community in Los Angeles. Woo volunteers at a community health center and helped develop a culturally sensitive depression collaborative treatment model. He writes articles for Chinese-language newspapers and appears on a Cantonese-language radio station to expand understanding of mental health conditions and treatments.

"The Chinese community didn't know how to talk about mental health, but now they do," he said.

The awards were sponsored by Otsuka Pharmaceuticals. PN

More information about the American Psychiatric Foundation's Awards for Advancing Minority Mental Health is posted at http://www.americanpsychiatricfoundation.org/what-we-do/awards/awards-for-advancing-minority-mental-health.

David Hathcox

Winners of the Awards for Advancing Minority Mental Health of the American Psychiatric Foundation (APF) gather for a photo. Top row, from left: Richard Harding, M.D., APF treasurer; Paul Burke, APF executive director; James H. Scully Jr., M.D., APA medical director and CEO; awardee Jack O'Brien, L.C.S.W., of the LGBT Affirmative Action Program of the South Beach Psychiatric Center in Brooklyn. First row, from left: Awardees Benjamin Woo, M.D., Los Angeles; William Lawson, M.D., Ph.D., a professor of psychiatry at Howard University; and Sarah Herbert, M.D., accepting for the Latino Program at Positive Impact in Atlanta.

Benson Sums Up Year As Assembly Speaker

As his term as Assembly speaker came to a close in May, R. Scott Benson, M.D., discussed what the Assembly accomplished this past year and what issues Assembly delegates will face in the near future. Topping the agenda, he noted, was the Assembly's involvement in the *DSM-5* process, reviewing changes to the manual and approving the final version. In addition, the group "engaged with members to better understand their concerns about the changes that the ABPN made in the certification and recertification process. We educated members on how to meet these requirements and pressed APA to use its influence to reduce the burden on clinicians."

R. Scott Benson, M.D.

Over the next year or two, Benson said that "psychiatrists will be challenged to maintain the quality of care necessary for effective treatment when confronted with increasing pressure to take employed positions and the struggle to maintain quality with reduced reimbursement for care." Assembly delegates will also have to push for increased support for district branches as they struggle with state-level issues. For example, "new health insurance exchanges must have products that include coverage for mental illness in their essential health benefits; state legislatures must protect their citizens by supporting the requirement that medical training is necessary for prescription of medication; and states must adequately fund treatment programs for people with mental illness, including substance use problems."

He said that as speaker, he was included "in every level of APA decision making. . . . It was a special pleasure for me to work closely with Dr. Dilip Jeste, who always asked for input from the Assembly" as he dealt with the many challenges that arose during his presidential year. PN

Assembly Chooses New Leaders

At their meeting in San Francisco last month, members of the APA Assembly elected Jenny Boyer, M.D., of Muskogee, Okla., to be the next speaker-elect. Boyer just completed a term as the Assembly's recorder. To succeed Boyer as recorder, Assembly delegates chose Glenn Martin, M.D., of Forest Hills, N.Y., who had been the Assembly's Area 2 representative. Both began their one-year terms at the close of the annual meeting. Also at that time, Melinda Young, M.D., of Lafayette, Calif., became speaker.

David Hathcox

Jenny Boyer, M.D., and Glenn Martin, M.D., were elected to Assembly top offices.

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Lieberman Says It's 'Our Time' for Equity and Fairness in Mental Health

The new APA president cites astonishing advances in psychiatric research and a broad acceptance of the importance of mental health as reasons to be optimistic.

BY MARK MORAN

David Hathcox

"This is 'our time,'" said incoming APA President Jeffrey Lieberman, M.D.—time for psychiatry to seize on its advantages and realize a long-deferred dream of equity and recovery for people with mental illness.

Speaking at the Opening Session of APA's 2013 annual meeting in San Francisco last month, Lieberman said he was angry about the continued stigma associated with mental illness and disparagement of psychiatry in some quarters.

Quoting the 1976 movie "Network," he said he was "mad as hell and not going to take it" anymore. "Although I saw this movie 37 years ago, I have recently thought about that scene in 'Network' because as I view what is happening to the field of psychiatry and all of mental health care, I feel 'mad as hell, and I don't want to take it anymore.' The truth be told, that is why I ran for APA president—because I felt mad and wanted to use all of the power and influence of APA to speak up and stick up for our profession and our patients.

"Throughout my career, I have been acutely sensitive to the stigma associated with mental illness, the disparities in mental health care, and the lack of respect toward psychiatry as a medical specialty," Lieberman said. "I suppose there might have been a time when psychiatry wasn't as scientifically based as it should have been. But that was then, and now is now. For such attitudes and practices to persist in the 21st century is nothing short of discriminatory and prejudicial."

But persist they do, he said. Lieberman noted that the mental health parity law was signed in 2008, yet no final rule on its implementation has been issued. He added that the recession of 2008 has gutted public mental health systems and encouraged private and voluntary hospitals to cut psychiatric services, as at Cedars Sinai Hospital in Los Angeles, which closed its psychiatry department.

"The pharmaceutical industry has all but abandoned the development of novel psychotropic drugs," he said. "And *DSM-5* has become a lightning rod for self-styled critics and the antipsychiatry movement. Mental illness is alternatively feared too much or not taken seriously enough, and psychiatry continues to be a punch line for jokes."

Yet at the same time, Lieberman said, he felt profoundly optimistic about the future.

"From a public-health perspective, people and policymakers alike have finally started to realize that brain diseases and mental disorders are among the most important causes of disability in our society," Lieberman said. "And then there's the amazing science. The scientific foundation of psychiatric medicine has grown by leaps and bounds in the last 50 years. The emergence of psychopharmacology, neuroimaging, molecular genetics and biology, and the disciplines of neuroscience and cognitive psychology have launched us into the mainstream of medicine and on a course for future growth and success. Though not everyone, including ourselves, is satisfied with the rate of our field's progress, no one can argue with one simple fact—if you or a loved one suffers from a mental illness, your ability to receive effective treatment, recover, and lead a productive life is better now than ever in human history. . . .

"It is for these reasons that despite the lingering effects of stigma and inequity, I say that this is our time, and our time is within our professional lifetimes," Lieberman said. He urged members individually and collectively to fight for the rights of patients and respect for the psychiatric profession.

He pointed out that APA has a key role to play in this process. "APA is our best weapon in the fight for respect and equality both for our patients and our profession," he said. "Therefore, I am calling on APA to redouble its efforts in representing our profession both inside the Beltway and across the country at the grassroots level of the membership and district branches. This is the time for us to seize the moment, for mental illness to step out of the shadows, for mental health care to be made accessible and fairly reimbursed, and for psychiatry to take its rightful role in the field of medicine." PN

Lieberman was interviewed by *Psychiatric News* Editor-in-Chief Jeffrey Borenstein, M.D., during the annual meeting. To watch the video, scan the QR code at left or go to http://www.youtube.com/watch?v=mctrZtjvFrU.

AMA's Psychiatrist President Hails Involvement of APA

Jeremy Lazarus, M.D., says that the high profile of psychiatry within the AMA has helped to sharpen that organization's focus on mental health issues.

BY MARK MORAN

Psychiatry needs the AMA, and the AMA needs psychiatry.

That's what AMA President and past APA Assembly Speaker Jeremy Lazarus, M.D., said at APA's 2013 annual meeting in San Francisco. In separate addresses to the APA Assembly and APA Board and in a lecture, Lazarus discussed issues of common ground between APA and the AMA including, among others, enactment of the Affordable Care Act (ACA), the movement toward collaborative care, and the AMA's strategic plan.

The latter includes three goals: improving health outcomes for patients, enhancing physician satisfaction by shaping delivery and payment models, and accelerating the pace of change in medical education. Lazarus's presidential term ends this month at the annual policymaking meeting of the AMA House of Delegates; Lazarus was only the third psychiatrist to be president of the AMA.

Passage of the ACA in 2010 depended on the crucial support of the AMA. "When the ACA was passed, we saw it

see ***Lazarus*** *on page 28*

David Hathcox

Jeremy Lazarus, M.D., AMA president and a former speaker of the APA Assembly, discusses the benefits of the strong partnership between APA and the AMA.

PROFESSIONAL NEWS

New Evidence Said to Challenge Psychiatry's Basic Paradigms

Now is the time to rethink the basic ideas shaping psychiatric practice and return to an emphasis on nontechnical concepts, says an eminent psychiatrist from Ireland.

BY AARON LEVIN

Psychiatry is at a crossroads, according to Patrick Bracken, M.D., Ph.D., clinical director of the West Cork Mental Health Service in Ireland, at APA's annual meeting in San Francisco in May.

"Accumulating evidence challenges the current paradigm underlying psychiatric thinking and practice," said Bracken. The problem lies deeper than just "too many drugs."

"Psychiatry faced three great quests over the last 30 years—the quest for valid classification systems, the quest for biological and psychological causal pathways in mental illness, and the quest for technological treatments used independently of context—and all are falling apart in front of our eyes," he maintained.

Bracken faults the profession's adherence to what he calls the "technological paradigm," an approach to understanding psychiatric symptoms and diagnoses mainly as broken mechanisms or processes that need fixing.

"These faulty cognitive or emotional processes are modeled in universal causal terms, separated from context," said Bracken. "This technical approach pushes nontechnical, nonspecific aspects of mental health to the margins."

Psychiatry is not like cardiology, he said. The mind is not simply another organ of the body, but encompasses relationships, values, and meaning.

However, the technological paradigm today guides training, service delivery, and research. Perhaps 95 percent of papers published in psychiatry fall into that category, he said.

The treatment of depression serves as an example. Antidepressant medications seem to work for about 60 percent to 70 percent of patients, yet little is known about their mechanism of action. "But how the treatment is carried out is as important as which drug is used," he stated.

Furthermore, while cognitive-behavioral therapy (CBT) is a recommended treatment for depression, studies show that specific features of CBT can vary and still benefit patients.

"CBT works," he said. "But what matters is the quality of the relationship between the patient and therapist, whether the patient feels respected, and whether the encounter is meaningful."

Thus, in Bracken's view, psychiatry needs to move beyond its current technological paradigm.

"The public and our medical colleagues are looking at us and asking, what's going on?" he said. "For three decades, we've been telling them that the classification systems are going to be gotten right, the neuroscience is going to be there, that we've got the new psychopharmacology."

But that promise is unfulfilled, he believes. "Unless we grapple with the fundamental paradigmatic issues and actually look at what the science is telling us, we are going to be made irrelevant."

Nevertheless, medical knowledge and expertise will remain relevant and vital to overcoming mental illness. "A post-technological psychiatry would not get rid of the theories and treatments we use today but would start to develop a primary discourse out of which choices could be made about what we search for and prioritize, what training our professionals should have and, crucially, what kinds of services we want to deliver," he said. PN

"Psychiatry Beyond the Current Paradigm," an article by Bracken and others in the British Journal of Psychiatry, is posted at http://bjp.rcpsych.org/content/201/6/430.full?sid=d0cde91b-f9aa-4092-ad0a-c1c300545dbf.

DSM-5 SELF-EXAM

Anxiety Disorders

The essential features of panic attacks remain unchanged in *DSM-5*, although the complicated *DSM-IV* terminology for describing different types of panic attacks (that is, situationally bound/cued, situationally predisposed, and unexpected/uncued) is replaced with the terms "unexpected" and "expected" panic attacks.

Panic disorder and agoraphobia are unlinked in *DSM-5*. Thus, the former *DSM-IV* diagnoses of "panic disorder with agoraphobia," "panic disorder without agoraphobia," and "agoraphobia without history of panic disorder" are now replaced by two diagnoses, namely, panic disorder and agoraphobia, each with separate criteria. The core features of specific phobia and social anxiety disorder remain the same. In *DSM-IV,* selective mutism and separation anxiety disorder were classified in disorders usually first diagnosed in infancy, childhood, or adolescence. They are now classified as anxiety disorders.

The following questions are from *DSM-5 Self-Exam Questions: Test Questions for the Diagnostic Criteria,* which may be preordered at http://www.appi.org/SearchCenter/Pages/SearchDetail.aspx?ItemId=62467 from American Psychiatric Publishing. The answers and rationales are posted at http://www.psychnews.org/pdfs/DSM-5_Self_Examination_QandA_7.pdf. The questions were developed under the leadership of Philip Muskin, M.D., a professor of clinical psychiatry at Columbia University College of Physicians and Surgeons. The book, available in August, contains 500 questions for all the categories of psychiatric disorders and includes Section III.

1. Which of the following disorders is included among the anxiety disorders in *DSM-5*?

a) obsessive-compulsive disorder
b) posttraumatic stress disorder
c) acute stress disorder
d) panic disorder with agoraphobia
e) separation anxiety disorder

2. A 65-year-old woman reports being housebound despite feeling physically healthy. She reports falling while shopping several years ago; although she sustained no injuries, the situation was so distressing to her that she becomes extremely nervous when she has to leave her house unaccompanied. She has no children and few friends. She is very distressed by the fact that she has few opportunities to venture outside her home. Which of the following disorders best accounts for her disability?

a) specific phobia—situational subtype
b) social anxiety disorder
c) posttraumatic stress disorder
d) agoraphobia
e) adjustment disorder

3. A 35-year-old man is in danger of losing his job; the job requires frequent long-range traveling, and for the past year he has avoided flying. Two years prior, he traveled on a particularly turbulent flight, and although he was not in any real danger, he was convinced that the pilot minimized the risk and that the plane almost crashed. He flew again one month later, and although he experienced a smooth flight, the anticipation of turbulence was so distressing that he experienced a panic attack during the flight. He has not flown since. Which of the following disorders is the most likely cause of his anxiety?

a) agoraphobia
b) acute stress disorder
c) specific phobia—situational type
d) social anxiety disorder
e) panic disorder PN

APA Membership Dues Deadline Fast Approaching

The deadline for paying current-year APA membership dues is June 30. You must pay your membership dues by that date or your membership will automatically expire on June 30. (Membership will not expire if you are enrolled in the APA Scheduled Payment Plan.) You can renew your membership dues online or enroll in the Scheduled Payment Plan, which allows you to pay your dues by credit card in either monthly, quarterly, biannual, or annual installments — with no interest or service fee.

Psychiatrists Have Role in Assessing Candidates for Asylum

Cultural factors and the effects of mental illness related to past trauma can significantly color an applicant's presentation before a judge or asylum officer.

BY MARK MORAN

Psychiatrists can have a decisive role in evaluating refugees from persecution who are seeking asylum in the United States.

Attorneys and forensic psychiatrists speaking at a symposium at APA's 2013 annual meeting in San Francisco said rates of mental illness—especially PTSD—are high among asylum-seeking refugees. And they said psychiatrists can provide expert insight into how mental illness may affect an individual's "credibility"—a key variable in decisions to grant asylum.

The symposium was titled "Immigration and Its Adversities: Mental Illness, Detention, and Deportation."

Karen Musalo, J.D., a professor at the Hastings College of Law at the University of California, outlined the legal, procedural, and psychosocial issues—including the sometimes horrific histories of trauma—affecting refugees seeking asylum. She explained that there are three categories under which a refugee may merit protection in the United States: asylum, withholding, or the Convention Against Torture.

To merit asylum, the individual must meet the definition of a "refugee" as someone seeking protection in the United States because of "a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion." Persecution can take many forms, including severe forms of discrimination, economic deprivation, and psychological harm, Musalo said.

The category of "withholding," also known as "restriction on removal," requires evidence that "life or freedom would be threatened" in the country from which he or she is fleeing on account of race, religion, nationality, membership in a particular social group, or political opinion.

Under the Convention Against Torture, an individual must establish that it is "more likely than not" that he or she would be tortured if forced to return to the proposed country of removal. Torture is defined as intentional acts that cause severe mental or physical pain.

Individuals can apply for "affirmative applications" at asylum offices around the country if they are in the United States legally or are here without legal documentation but have not been apprehended by immigration authorities; these are "nonadversarial" proceedings. Or they can enter "defensive applications" in immigration court proceedings if they have no legal right to be in the United States, are apprehended by immigration authorities, and have raised claims to protection as a "defense" to removal to their home countries.

David Hathcox

Howard Zonana, M.D.: The "power of a psychiatric narrative" can be extremely compelling in making the case for a person to be granted asylum in the United States.

Whether before an immigration court judge or the asylum office, an applicant's "credibility" is a key determinant in the outcome. Criteria for determining credibility have been codified under the REAL ID Act of 2005, which cites such factors as demeanor of the applicant, consistency of written and oral statements, candor and responsiveness to questions, plausibility of the applicant's account, and inaccuracies or falsehoods in written or oral statements.

"Many of these factors are inherently problematic given the experience of persecution or torture of the individual," Musalo said. She emphasized that though it is widely assumed that credibility can be intuitively determined in most cases, in fact cultural factors and the effects of mental illness related to past trauma can significantly color an applicant's presentation.

For instance, she cited the case of a young woman who appeared before an immigration judge seeking asylum. She and a circle of friends were nonviolent activists against the government of her country of origin; her fiancé was "disappeared," four of his six brothers were abducted, and their dismembered bodies were later found.

The woman claimed that armed men had sought her out and that she went into hiding until she could escape from the country. But the judge found her not to be credible, citing among other reasons that her testimony was "hesitant, unemotional, and vague," Musalo said.

"These kinds of decisions led to the recognition that adjudicators needed to be educated about the potential effect of trauma upon asylum seekers," she said. "An expert psychological evaluation can help preclude adverse credibility findings by addressing issues of demeanor, memory—which is relevant to consistency and ability to provide detail—and inaccuracies or falsehoods."

Forensic psychiatrist Howard Zonana, M.D., presented data and case examples from psychiatric consultations conducted at the Yale Law School's Asylum Law Clinic for some 62 refugees from Africa, Serbia, Mexico, Central America, South America, Haiti, Jamaica, China, and the Middle East. (The clinic was established in 1990 and formalized a collaboration with the school's law and psychiatry division in 2000.)

The rates of mental illness among these individuals were extraordinary: PTSD (84 percent), depression (61 percent), dementia /traumatic brain injury (0.5 percent), and cognitive limitations (9 percent). Approximately 9 percent had no diagnosis, and 0.5 percent were deemed to be malingering.

"Referral often begins as consultation because the attorneys and law students are having difficulty with the interviews and in formulating the legal case," Zonana explained. "Memory problems, inconsistency, resistance to giving details are issues. The referral questions are shaped by the legal circumstance and include diagnosis of a psychiatric disorder, response to trauma, and a preemptive explanation for why the interview with the asylum officer or testimony in the court may not go smoothly."

Zonana said an underlying agenda on the part of attorneys seeking consultation is to use the psychiatric report to bolster the credibility of the claim. But he said psychiatric reports are not intended to verity the events described by the applicant. "Rather, issues of malingering and validity of symptoms are addressed as they would be in any psychiatric evaluation and report," he said.

For instance, he cited the case of a 26-year-old man who was convicted of armed robbery and served four years in jail. Attorneys for the man sought a psychiatric consultation to determine whether the client had a mental disorder that may have made him unable to appreciate or control his behavior when he committed the crime, resulting in his being slated for deportation to his country of origin.

Zonana said the evaluation showed malingering as well as collateral evidence of gang activity and drug dealing, and no psychiatric report was filed.

But in other cases, psychiatric evaluation proved valuable in the granting of asylum. In one instance, attorneys sought psychiatric consultation regarding a 26-year-old man they said "doesn't talk and misses appointments" and was unforthcoming about important details. The man had fled his country of origin after being targeted for support of an opposition party.

Evaluation determined that he had depression and PTSD related to an earthquake in his country of origin. His case went to trial with the psychiatric report, and he was granted suspension of removal under the Convention Against Torture.

In another instance, attorneys sought a psychiatric evaluation for a 65-year-old man who had been a leader of political resistance in his country of origin, had been attacked there, and was now receiving care for cancer in the United States. Attorneys seeking psychiatric consultation said the man "doesn't seem to want asylum, what he says contradicts his written documents, [and] he does not seem concerned about it."

Evaluation determined that he had a diagnosis of dementia and was medically compromised. He was hospitalized and granted asylum.

Zonana said the "power of a psychiatric narrative" can be extremely compelling. "Having the benefit of an American, professional, erudite voice that can provide a psychiatrically or psychologically informed account of trauma and the typical kinds of response to trauma can transform a 'case' into a 'person' and can create a connection across cultural barriers." PN

ANNUAL MEETING

Landmark Events Highlight San Francisco Annual Meeting

Excitement ran high at APA's 2013 annual meeting last month as thousands of psychiatrists soaked up a scientific program rich in cutting-edge knowledge in research and clinical care as well as the spectacular scenery provided by the host city, San Francisco. The meeting was especially noteworthy because it marked the official release of *DSM-5,* and those in attendance had the opportunity to purchase their copy before it went on sale to the public. And while an impressive roster of distinguished people have addressed previous annual meetings, this is the first time a former U.S. President spoke to meeting attendees, as Bill Clinton delivered a stirring keynote address.

APA's next scientific meeting, the Institute on Psychiatric Services, will be held October 10 to 13 in another of APA's popular meeting cities—Philadelphia. It's not too early to plan!

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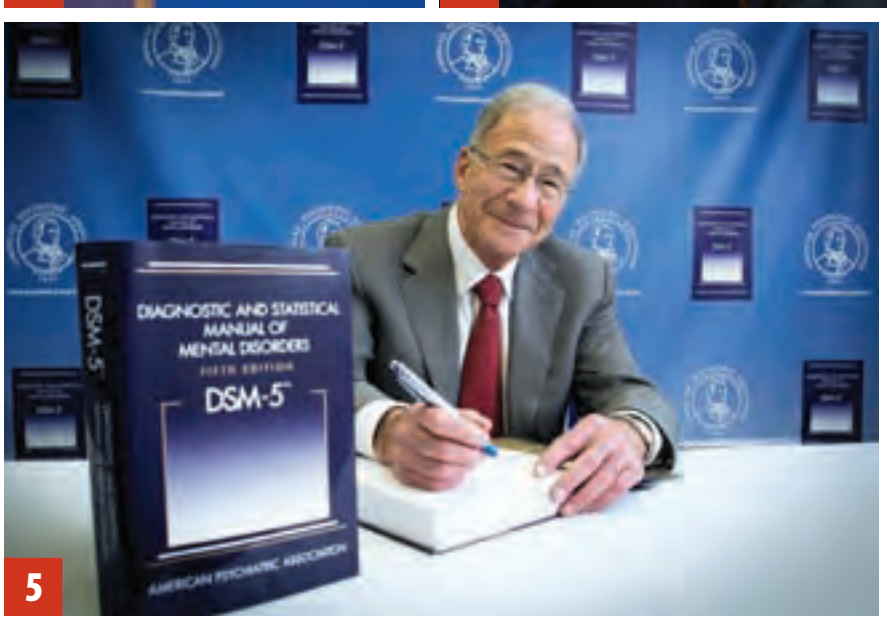
1 At the Opening Session, outgoing APA President Dilip Jeste, M.D., interviews Elyn Saks, J.D., Ph.D., about her experiences as a professional with a serious mental illness and her insights about the psychiatric care she received. (See next issue for details.)

2 Former President Bill Clinton presents the meeting's keynote address via satellite to a packed hall. (See the June 7 issue for a report on the session.)

3 Baroness Susan Greenfield, C.B.E., D.Phil., calls for a "Century of the Mind" (see page 21).



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6

ANNUAL MEETING

4 Incoming APA President Jeffrey Lieberman, M.D., chats with former member of Congress Patrick Kennedy and his wife, Amy, before the Clinton address. Kennedy is helping APA fight for release of a final rule to implement the mental health parity law as the law was intended.

5 David Kupfer, M.D., chair of the *DSM-5* Task Force, signs a copy of the new manual at the *DSM-5* launch event on Saturday, May 18.

6 From left: Anyssa Shakeri, M.D., Sarah Mark, M.D., and Charlena Chan, M.D., of Canada check out a computer program in the Exhibit Hall.

7 Incoming APA Medical Director and CEO Saul Levin, M.D. (right), spends a moment with former APA President Alan Schatzberg, M.D. (left), and AMA President and psychiatrist Jeremy Lazarus, M.D., before the Board of Trustees meeting.

8 APA President Dilip Jeste, M.D. (right), presents a check at the Opening Session to Eduardo Vega, the executive director of the Mental Health Association of San Francisco. The association was chosen as this year's recipient of the "APA Gives Back" program.

9 The New Research poster sessions were a popular draw.

10 The Moscone Convention Center served as the headquarters for this year's annual meeting.

11 Jane Dulay, M.D., of Berkeley, Calif. (left), and Kirsi Nikkenen, M.D., of the Netherlands, peruse the APA Art Association's exhibit.

12 The Assembly paid a surprise tribute to APA Medical Director and CEO James H. Scully Jr., M.D., who will retire in the fall. At left, former Speaker Al Gaw, M.D., presents a memento to Scully, and the Assembly made him an honorary member.

Photos: David Hathcox

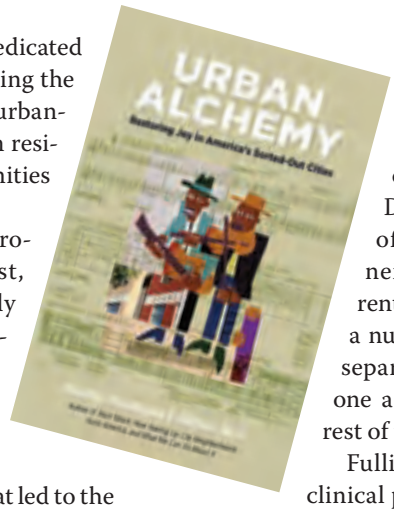
MEMBERS IN THE NEWS

Psychiatrist Exposes How Public Policies Have Devastated Health of Communities

While meant to be restorative, many urban-renewal policies create harmful mental health conditions for community residents. One psychiatrist is tackling these issues and encourages her colleagues to do the same.

BY EVE BENDER

Terms such as "planned shrinkage," "serial displacement," and "Hope VI" are nowhere to be found in the lexicon of the average psychiatrist, but then again, Mindy Fullilove, M.D., is no average psychiatrist. She has dedicated her career to studying the harmful effects of urban-renewal policies on residents of communities and cities.



As an author, professor, and activist, she has carefully studied the epidemics of violence and of diseases such as HIV and addiction and traced them to policies that led to the fracturing of communities. Her seventh book on the subject, *Urban Alchemy: Restoring Joy in America's Sorted Out Cities,* is set to be published in June and explores some of her work with residents living in the Hill District neighborhood of Pittsburgh. This neighborhood is currently recovering from a number of policies that separated residents from one another and from the rest of the city.


Beatrice Spolidoro

By challenging destructive public policies that create dangerous living conditions for those living in poor neighborhoods, psychiatrist Mindy Fullilove, M.D., aims to improve the mental health of these communities.

Fullilove is a professor of clinical psychiatry and public health at Columbia University.

At the beginning of her career, Fullilove worked as a community psychiatrist in the South Bronx and then in San Francisco during the beginning of the AIDS epidemic and then the crack cocaine epidemic, both of which she went on to research on a full-time basis. "In San Francisco, seeing these epidemics tear the city apart with such force was a stunning experience," she told *Psychiatric News*.

It was around that time that Fullilove read an article that became seminal to her thinking—the author was Rodrick Wallace, Ph.D., and he linked an urban planning policy called "planned shrinkage" in the South Bronx to the spread of HIV and the creation of conditions that led to a massive increase in violence and drug addiction in that area.

Planned shrinkage, first employed in New York City in 1976, is the deliberate withdrawal of city services such as police patrols, garbage removal, and street repairs, for instance, from lower-income neighborhoods. While it has been justified by some as a way to preserve city services in times of fiscal shortages, it has been criticized by others as a way to destroy poor neighborhoods by driving residents elsewhere.

Wallace wrote that as the South Bronx population dispersed due to the stoppage of services, close social networks were shredded, and HIV-control strategies were disrupted.

"It became apparent to me that the policies that influenced community health originate in higher structures like the city, state, and federal government, which are distributing resources to these communities. The real question is how you influence these policies," Fullilove remarked.

In the next stage of Fullilove's career, another city would serve as a learning experience for her and would, in turn, benefit from her activism. A fellowship funded by the Maurice Falk Medical Fund brought Fullilove to the University of Pittsburgh Graduate School of Public Health's Center for Minority Health in the late 1990s. While spending time in the city then and in the years to follow, she was invited to speak to residents of the Hill District neighborhood of Pittsburgh, which is nestled against the city's downtown and lies between the Allegheny and Monongahela rivers.

She learned that Hill District residents were distressed about the city's plans to implement a federal program called Hope VI that would demolish 25 percent of public housing for nearly 1,000 Hill District residents and replace it with dwellings meant for "mixed income" families. The Hope VI program had first driven thousands of Hill District residents from their homes in the 1960s.

The Hill District, known as "Little Harlem" in the 1930s and 1940s, was once a vibrant community known for its jazz clubs. Musicians such as Art Blakey, John Coltrane, and Dizzy Gillespie once headlined at the Crawford Grill on Centre Avenue. By the early 1950s, however, the Hill was falling under the shadow of the newly erected Civic Arena, and the city decided to demolish large portions of the neighborhood. More than 8,000 residents and 400 businesses were eventually displaced. "If you destabilize neighborhoods continuously," Fullilove noted, "they can't repair themselves."

Over the years Fullilove has spent a great deal of time with Hill District residents, talking with them about the toll that serial displacement has taken on their communi-

see ***Public Policies*** *on page 35*

Newspaper Names Psychiatrist 'Health Care Hero'

A psychiatrist who has played major roles in academia, clinical services, and APA adds a new honor to a distinguished career.

BY KEN HAUSMAN

Robert Hales, M.D., chair of the Department of Psychiatry and Behavioral Sciences at the University of California, Davis, and editor in chief of books for American Psychiatric Publishing, has been named a Health Care Hero by the *Sacramento Business Journal*.

In addition to his academic and publishing responsibilities, Hales has been active in the mental health care system in the Sacramento area and serves as medical director for mental health services in Sacramento County.

He was nominated for the honor by Mary Ann Carrasco, deputy director of Sacramento County's Division of Behavioral Services, who said she nominated Hales for his extensive efforts to ensure that the county's residents have access to county-run mental health care and for his work in integrating mental health and general health care services. "He is extremely knowledgeable and is always willing to assist with any programming issues," Carassco said. "He is also a very compassionate doctor and is very client centered in his thoughtful advice and guidance."


Robert Hales, M.D.

After the award was announced, Hales told *Psychiatric News* that "The [psychiatry] department has been fortunate to have the County of Sacramento as a strong partner, which has allowed the training program to flourish, and in return, the quality of care provided to county patients with mental illness has improved through this collaboration."

His clinical work is not the only arena in which Hales has come in for praise. In 2006 his academic and educational efforts were honored when he was named Educator of the Year by the Association for Academic Psychiatry.

Educating psychiatrists and others in the mental health field is of course part of his mission at American Psychiatric Publishing (APP) as well. John McDuffie, editorial director for books at APP, cited Hales's leadership as APP's editor in chief for books, noting that "he is both strategic and tactical in his approach to content development, and he provides wise and practical counsel on a wide variety of publishing issues."

"Not only is Bob Hales an extraordinary editor of the largest psychiatry book publisher in the world," said APA Medical Director James H. Scully Jr., M.D., "it turns out he is also a great clinical leader in improving care. A true hero." PN

China Needs to Build Community MH Structure

Now that China's first national mental health law has taken effect, a major challenge will be to build a community mental health infrastructure where none exists.

BY JOAN AREHART-TREICHEL

On May 1, China's first National Mental Health Law—something that had been in the works for 27 years—went into effect.

Michael Phillips, M.D., an American psychiatrist and China mental health expert, and colleagues wrote April 29 in *AJP in Advance* that "this new law is a high-water mark for Chinese psychiatry, and potentially for global mental health." The new law eliminates most forms of involuntary treatment, puts strict limits on seclusion and restraints, and bans the use of treatment as a form of punishment (*Psychiatric News,* June 7).

And now that the law is being implemented, it is time to make community mental health services in China a reality, Chinese mental health professionals pointed out in a paper to be published in the July *Psychiatric Services.*

The leading commentator is Samson Tse, Ph.D., an associate professor of social work at the University of Hong Kong who is currently working at Yale University.

The new law "has highlighted the urgent need to properly develop a community mental health service," Tse and his colleagues said. They contend that a mental health reform initiative used in China since 2004 called the "686 Project" might be the way to go.

The project is based on a World Health Organization model that integrates hospital-based services with community mental health services. "People with mental illness and their families are often frustrated at being offered treatment by different providers who do not communicate with each other and then having to negotiate the many gaps by themselves," they explained. Moreover, the initiative has already received a generous investment from the Chinese government and, as of November 2011, had led to the treatment of almost 2 million Chinese with severe mental illness and had covered 766 sites in 170 cities with a total catchment population of 43 million.

Tse and his colleagues also proposed that psychiatrists and other mental health workers providing community mental health services be educated in a mental illness recovery approach. "The recovery approach," they asserted, "is highly consistent with the values embedded within the 686 Project, such as paying more attention to the person's level of functioning and strengths, rather than disabilities and psychopathology."

Furthermore, recovery strategies are based on three decades' worth of studies and clinical evidence, "most of which has been collected in the United States, the United Kingdom, Australia, and more recently, Hong Kong," they noted.

And the recovery approach, which focuses on hope, empowerment, self-determination, and illness management, "resonates strongly with traditional Chinese culture in terms of hardiness and the amazing resilience the Chinese people

see ***China*** *on page 35*

EDUCATION & TRAINING

DSM-5 Offers Creative Teaching Opportunity

Educators should focus on underlying concepts of diagnosis and why psychiatric nosology changes over time with emerging research.

BY MARK MORAN

The publication of *DSM-5* can be an opportunity for creative teaching about psychiatric diagnosis at educational institutions.

That was the consensus of psychiatric educators and residents at a symposium on "*DSM-5* and Residency Training: Opportunities and Challenges" at APA's 2013 annual meeting in San Francisco in May.

The new manual, published last month, may present challenges to educational institutions around how case logs are written up by residents, medical records are transcribed, and varying timetables for conversion to *DSM-5* criteria in licensing and board examinations.

But Sheldon Benjamin, M.D., vice chair for education and a professor of psychiatry and neurology at the University of Massachusetts, said the publication of the revised manual should be an exciting opportunity for everyone involved in academic psychiatry—department chairs, training directors, faculty, and residents—to engage in a creative educational dialogue about the reasons for changes in criteria and more generally about the evolving nature of psychiatric diagnosis and nosology.

He was joined by *DSM-5* Task Force Chair David Kupfer, M.D.; Laura Roberts, M.D., chair of the Department of Psychiatry at Stanford University; Arden Dingle, M.D., program director for child and adolescent psychiatry at Emory University; and Neisha D'Souza, M.D., a resident at Oregon Health Sciences University. The session was chaired by Richard Summers, M.D., director of residency training at the University of Pennsylvania.

Benjamin presented results from an informal survey of residents and faculty at his institution about *DSM-5* that found that generally respondents understood and agreed with the need for an updated diagnostic manual and were positive about its effect on practice.

Nonetheless, he said, a central challenge for educators is that the changing and evolving nature of diagnostic nosology for psychiatry may be viewed by students as evidence that psychiatry lacks the underpinnings of basic science that exist in other fields.

"I think our faculty and our residents will need to be prepared to confront this and discuss the reasons for change with medical students," he said. "We need to have a departmentwide conversation about the fact that we are doing syndromal diagnoses that evolve as the research evolves.

"And we need to take great care in our exams for medical students that we are testing underlying concepts and avoiding simplistic questions about diagnostic criteria that are really asking 'Why was this answer right last year and wrong this year?' "

Benjamin said that at his institution residents will be required to review *DSM-5* criteria and compare them

see **Creative Teaching** *on page 24*

GOVERNMENT NEWS

Prescribing Bill Dies In Illinois Legislature

Illinois psychologists are unsuccessful in their legislative push to expand their scope of practice to include the right to prescribe.

BY KEN HAUSMAN

The push by Illinois psychologists and their legislative allies to permit the state's doctoral-level psychologists to prescribe medication has come to an end for now, as the lead sponsor of the bill in the Illinois House of Representatives, Rep. John Bradley (D), withdrew it from consideration in committee. A companion bill on the issue had passed the state Senate. The session ended June 1 with no further action on the scope-of-practice expansion.

The Illinois Psychiatric Society (IPS) and APA were active in leading the opposition to the bill, as was the Illinois State Medical Society. The legislation would have permitted psychologists to prescribe, with oversight of their prescribing credentials and activities coming from the state's psychological licensing board rather than from the medical licensing board. In Louisiana and New Mexico, where laws have already been enacted to allow psychologists to prescribe psychoactive medications, regulations put them under the purview of the state medical licensing board (*Psychiatric News*, March 15).

The bill also said that the Illinois Psychological Association would provide 20 percent of the training psychologists would need to qualify for prescribing privileges in the state, a provision that Lisa Rone, M.D., an IPS representative to the APA Assembly and former IPS president, called "an appalling conflict of interest" because the state psychological association stood to reap financial gains if the bill had become law.

Matt Gibson/Shutterstock

APA provided a grant to the IPS to fight the legislation. In its campaign to defeat the prescribing bill, the IPS rallied its members with a legislative alert urging them to register their opposition with their state representatives. It said, in part, "Please remind your state legislator that there can be NO shortcuts when it comes to patient safety."

IPS President-elect Linda Gruenberg, M.D., told *Psychiatric News* that the district branch fought very hard to defeat this proposal out of a serious concern for its impact on patient safety and will remain vigilant should the bill reappear in the legislature. She noted that it can still be resurrected this year during a veto session scheduled for late November and early December.

In a June 2 letter to members of the IPS, APA President Jeffrey Lieberman, M.D., and President-elect Paul Summergrad, M.D., thanked Illinois psychiatrists for their "tireless and successful efforts . . . to defeat psychologist prescribing in the most recent session of the Illinois legislature." They added, "While we know that this issue can still resurface later in the year, we are very grateful for your extraordinary efforts." They also indicated that APA stands ready to assist in future efforts should this or a similar bill be introduced in the future. PN

RESIDENTS' FORUM

Med Students Can Learn From—and Teach—Psychiatry Residents

BY JONATHAN SCARFF, M.D.

For most medical students, the clerkship in psychiatry is their first, and often only, exposure to clinical psychiatry. Their clerkship experience can be considerably enhanced through collaborative teaching and learning with psychiatry residents.

Although students are expected to acquire knowledge about diagnosing and treating mental illnesses, certain experiences on the rotation may broaden their understanding of how to practice medicine in general. Students can encounter patients at different clinical sites, with different illness presentations, or in need of different treatments (despite having the same diagnosis). Students witness the effects of physical and socioeconomic environments on the course of mental illness, and they learn about the influence of mental illness on the treatment and outcome of comorbid physical illnesses.

Residents have the unique opportunity to enrich students' experiences on the rotation because they work so closely with them.

Both during and after the rotation, residents may serve as mentors for students who are interested in a career in psychiatry. In addition to teaching rotation objectives or supervising clinical performance, residents can enrich students' experiences by displaying empathy, modeling professionalism, demonstrating basic psychotherapy techniques, encouraging self-reflection, and sharing the importance of a meaningful doctor-patient relationship, as noted by Michael Ascher, M.D., and Jonathan Avery, M.D., in their October 19, 2012, *Psychiatric News* column.

A decline in empathy in medical students from matriculation to graduation was described in a study by Hojat and colleagues in *Academic Medicine* in 2009. But the clinical rotation can be an opportunity for residents to attenuate, arrest, or even reverse this trend. During that time, students can develop genuine empathy by observing residents' interactions with patients and with the students themselves. Resident behavior can make a significant and lasting impression on medical students. Therefore, when residents demonstrate active listening, respect, and professionalism during interactions with families, nurses, treatment team members, and other physicians, nonverbal teaching occurs that can create a positive and lasting impact on a student's professional development.

Regardless of the clinical rotation site, residents can educate students about the importance of psychotherapy in alleviating symptoms. They can offer instruction in basic techniques, such as motivational interviewing or identifying cognitive distortions. Students may develop countertransference toward patients or witness patients using a variety of defenses. In these cases, residents can encourage students to reflect and identify these feelings or defenses. This insight can serve as a tool for providing consistent, empathic care for future patients.

The rotation is also an opportunity to underscore the significance of the doctor-patient relationship and its uniquely therapeutic role in psychiatry. Students can recognize the reward of developing meaningful relationships with patients and the importance of treating a patient and not merely an illness.

Also, little emphasis has traditionally been given to teaching medical students how to teach. But in a short time, these students will find themselves in teaching roles as residents. Both the positive and negative interactions they experience with residents, including manner of teaching, will no doubt shape their professional personae and teaching styles. The interaction between resident and student might be compared to the functioning of a sled-dog team. Little is accomplished when one member is domineering toward or feeling downtrodden by the other, nor is much achieved when one team member is behind pushing or in front pulling. Even less is accomplished if the two individuals are pulling in opposite directions. Instead, an environment of mutual respect, in which resident and student are collaborating beside each other, is most conducive for students to acquire knowledge and hone their interpersonal skills.

Contact with students has deeply enriched my residency experience by giving me an opportunity to learn from the very students whom I teach. Whether they ask stimulating questions, reinforce pertinent topics from other fields of medicine, or share new developments in psychiatry, students give me inspiration to learn anew and help me maintain my commitment to lifelong learning. Furthermore, their curiosity, altruism, humor, and compassion remind me of the "complete" physician that I aspire to be. This makes me pause to appreciate the art, humanity, and reward of practicing medicine. The psychiatry rotation can indeed be an enriching experience for students and residents alike. PN

Jonathan Scarff, M.D., is a PGY-4 resident at the University of Louisville.

JOURNAL DIGEST

BY LESLIE SINCLAIR

Serious Mental Illness Linked to Neighborhood Characteristics

Neighborhoods in which adults with serious mental illness reside are more apt to have higher levels of physical and structural inadequacy, drug-related activity, and crime than comparison neighborhoods, said Philadelphia-based researchers. They evaluated the characteristics of the neighborhoods of residence of a sample of 15,246 adults who were treated for serious mental illness in Philadelphia from 1997 to 2000 and compared them with an equally sized group of neighborhoods created by randomly generated addresses representative of the city's general population.

"Although this study was unable to directly test the relationship between neighborhood environmental context and the functioning of persons with serious mental illness, its findings are nonetheless concerning in light of emerging evidence that worse neighborhood characteristics impede the community integration of persons with serious mental illness," said the researchers, who also noted that their findings establish the importance of further exploration of the degree to which environmental factors may act as either barriers or facilitators to the functioning and participation of persons with serious mental illness.

Byrne T, Prvu Bettger J, Brusilovskiy E, et al. "Comparing Neighborhoods of Adults With Serious Mental Illness and of the General Population: Research Implications." 2013. Psychiatric Services in Advance. May 15 [Epub ahead of print]. http://ps.psychiatryonline.org/article.aspx?articleid=1687833

Exposure to Suicide Predicts Increased Suicidality In Adolescents

Being exposed to suicide can lead to suicidal ideation and suicide attempts among adolescents, researchers at the Harvard School of Public Health reported. Their finding was based on responses from 8,766 adolescents aged 12 to 17 who were part of the National Longitudinal Survey of Children and Youth, carried out from 1998 to 2007. Study participants were asked whether anyone in their school had died by suicide and whether they personally knew anyone who had died by suicide. Social support for the youth and stressful life events were also assessed.

The prevalence of exposure to a schoolmate's suicide and personally knowing someone who died by suicide increased with age, and such exposure was consistently associated with suicide attempts and, to a lesser degree, with suicidal ideation. "Our results support schoolwide interventions over current targeted interventions, particularly over strategies that target interventions toward children closest to the decedent," the researchers concluded.

Swanson S, Colman I. "Association Between Exposure to Suicide and Suicidality Outcomes in Youth. 2013." Canadian Medical Association Journal. May 27 [Epub ahead of print]. http://www.cmaj.ca/content/early/2013/05/21/cmaj.121377

Piotr Marcinski/Shutterstock.

Teens who are acquainted with someone who has died by suicide are at greater risk of suicidal ideation themselves.

No Serologic Tie Found Between Autism And Lyme Disease

Despite reports of a link between Lyme disease and autism, controlled studies to assess serological evidence of infection with *Borrelia burgdorferi* (the causative agent of Lyme disease) in patients with autism are lacking. Researchers based at Weill Cornell Medical College and New York Medical College obtained serum samples from 120 children aged 2 through 18 (70 with autism and 50 unaffected controls) acquired from the Autism Genetic Resource Exchange and the Weill Cornell Autism Research Program and then tested them for antibodies to *B. burgdorferi.* None of the children with autism or the unaffected controls had serological evidence of Lyme disease by two-tier testing. "The data do not address whether Lyme disease may cause autism-like behavioral deficits in some cases," said the researchers. "However, the study's sample size is large enough to effectively rule out the suggested high rates of Lyme disease or associated seroprevalence among affected children."

Ajamian J, Kosofsky B, Wormser G, et al. "Serologic Markers of Lyme Disease in Children With Autism." 2013. JAMA. 309 (17) 1771 – 1773. http://jama.jamanetwork.com/article.aspx?articleid=1682933

Case Report: Tachycardia Treatment Thought to Resolve Suicidal Depression

Researchers at the UCLA Mattel Children's Hospital in Los Angeles reported a case of a 14-year-old girl whose suicidal depression resolved after treatment for ectopic atrial tachycardia (EAT). The patient had no other significant medical history until she began experiencing several life stressors that gradually escalated prior to her suicide attempt with lorazepam and alcohol. She suffered depression, anxiety, panic attacks, insomnia, and anhedonia and eventually sought psychiatric evaluation when she experienced suicidal ideations and began cutting her wrists. Her EAT was subsequently diagnosed when she was hospitalized after her suicide attempt. She was transferred to an inpatient psychiatric ward, where her symptoms improved but did not resolve completely. Once stable, she underwent catheter ablation, after which her feelings of anxiety and depression dramatically improved; the patient had been asymptomatic without recurrence for over a year since her procedure. Follow-up echocardiography revealed normalization of ventricular function. "This case underscores the need to screen patients for arrhythmia when being evaluated by their general pediatrician or psychiatrist for psychiatric illness," concluded the researchers. PN

Chau P and Moore J. "Psychiatric Disorder and Incessant Tachyarrhythmia in a Child." 2013. Case Reports in Pediatrics. April 3 [Epub ahead of print]. http://www.hindawi.com/crim/pediatrics/2013/572301/

Convocation Speaker Calls For 'Century of the Mind'

What has long been called the "mind" can now be understood as the growth of connections between neurons that arises from individual human encounter with experience.

BY MARK MORAN

"Mind change"—a result of the threat to neuronal connections and growth of the brain posed by digital technology—may be as important a challenge in the 21st century as climate change.

That's what Susan Greenfield, C.B.E., D.Phil., told APA members during the William C. Menninger Memorial Convocation Lecture at APA's 2013 annual meeting in San Francisco last month. Greenfield, a neuroscientist at the University of Oxford and author of a neuroscientific theory of consciousness titled *The Private Life of the Brain,* described her work searching for biomarkers of—and pharmacologic interventions for—neurodegenerative diseases.

She outlined what she said is a neuroscientific theory of the mind. "The wonderful thing about being born a human being is that you are born with a full complement of neurons, but it is the growth of the connections between those neurons that accounts for the growth of the brain after birth," Greenfield said. "You are going to be unique—no one will have a brain like yours in the 100,000 years we have stalked this planet because those connections are formed, updated, changed, and endlessly revised by the dialogue you as a human being have with the outside world. That is why we occupy more ecological niches than any other species on the planet, and it is why we are individuals, because if you have individual experiences—unlike, say the goldfish that doesn't have a great personality—then you are going to be an individual."

But Greenfield also expressed her belief that the vast amounts of time many people—especially children and adolescents—are spending in isolated contemplation of computer screens, tablets, or smartphones may be threatening the growth of connections by depleting the opportunities for real encounters with experience.

David Hathcox

Susan Greenfield, C.B.E., D.Phil., tells annual meeting attendees that long hours using electronic communication devices could threaten the growth of neuronal connections by depleting opportunites for human interaction.

"If you are spending, as some kids are, five hours-plus a day not walking on the beach, not giving someone a hug, not looking someone in the eye, . . . you should expect to see some differences, and not all of them are going to be good," she said.

Greenfield, who also is the author of *You and Me: The Neuroscience of Identity*, said there is a "huge amount of evidence accumulating" that mind change, analogous to climate change, is happening. "We need to take this seriously," she said.

But unlike climate change—to which the human response can be only damage control—Greenfield said we can harness the power of neuroscience to make positive changes.

She recalled that President George H. W. Bush proclaimed the 1990s as the "Decade of the Brain." But she said the accomplishments of that period and since have only scratched the surface of what is possible with the expanding reach of neuroscience. "That is nothing compared to this century, and I would like to persuade you that what we should really be thinking about is the 21st century—the whole century—as the century of the mind.

"For the first time in our privileged Western world, we have a longer life expectancy than at any other time," she said. "So what are we going to do with all this time?. . . . That is the challenge, and that is what is so different about mind change. We have the enormous chance to truly make the 21st century the century of the individual human mind." PN

FROM THE EXPERTS

The Pharmacotherapy of Maladaptive Aggression in Children

BY ROBERT FINDLING, M.D., M.B.A., AND MOLLY MCVOY, M.D.

In the June 2012 *Pediatrics,* two papers were published, one by Knapp and colleagues and the other by Scotto Rosato and colleagues, regarding guidelines for the treatment of maladaptive aggression in young people. When it comes to intervening in youngsters with dysfunctional aggressive behavior, pharmacotherapy may be a treatment option for some patients.

In our opinion, one of the key reasons that guidelines pertaining to maladaptive aggression in young people are so clinically relevant is that medication treatment of this patient group remains controversial. Concerns are raised about whether medications, many of which are associated with significant risks, are not being used to treat a patient in need, but rather being used as either a form of punishment or behavioral control.

Another issue relates to concerns that the practice of treating disruptive behavior is a key driver of the increased rates at which atypical antipsychotics are prescribed to children. Interestingly, a paper published by Findling and colleagues in 2011 in the *Journal of Child and Adolescent Psychopharmacology* reported that in an epidemiologically ascertained cohort of outpatient children, the only two diagnoses associated with a higher likelihood of being prescribed an antipsychotic were bipolar I disorder (and not bipolar disorder not otherwise specified) and psychotic illnesses. Because the information that was described in that report was collected in a face-to-face manner, and because these results differed from those reported in papers that were based on claims-based sources, the authors recommended that external validation studies be done to confirm or refute the accuracy of data derived from large databases.

Even though more research needs to be done in the field of pediatric psychopharmacology, clinicians are faced with helping their patients who are struggling now. The papers by Knapp and Scotto Rosato highlight approaches that can be useful to clinicians when a child presents with maladaptive aggression. Guidelines regarding both assessment and treatment are included in these papers. Although the topic at hand here is the pharmacotherapy of dysfunctional aggression, we both are of the opinion that the paper by Knapp and colleagues that considers the evaluation processes of these youngsters is as important, if not more so, than the paper on intervention.

We recommend that clinicians who are faced with these challenging patients consider reading both these papers. However, in this column we want to highlight considerations that we believe are particularly salient regarding the pharmacotherapy of dysfunctional aggressive behavior.

The first point we would like to emphasize is that when considering the topic of medication-therapy studies of maladaptive aggression, results pertain to specific groups of well-characterized patients. For that reason, such results might not necessarily be applicable to other patient groups with similar behaviors. Put in other words, although clinical trials data might suggest reduced maladaptive aggression in a certain population of children, that does not necessarily mean that the medication that was considered under the auspices of that clinical trial is effective in the treatment

see ***From the Experts*** *on page 32*

Robert Findling, M.D., M.B.A., is a professor of psychiatry and director of child and adolescent psychiatry at Johns Hopkins University. Molly McVoy, M.D., is the assistant training director in the Department of Child and Adolescent Psychiatry at University Hospitals/Case Western Reserve. They are the coeditors of American Psychiatric Publishing's *Clinical Manual of Child and Adolescent Psychopharmacology, Second Edition*. The book may be purchased at http://www.appi.org/SearchCenter/Pages/SearchDetail.aspx?ItemId=62435. APA members are eligible for a discount.

CLINICAL & RESEARCH NEWS

For Now, Preventive Efforts Are Best Alzheimer's Weapon

Several factors can help maintain the brain's health as people age, says a geriatric psychiatry expert.

BY AARON LEVIN

"The brain undergoes a lot of wear and tear as it ages," geriatric psychiatrist Gary Small, M.D., explained at APA's 2013 annual meeting in May. Small has spent a career seeking ways to understand how that happens and how to mitigate or even prevent some of that decline.

"People equate brain health with memory, but it also involves thinking, reasoning, mood, relaxation, and physical activity," said Small, a professor of psychiatry and biobehavioral sciences at the University of California, Los Angeles.

In the public mind at least, the neurodegenerative effects of aging are embodied in Alzheimer's disease, he said. "The 'A' word terrifies everyone."

Postmortem studies show that the brains of Alzheimer's patients are marked by gross atrophy and are dotted with amyloid plaques and tau tangles. Since normal brains have small numbers of plaques and tangles, it is likely that Alzheimer's develops slowly over the lifetime. Researchers are looking for imaging tests or biomarkers in blood or cerebrospinal fluid to identify and evaluate those precursor levels of the disease, Small noted.

So far, no medications have been found to stop the disease, although cholinesterase inhibitors can temporarily slow the decline of memory. Other drugs have been suggested but either are unproven for this use or have significant drawbacks. For instance, anti-inflammatory drugs do boost cognition and brain function, but Small does not recommend them because of their side effects.

If useful treatments await further development, enough is known to recommend preventive measures, Small pointed out. These include physical conditioning, mental stimulation, stress management, good sleep habits, and nutrition.

Physical activity in laboratory animals seems to result in larger brains and better memory, he noted. In human studies, cardiovascular conditioning is associated with larger parietal, temporal and frontal areas and with increased BDNF levels.

Education, even later in life, reduces Alzheimer's risk, and training can improve cognitive skills, he said. A second language helps, too. Being bilingual reduces the risk of dementia.


Gary Small, M.D.

"The Mediterranean diet—rich in antioxidants, fruits, vegetables, and protein—is good for the heart and the brain," he said. Eating fish or other sources of omega-3 fatty acids appears to help, as does moderate intake of alcohol and caffeine.

"Memory training can improve memory ability quickly and can maintain higher performance for at least five years," he said. He cited a Gallup survey indicating that at all ages, engaging in a greater number of healthy behaviors reduced the likelihood of reporting memory problems.

"Avoiding head trauma, stopping smoking, treating hypertension, and not being overweight are likely to help as well," he said. Since genetic factors account for only one-third of the incidence of Alzheimer's disease, such lifestyle interventions could help delay its onset in many people.

Genetic markers associated with Alzheimer's confer risk but are not predictive, said Small. The ApoE4 variant appears in 20 percent of the population, but some carriers never develop Alzheimer's, and again, physical activity can be preventive.

Psychiatrists are frequently confronted by elderly patients who have depression, and deciding on the optimal treatment when mood symptoms and cognitive symptoms overlap can often be a challenge. Small and colleagues have used PET scans to look at the effects of geriatric depression in Alzheimer's cases. They saw evidence of plaques and tangles in the anterior and posterior cingulate and the frontal lobe.

"Perhaps some of the phenotype of geriatric depression is actually an expression of an underlying neurodegenerative process rather than a psychological reaction to something else," he speculated.

For the moment, it is probably wrong to ask about preventing Alzheimer's disease, he said. "The goal for the foreseeable future is not a cure but forestalling symptoms."

Drug and biomarker development are keys to future effective interventions and prevention strategies, but current diagnostic and treatment strategies can improve function and quality of life. Concentrating on modifiable risk factors (like exercise and diet) can improve the quality of life today and stave off future Alzheimer's symptoms, he concluded. PN

VIEWPOINTS

Physicians Should Talk to Alzheimer's Patients About Their Illness

BY ROBERT MCALLISTER, M.D., PH.D.

After my wife was diagnosed with Alzheimer's, she lived eight years. During that time, we visited 12 physicians: internists and a variety of specialists, including neurologists and psychiatrists. After appointments, Jane would say, "Why doesn't the physician talk to me about what's going to happen?" Not one physician ever asked her how she felt about having the disease or what symptoms she was aware of or how her life had changed because of the illness. Not one physician ever said the word "Alzheimer's" to her. Initially our internist told us she had "dementia." She often referred to that word and her resultant fear that she was "going crazy." Do health care professionals think a person has to be a Latin scholar to know that "dementia" means "out of your mind"?

It was heartening to read that *DSM-5* uses the term "neurocognitive disorder" to replace "dementia." Would that the entire medical profession might accept APA's precedent and eliminate it and the term "the demented."

Alzheimer's patients are not out of their minds. They are very much in their minds, and it is a dark, frightening, and lonely place. Perhaps that's why physicians and caregivers don't want to go there. After Jane's death, I asked our internist why he never talked to her about her illness. His reply: "We believe it will make the patient only depressed and frightened." What do physicians think is going on in the heads of Alzheimer's patients? Their heads are full of uncertainty, fear, sadness, and a sense of isolation.

I believe most physicians don't talk to their patients about Alzheimer's because in reality they know little about the disease other than it causes memory impairment and periods of emotional instability and limits executive function. Perhaps other physicians feel the press of time during brief appointments. Nevertheless, physicians should talk about it. If they don't know what to say, they should learn.

At age 94, I have been a physician for 57 years. I knew essentially nothing about Alzheimer's and, to my knowledge, had never seen an Alzheimer's patient. As a psychiatrist, I saw patients with "senility" but never Alzheimer's. Or did I just not know what to call it back in the 60s, 70s, 80s, and even the 90s?

Suddenly I had the sad but love-filled opportunity to be the sole caregiver for my life partner. The experience expanded my knowledge, enlarged my life, strengthened my being, enriched me emotionally, and deepened my faith.

Jane and I talked almost daily, often two or three hours, about what was happening in her head. Her intelligence, emotional depth, uncanny insight, verbal abilities, and trust in me enabled her to share her thoughts and feelings. I was her pupil. She taught me Alzheimer's. I share her insights with others by reporting the last six years of her life in my book *An Alzheimer's Love Story* and in lectures I give on the subject.

Jane described her observations, thought processes, memory, and emotions. Jane might remember only a small segment from an entire episode in our day. For Alzheimer's patients, life is not a running film but isolated snapshots they try to connect, a jigsaw puzzle with some pieces they will never find. Jane often did not hear sentences but just words that sometimes never came together with meaning.

Jane's impaired executive function took over and prevented her from completing minor household tasks, even those she enjoyed. She was often "lost" in her immediate environment. Yet 12 days before her death, we talked calmly and rationally about our plans related to dying and who might die first. Later she thanked me for our talk.

see ***Viewpoints*** *on page 24*

Robert McAllister, M.D., Ph.D., is a retired private practitioner. In the 1960s, he taught at Catholic University and consulted at NSA; later he became the Nevada State Hospital superintendent and obtained the first NIMH grant in the Western Interstate Commission for Higher Education to construct a CMHC in Las Vegas. In the 1980s he went to Taylor Manor Hospital in Ellicott City, Md., and was the director of the Institute of Psychiatry and Religion and an adjunct professor at Loyola University for 20 years.

Data Point to Enzyme's Role in Stress, Depression

Experiments on neurons, stress hormones, and proteins clarify a chain of events that impair neural growth in a key part of the brain and suggest a new strategy to treat depression.

BY JUN YAN

New research by British scientists sheds light on how stress can cause a series of molecular events in the brain that blocks nerve-cell growth in the hippocampus, which is linked to depression and other dysfunctions.

These findings were published online May 6 in *Proceedings of the National Academy of Sciences* by Christoph Anacker, Ph.D., of the Institute of Psychiatry at King's College London, and colleagues.

The study points to an enzyme, known as serum- and glucocorticoid-regulated kinase 1 (SGK1), as a potential target for the development of new treatments for depression.

In past research, the proliferation and differentiation of neurons has been linked to the therapeutic effects of antidepressants. It has also been shown that patients with depression have chronically elevated glucocorticoids, hormones that are released under stressful conditions. The elevation of glucocorticoids activates the glucocorticoid receptor (GR) in the brain and blocks the process known as the Hedgehog signaling pathway, a key molecular process that "tells" stem cells to grow into specialized cells of various functions.

By adding cortisol to precursor cells of human hippocampal neurons, the researchers found that GR activation alone is not enough to block cell growth. Rather, this process is mediated by SGK1 and can be prevented by a small molecule that inhibits SGK1. In addition, the cortisol's negative effect on the Hedgehog signaling pathway and on reduced neurogenesis can be counteracted by the SGK1 inhibitor.

Curiously, the authors also discovered that, although SGK1 acts downstream from GR activation, the kinase also acts on GR and prolongs GR activation after cortisol is removed from the cell environment. Hours after cortisol is removed, SGK1 expression remains elevated and GR remains activated. The authors suggested that this mechanism may be responsible for long-lasting detrimental effect of stress on brain cells, even after glucocorticoids return to normal levels.

Beyond the in vitro experiments with neural stem cells, the researchers found additional evidence of SGK1's role in mice and humans. First, they analyzed blood samples taken from 25 depressed patients and 14 healthy controls who participated in the GENDEP clinical trial. The patients, who had been treatment free for at least two weeks before the test, had a 2.5-fold increase in the SGK1 mRNA level compared with the healthy controls, and the difference was statistically significant.

Next, mice were put under unpredictable chronic mild stress or prenatal stress. These types of stress have been shown to reduce neurogenesis in mouse hippocampus. Consistent with all the previous results, the mouse brain showed elevated

see **Enzyme** *on page 27*

CLINICAL & RESEARCH NEWS

Visual Perception Appears Heightened in Autism

Children with autism have more heightened visual sensitivity to moving objects than peers without autism, which may point to their brain's difficulty in filtering and controlling outside signals.

BY JUN YAN

What is it like to see the world through the eyes of a person with autism? Patients' subjective reports and brain research suggest it might be more chaotic and disturbing than a nonautistic person's experience. Understanding the sensory dysfunctions could lead to better treatment of the disorder.

A recent study, published in the May 8 *Journal of Neuroscience,* reports an unexpected finding that children with autism have a sharper visual perception of moving objects than healthy peers do.

In a computer-assisted experiment, children and adolescents aged 8 to 17 with and without autistic spectrum disorder were asked to look at a circle on a screen against a gray background. In the circle were parallel vertical black and white bars that shifted from left to right or from right to left at varying speeds. Subjects pressed a button on the keyboard to indicate the direction of the movement as they saw it. The more they answered correctly, the faster the bars moved, until the child could not see the motions clearly and got it wrong. The autism test group was matched in age and IQ to the healthy subject group.

Besides varying the speed of motion, the researchers used a high-contrast moving image and low-contrast moving image in the test (see chart). As one would expect, a low-contrast image is more difficult to see than a high-contrast image. In the low-contrast test, both groups performed similarly, but when the moving image became sharper in the high-contrast test, the children with autism significantly outperformed the healthy ones. In other words, the autistic patients could perceive movement more clearly than healthy children under the high-contrast condition.

"We went into the study hoping to measure just the spatial suppression in autistic patients because this is an inhibitory mechanism, and autism is suspected to involve excitatory/inhibitory imbalance," Duje Tadin, Ph.D., an assistant professor of Brain and Cognitive Sciences and Ophthalmology at the University of Rochester, one of the lead authors of the study, told *Psychiatric News*.

Spatial suppression refers to the somewhat counterintuitive phenomenon that when the size of a moving object is larger, the brain has more difficulty processing the image, Tadin explained. The brain suppresses visual perception of large moving objects because larger moving objects tend to be background motions and not very important in nature. The brain is better at recognizing smaller moving objects because they tend to be more important for humans to recognize clearly. Thus, the brain "blurs" large background moving objects through inhibition.

It has been theorized that the inhibitory function in patients with autism might be compromised. Although these researchers did observe some impairment in spatial suppression when both groups were tested with a low-contrast image, the results in the high-contrast test surprised them. The children with autism not only outperformed the healthy children but also showed a pattern of spatial suppression like the healthy children did. Tadin thinks that this observation can be explained by autistic children's enhanced performance at the high-contrast condition that compensated for a small effect of spatial suppression.

Why do children with autism recognize movements faster than the peers without the disorder? The researchers believe it points to dysfunction in contrast saturation, which refers to the brain's ability to cap the intensity of sensory stimuli at a certain level to prevent signal overload.

"It's a braking mechanism of the brain that dampens high-intensity stimuli," Tadin explained. "It's like listening to radio. If the volume is too low, you can't hear it, but if you turn it up too high, it hurts the ear. Your brain reaches a plateau at some point." And, he noted, this study seems to suggest that the autistic brain had difficulty dampening the intensity of the visual stimulus by improving performance more than did the nonautistic brain when the test went from low to high contrast.

"Since we published this study, I got a lot of calls and e-mails from autistic patients who say that this overstimulation extends to other senses, like hearing," he noted.

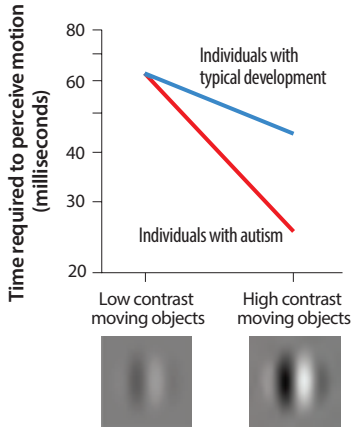
"We tend to consider autism as a social and behavioral disorder," Tadin pointed out, but growing evidence supports an excitatory/inhibitory imbalance as a major neurological pathology. "When the stimuli are too strong, the lights are too bright, the sound is too loud, social situations can be disturbing."

To further explore this theory, Tadin and colleagues plan to study possible impairments in other visual modalities such as brightness and color and other senses, as well as quantify the levels of contrast saturation. "The benefit of this visual test is that it's easy to measure accurately and quantify differences in patients, while behavioral symptoms can't be easily quantified," Tadin said.

Potential clinical use of the findings may be far away, however, Tadin admitted, as the excitatory/inhibitory pathways in the brain involve various interconnected circuits. GABA and glutamate transmissions are suspected of playing a key role. PN

Perception Differs

Children with and without autism were given a computerized visual test, in which motion was shown in vertical black-and-white bars at low and high contrast moving laterally. Autistic children were able to identify correctly the direction of motion faster than nonautistic children in the high-contrast but not the low-contrast test.



Source: Jennifer H. Foss-Feig, Ph.D., et al., *Journal of Neuroscience*, May 8, 2013

↗ An abstract of "A Substantial and Unexpected Enhancement of Motion Perception in Autism" is posted at http://www.jneurosci.org/content/33/19/8243.abstract.

Viewpoints

continued from page 22

She described her anger, her fears, her sadness. "It's terrifying to watch my feelings take over and put ideas in my head that I don't want to be there and cause me to say hurtful things I don't want to say," she said. When the storms subsided, she said she felt totally humiliated, scornful of herself, and deeply embarrassed. We spoke openly about these episodes. We called them "Alzheimer's storms" and likened them to summer storms that come and go, last minutes or hours, but always pass. Those lasting for days were blissfully forgotten. At lowest ebb, she wanted to die and threatened suicide. This was her greatest fear in the midst of an Alzheimer's storm: "Someday I will always be like this."

They say, "If you've seen one Alzheimer's patient, you've seen one Alzheimer's patient." I say, "If you listen long and carefully to one Alzheimer's patient, you will understand all Alzheimer's patients." PN

Creative Teaching

continued from page 18

with *DSM-IV* criteria for all resident-presented conferences. "So it won't be enough to talk about the diagnoses," he said. "We are going to ask each resident to say how they are different [from those in *DSM-IV*], and how the diagnoses they are talking about may be affected by evolving research knowledge."

Importantly, Benjamin said his institution would also be incorporating the NIMH Research Domain Criteria (RDoC) for learning purposes. In that program basic dimensions of functioning (such as fear circuitry or working memory) are being studied across multiple units of analysis, from genes to neural circuits to behaviors, cutting across disorders as traditionally defined by *DSM*.

So faculty, residents, and students would be thinking about both underlying neurocircuitry—which may be shared by multiple disorders—as well as the clusters of behavioral symptoms that are labeled in *DSM-5* for diagnostic purposes. "We believe having to think about two different systems will stretch us to do more," Benjamin said. "We are going to be emphasizing syndromes and neurobiology over nomenclature as this sinks in."

He added, "In terms of clerkships and electives, we think it's important to establish communication between residency, clerkship, and elective directors so that residents who are tutoring medical students are on the same page. We are going to recommend that our medical [school] faculty talk about how nosology changes and how research has led to these changes, and not be so concerned about the exact criteria."

Benjamin noted that one major change to a diagnostic category is the elimination of subtypes for schizophrenia. He said the schizophrenia criteria alone will offer a good platform for discussing why diagnostic criteria and nosology change over time.

"We think this is going to provide us an opportunity to review the history of *DSM* and of psychiatric nosology and to review etiological hypotheses by comparing classic descriptions of schizophrenia with the new *DSM-5* criteria," Benjamin said at the symposium. "I think it will

continued on facing page

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Program Presenter Full-Time	$200	$200	$270
Program Presenter Daily	$100	$100	$135
Program Presenter-Sunday Only	$50	$50	$70

NON-MEMBERS (continued)

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Course on Primary Care Skills for Psychiatrists	$165	$175	$190
Course on DSM-5	$325	$350	$380
Full-Day Course on Treating the Homeless Mentally Ill	Fee Exempt	Fee Exempt	Fee Exempt
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Non-Physician [3]	$255	$285	$315
Daily Registrant	$565	$600	$640
Daily Registrant-Sunday Only	$430	$450	$470
Program Presenter Full-Time	$500	$500	$570
Program Presenter Daily	$400	$400	$435
Program Presenter-Sunday Only	$350	$350	$370
Medical Student	$150	$150	$150
Spouse/Significant Other [4]	$560	$595	$635

1 Does not include APA Fellows, Distinguished Fellows, Distinguished Life Fellows, or Life Fellows.

2 Proper credentials, such as a copy of your ID, or letter from your program director must be submitted with your registration form or within 7 days of your online registration.

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4 This category is only for a spouse/significant other who is not an APA member and who resides at the same address as the main registrant.

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All registration and/or course cancellation requests must be received in writing by the APA Office (703- 907-1097 fax or registration@psych.org) by September 20, 2013. A confirmation will be sent once the request has been processed. Fee will be refunded in the manner in which it was received. Refund policy and cancellation fees are as follows:

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Begin the visa application process immediately. The visa process takes longer then you may anticipate. For further information, visit the State Department website at https://esta.cbp.dhs.gov.

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Attendees may pick up their registration badge and materials in Franklin Hall B, Level 4, Philadelphia Downtown Marriott during these times:

Wednesday, October 9	3:30 p.m. – 5:00 p.m. (Members Only)
Thursday, October 10	7:30 a.m. – 5:30 p.m.
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Recovered BPD Patients More Likely To Marry, Have Children

Recovery from borderline personality disorder, including stable marriage and childrearing, is quite possible but may happen later in life after patients have had time to deal with their illness.

BY MARK MORAN

Patients who meet criteria for recovery from borderline personality disorder (BPD) are more likely to marry and be parents than those who do not recover, and they are more likely to do so at an older age.

That's what Mary Zanarini, Ed.D., of McLean Hospital in Belmont, Mass., reported at a symposium on long-term outcome for BPD at APA's 2013 annual meeting in San Francisco last month. Zanarini—who is one of the leading researchers on BPD—discussed findings from the McLean Adult Development Study (MADS), which looked at marriage stability and parenting as variables in recovery from BPD.

"The study focuses on marriage or living stably with a partner and parenting because they are two of the main markers of successful adult adaptation," Zanarini told *Psychiatric News* prior to the meeting.

In the study, "recovery" from BPD was defined as being symptom-free, having at least one stable close relationship, and being employed.

The MADS was the first NIMH-funded prospective study of the longitudinal course of BPD. It involved 362 McLean inpatients assessed at baseline with eight waves of blind follow-up completed, including 2- , 4- , 6- , 8- , 10- , 12- , 14- , and 16-year data. (Data from the 18-year wave began in July 2010 and from the 20-year wave in July 2012.)

A total of 290 patients met *DSM-III-R* criteria for BPD. There were 72 Axis II comparison subjects meeting *DSM-III-R* criteria for another personality disorder but not for BPD.

By the time of the 16-year follow-up, 60 percent of BPD patients had achieved at least a two-year recovery. Interestingly, the failure to meet criteria for recovery was not due to a lack of remission of symptoms; in fact, 99 percent of those with BPD had at least a two-year remission by the time of the 16-year follow-up. Rather, it was the inability to work full time that was the most troublesome aspect of psychosocial functioning, Zanarini reported.

Mark Moran

Mary Zanarini, Ed.D., says that people with borderline personality disorder can be successful in a relationship or as a parent if they wait until they are symptomatically and psychosocially improved.

But what are the factors related to recovery?

Zanarini and colleagues found that recovered patients were significantly more likely to marry and have children—but that they tended to do this later in life. Correspondingly, they were less likely to divorce or to give up custody of their children. (She noted at the meeting that when patients did give up custody, it was typically voluntarily—rather than by mandate of the state—because they or family members felt they needed to be hospitalized or were too ill to attend to the children.)

Of recovered BPD patients, 78.7 were ever married or lived together for more than five years compared with just 39.3 of nonrecovered individuals. Average age of marriage or beginning of sustained cohabitation for recovered patients was 29, while the average age of marriage among nonrecovered patients was 25.

More striking, of recovered patients 42.4 percent had divorced, but 74.6 percent of nonrecovered patients had divorced.

Similarly, 49.3 percent of recovered patients had ever had or adopted a child, while only 30.7 percent of nonrecovered patients had. And parenthood, like marriage, tended to occur later in life for recovered patients (average age 29.6) than for nonrecovered individuals (22.6).

Zanarini also reported on factors that were associated with successful marriage and parenting. She found that absence of childhood sexual abuse and higher IQ were the most significant multivariate predictors of stable marriage or cohabitation. The multivariate predictors of stable parenting were higher IQ, absence of a history of drug abuse, and extraversion.

"We found that recovered BPD patients are more likely to marry than those who do not recover," Zanarini told *Psychiatric News*. "They marry for the first time at an older age when their lives are settled, and they are less likely to get a divorce. In the area of parenting, they are significantly more likely to have a child or adopt a child. They become a parent at a significantly older age and are less likely to lose or relinquish custody of their children."

What's the take-home message? "Clinicians should know that people with BPD can successfully marry or live with a partner in a stable relationship and become parents. But if they do these things while they are still acutely ill and when they are young, it is not as likely to turn out as well as if they wait, symptomatically and psychosocially improve quite a bit, and get a bit older and calmer—[in which case]it is quite likely to turn out well." PN

To listen to an audio interview of Mary Zanarini, Ed.D., scan the QR code at left or go to http://www.psychnews.org/update/audio/MARY_ZANARINI.mp3.

continued from facing page

really change the tenor of our seminars because we are going to be constantly looking at why these changes were made and what other research is going on."

Benjamin also emphasized the utility for teaching purposes of Section III in the revised manual, which includes patient-rated cross-cutting symptoms measures and dimensional and severity measures that are incorporated throughout the criteria. "This will be positive in terms of moving our field more toward using rating scales," he said.

Invariably there will be some logistical hurdles, particularly around the varying timetables for conversion to new criteria among different licensing and certifying exams. For instance, the Psychiatry Resident-In-Training Examination (PRITE) conversion to *DSM-5* criteria is slated for the 2014 exam, so that PGY-2 and -3 residents will be tested on the PRITE using *DSM-5* criteria but will be tested on the American Board of Psychiatry and Neurology (ABPN) exam using *DSM-IV* criteria. (The date for conversion to *DSM-5* criteria for the ABPN exam is September 2017.)

But Benjamin and fellow panel members emphasized that changing to the new diagnostic system, though it may involve some difficulty, can ultimately be a creative teaching opportunity.

"The conversion to *DSM-5* in educational institutions will require communication among student course, clerkship, and residency training directors, as well as with medical record-keeping and other departments and clinicians," he said. "But this is an opportunity, and I think we need to acknowledge the controversies and focus on evidence and the goals of diagnostic nosology." PN

David Hathcox

From left: Richard Summers, M.D., Sheldon Benjamin, M.D., and Laura Roberts, M.D., talk about including *DSM-5* in psychiatric education.

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Volkow

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which has no moral precepts?"

Other ideas about addiction have also changed in recent years, she said. Once it was thought that addicts were overly sensitive to dopaminergic effects, but now it appears that they have an attenuated response in the dopamine system to drug consumption.

Repeated drug use leads to less D_2 receptor pathway signaling, inhibiting sensitivity to reward, she said.

This makes evolutionary sense as the reward value of dopamine signaling shifts from consumption of drugs or food to expectation and stimulus.

"As in addiction, it motivates your behavior to get that reward," she said. "Once consumed, it doesn't matter. You don't need to motivate behavior then."

For example, simply showing videos to addicts of people using cocaine releases dopamine in the striatum and provokes a desire for the drug. This may also explain why it is better for psychiatrists to help patients avoid settings where they risk taking drugs, rather than having to intervene once they have started using again.

Yet another discovery is that addiction is not solely a property of the limbic system but also involves the prefrontal cortex, said Volkow. D_1 and D_2 receptors there are important for normal executive function. However, D_2 expression is lower during addiction to cocaine, methamphetamine, alcohol, heroin, and nicotine (but not marijuana). Reduced D_2 receptor signaling in addiction decreases inhibitory control in the prefrontal area, letting up on the neural "brakes" on compulsive drug use.

"That's why the process of addiction becomes so ingrained and why patients go to tremendous effort to get drugs at such a horrific price," she said. Awareness of deficits in the prefrontal cortex can help psychiatrists treat addicted individuals using approaches that allow them to assert better self-control, extinguish conditioned responses to drugs, and enhance the value of alternative rewards.

A third insight has come from genetic studies of smoking. Three alleles for nicotine receptors—α5, α3, and β4—are heavily concentrated in the habenula, a region that has been targeted by deep brain stimulation for treatment of depression.

"That may be related to the antidepressant properties of smoking," she speculated.

Nevertheless, no single area of the brain is implicated in addiction, she said. "Multiple circuits are disrupted as they are in other mental illnesses, like schizophrenia, ADHD, and mood disorders."

Perhaps as a consequence, the treatment of addiction requires a multipronged approach to strengthen brain circuits that have been impaired by the use of drugs, she said. Thus, in addition to research into behavioral and medi-

David Hathcox

Nora Volkow, M.D.: Increasing—and sometimes surprising—advances in research are fueling a better understanding of the mechanisms of drug addiction and potential treatments.

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cal treatments, NIDA also is funding a search for vaccines to produce antibodies that would bind to cocaine, heroin, methamphetamine, and other addictive substances in the bloodstream and prevent their entry into the brain.

"These are some of the most exciting areas of science in the field of drug addiction," said Volkow. PN

An extended discussion of addiction and reward circuitry by Nora Volkow and colleagues is posted at http://www.pnas.org/content/108/37/15037.full. To watch a video interview with Volkow, scan the QR code at left or go to http://www.youtube.com/watch?v=zXzU9uFF5G0.

Enzyme

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SGK1 mRNA in ventral and dorsal hippocampus after being exposed to stress. These areas of the hippocampus have been associated with mood and cognition.

Given the central role of SGK1 linking stress to reduced neuronal growth in the hippocampus, the authors suggested that "SKG1 may represent an antidepressant treatment strategy." PN

"Role for the Kinase SGK1 in Stress, Depression, and Glucocorticoid Effects on Hippocampal Neurogenesis" is posted at http://www.pnas.org/content/early/2013/05/03/1300886110.full.pdf.

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Lazarus

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as the only available response to gross inequity in access to quality health care, soaring medical costs, and a desire to better serve this country's citizens," Lazarus said. "The law was far from perfect, but it was best the vehicle available to reach some important goals. . . . Besides extending coverage to millions, it will promote care coordination, improve quality, and invest in prevention, all while reducing costs. Since then, the AMA has been working hard to make sure the ACA lives up to its promise."

He added that the new law benefits treatment of mental illness. "Because of the ACA, in 2014, plans can't exclude people with preexisting mental illness or substance use disorders," he said. "Moreover, they can't discriminate or drop coverage because the person has had a psychiatric illness. Clearly the end of lifetime and annual dollar limits helps those with chronic mental illness, as does the extension of coverage to those under 26, since many of these persistent long-term illnesses can emerge in the late teens and early 20s."

Lazarus noted that when health insurance exchanges kick in next year, mental health and substance use must be part of the core benefits package, and the coverage for mental health must be

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at parity with other medical benefits. Meanwhile, Medicaid expansion in a number of states will help combat the high rate of unaddressed mental illness among lower-income individuals and communities, he said.

Collaborative Care Works

Collaborative, or integrated, care has also been a focus of Lazarus's AMA presidential year. He said the ACA's emphasis on care coordination and team-based care creates incentives for pediatricians and other primary care physicians to work closely with psychiatrists, in-home care professionals, and others to address patient needs from a holistic perspective.

"The AMA has advocated for this approach for many years, and it is particularly important for at-risk children and adolescents," Lazarus said.

He said several states and communities have made progress linking or integrating the various components of care to improve connectivity and secure better outcomes for children by integrating residential and inpatient care with community-based care, family priorities into professional care plans, primary medical and mental health care, and children's mental health services and school-based services.

For adults, he cited the Diamond Initiative, a Minnesota-based program

see **Lazarus** *on page 30*

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Lazarus

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that helps primary care clinics more effectively care for patients with depression.

By the beginning of 2012, more than 8,000 adult patients with major depression or dysthymia had participated in the Diamond program. Twelve-month remission and response rates for Diamond patients were 53 percent and 70 percent, respectively, he reported.

"Because the Diamond program has been so successful, plans are under way to expand this approach to treat other chronic and behavioral health conditions and to provide a foundation for the design of a health-care home," Lazarus said.

Issues Gain Prominence

In recent years, the presence of psychiatry within the AMA House of Delegates has grown enormously—a fact of which Lazarus's presidency is a reflection. "Right now, the AMA has 38 psychiatrists in our House of Delegates and nearly 8,500 psychiatrists among our total membership—that's about 4 percent," he said. "And having psychiatrists in the highest offices of the AMA is a sure sign of the enormous respect psychiatry has attained within medicine generally.

"I can tell you that our presence has been important in keeping the focus on

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mental health," he said. "Improving the AMA's involvement in mental health initiatives has been one of my goals over the past year, because we know that you can no more separate the heart from the mind of a person any more than you can separate the heart from the lungs and expect the person to still function."

Lazarus concluded his remarks by saying that he believes there has been a shift in attitudes toward mental health and in funding for mental health care. He said this new attitude can be seen in the mandate for mental health coverage to be an essential benefit and in the growing focus on collaborative care; the expanded mental health coverage for Medicaid patients; the emphasis on community-based psychiatric services; and in increasing public, if not legislative, concern about violence and gun regulation.

"I am still not satisfied that all Americans who need mental health care will be able to receive it, but the country seems to be awakening to the great need that exists, and I believe we are beginning to take important steps forward," he said. "It remains up to us to maintain our vigilance so it is woven into the fabric of 21st-century health care." PN

To watch a video interview with Jeremy Lazarus, M.D., scan the QR code at left or go to http://www.youtube.com/watch?v=PxdOi1uuOsI.

Weight Gain

Weight gain has been observed with atypical antipsychotic use. Clinical monitoring of weight is recommended.

Across all short- and long-term studies, the overall mean change from baseline at endpoint was 2.1 kg.

Changes in body weight (kg) and the proportion of subjects with ≥7% gain in body weight from four placebo-controlled, 4- or 6-week, fixed- or flexible-dose studies in adult subjects are presented in Table 6.

Table 6: Change in Body Weight

	Placebo	FANAPT 10-16 mg/day	FANAPT 20-24 mg/day
	n=576	n=481	n=391
Weight (kg) Change from Baseline	-0.1	2.0	2.7
Weight Gain ≥7% increase from Baseline	4%	12%	18%

5.6 Seizures

In short-term placebo-controlled trials (4- to 6-weeks), seizures occurred in 0.1% (1/1344) of patients treated with FANAPT compared to 0.3% (2/587) on placebo. As with other antipsychotics, FANAPT should be used cautiously in patients with a history of seizures or with conditions that potentially lower the seizure threshold, e.g., Alzheimer's dementia. Conditions that lower the seizure threshold may be more prevalent in a population of 65 years or older.

5.7 Orthostatic Hypotension and Syncope

FANAPT can induce orthostatic hypotension associated with dizziness, tachycardia, and syncope. This reflects its alpha1-adrenergic antagonist properties. In double-blind placebo-controlled short-term studies, where the dose was increased slowly, as recommended above, syncope was reported in 0.4% (5/1344) of patients treated with FANAPT, compared with 0.2% (1/587) on placebo. Orthostatic hypotension was reported in 5% of patients given 20-24 mg/day, 3% of patients given 10-16 mg/day, and 1% of patients given placebo. More rapid titration would be expected to increase the rate of orthostatic hypotension and syncope.

FANAPT should be used with caution in patients with known cardiovascular disease (e.g., heart failure, history of myocardial infarction, ischemia, or conduction abnormalities), cerebrovascular disease, or conditions that predispose the patient to hypotension (dehydration, hypovolemia, and treatment with antihypertensive medications). Monitoring of orthostatic vital signs should be considered in patients who are vulnerable to hypotension.

5.8 Leukopenia, Neutropenia and Agranulocytosis

In clinical trial and postmarketing experience, events of leukopenia/neutropenia have been reported temporally related to antipsychotic agents. Agranulocytosis (including fatal cases) has also been reported.

Possible risk factors for leukopenia/neutropenia include preexisting low white blood cell count (WBC) and history of drug induced leukopenia/neutropenia. Patients with a pre-existing low WBC or a history of drug induced leukopenia/neutropenia should have their complete blood count (CBC) monitored frequently during the first few months of therapy and should discontinue FANAPT at the first sign of a decline in WBC in the absence of other causative factors.

Patients with neutropenia should be carefully monitored for fever or other symptoms or signs of infection and treated promptly if such symptoms or signs occur. Patients with severe neutropenia (absolute neutrophil count <1000/mm^3) should discontinue FANAPT and have their WBC followed until recovery.

5.9 Hyperprolactinemia

As with other drugs that antagonize dopamine D2 receptors, FANAPT elevates prolactin levels.

Hyperprolactinemia may suppress hypothalamic GnRH, resulting in reduced pituitary gonadotropin secretion. This, in turn, may inhibit reproductive function by impairing gonadalsteroidogenesis in both female and male patients. Galactorrhea, amenorrhea, gynecomastia, and impotence have been reported with prolactin-elevating compounds. Long-standing hyperprolactinemia when associated with hypogonadism may lead to decreased bone density in both female and male patients.

Tissue culture experiments indicate that approximately one-third of human breast cancers are prolactin-dependent *in vitro*, a factor of potential importance if the prescription of these drugs is contemplated in a patient with previously detected breast cancer. Mammary gland proliferative changes and increases in serum prolactin were seen in mice and rats treated with FANAPT *[see Nonclinical Toxicology (13.1) in the full prescribing information]*. Neither clinical studies nor epidemiologic studies conducted to date have shown an association between chronic administration of this class of drugs and tumorigenesis in humans; the available evidence is considered too limited to be conclusive at this time.

In a short-term placebo-controlled trial (4-weeks), the mean change from baseline to endpoint in plasma prolactin levels for the FANAPT 24 mg/day-treated group was an increase of 2.6 ng/mL compared to a decrease of 6.3 ng/mL in the placebo-group. In this trial, elevated plasma prolactin levels were observed in 26% of adults treated with FANAPT compared to 12% in the placebo group. In the short-term trials, FANAPT was associated with modest levels of prolactin elevation compared to greater prolactin elevations observed with some other antipsychotic agents. In pooled analysis from clinical studies including longer term trials, in 3210 adults treated with iloperidone, gynecomastia was reported in 2 male subjects (0.1%) compared to 0% in placebo-treated patients, and galactorrhea was reported in 8 female subjects (0.2%) compared to 3 female subjects (0.5%) in placebo-treated patients.

5.10 Body Temperature Regulation

Disruption of the body's ability to reduce core body temperature has been attributed to antipsychotic agents. Appropriate care is advised when prescribing FANAPT for patients who will be experiencing conditions which may contribute to an elevation in core body temperature, e.g., exercising strenuously, exposure to extreme heat, receiving concomitant medication with anticholinergic activity, or being subject to dehydration.

5.11 Dysphagia

Esophageal dysmotility and aspiration have been associated with antipsychotic drug use. Aspiration pneumonia is a common cause of morbidity and mortality in elderly patients, in particular those with advanced Alzheimer's dementia. FANAPT and other antipsychotic drugs should be used cautiously in patients at risk for aspiration pneumonia *[see Boxed Warning]*.

5.12 Suicide

The possibility of a suicide attempt is inherent in psychotic illness, and close supervision of high-risk patients should accompany drug therapy. Prescriptions for FANAPT should be written for the smallest quantity of tablets consistent with good patient management in order to reduce the risk of overdose.

5.13 Priapism

Three cases of priapism were reported in the pre-marketing FANAPT program. Drugs with alpha-adrenergic blocking effects have been reported to induce priapism. FANAPT shares this pharmacologic activity. Severe priapism may require surgical intervention.

5.14 Potential for Cognitive and Motor Impairment

FANAPT, like other antipsychotics, has the potential to impair judgment, thinking or motor skills. In short-term, placebo-controlled trials, somnolence (including sedation) was reported in 11.9% (104/874) of adult patients treated with FANAPT at doses of 10 mg/day or greater versus 5.3% (31/587) treated with placebo. Patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that therapy with FANAPT does not affect them adversely.

6 ADVERSE REACTIONS

6.1 Clinical Studies Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trial of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in clinical practice. The information below is derived from a clinical trial database for FANAPT consisting of 2070 patients exposed to FANAPT at doses of 10 mg/day or greater, for the treatment of schizophrenia. Of these, 806 received FANAPT for at least 6 months, with 463 exposed to FANAPT for at least 12 months. All of these patients who received FANAPT were participating in multiple-dose clinical trials. The conditions and duration of treatment with FANAPT varied greatly and included (in overlapping categories), open-label and double-blind phases of studies, inpatients and outpatients, fixed-dose and flexible-dose studies, and short-term and longer-term exposure.

Adverse reactions during exposure were obtained by general inquiry and recorded by clinical investigators using their own terminology. Consequently, to provide a meaningful estimate of the proportion of individuals experiencing adverse reactions, reactions were grouped in standardized categories using MedDRA terminology.

The stated frequencies of adverse reactions represent the proportions of individuals who experienced a treatment-emergent adverse reaction of the type listed. A reaction was considered treatment emergent if it occurred for the first time or worsened while receiving therapy following baseline evaluation.

The information presented in these sections was derived from pooled data from four placebo-controlled, 4- or 6-week, fixed- or flexible-dose studies in patients who received FANAPT at daily doses within a range of 10 to 24 mg (n=874).

Adverse Reactions Occurring at an Incidence of 2% or More among FANAPT-Treated Patients and More Frequent than Placebo

Table 7 enumerates the pooled incidences of treatment-emergent adverse reactions that were spontaneously reported in four placebo-controlled, 4- or 6-week, fixed- or flexible-dose studies, listing those reactions that occurred in 2% or more of patients treated with FANAPT in any of the dose groups, and for which the incidence in FANAPT-treated patients in any dose group was greater than the incidence in patients treated with placebo.

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From the Experts

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of problematic aggression per se.

In addition, when thinking about starting or continuing a medication trial for a given patient with maladaptive aggressive behavior, it appears to us that the characteristics of the aggressive behavior also matter. One might consider aggression to fall along a spectrum that on one end consists of reactive, emotional, or impulsive aggression and on the other end is characterized by planned and premeditated aggressive acts. Although this topic has not been extensively considered, it appears that only the impulsive and reactive aggressive behaviors are those that are potentially amenable to pharmacotherapy. Parents have told us that medication treatments give their children the ability to "think about what they want to do" rather than simply reacting to their environment without the ability to consider potential consequences.

As mentioned above, atypical antipsychotics appear to be the most commonly prescribed agents in this patient population. However, it should be noted that treatment options that do not include medication and pharmacological treatments from different classes of agents also have evidence to support their use in these vulnerable children.

If one is indeed faced with a youngster

Table 7: Treatment-Emergent Adverse Reactions in Short-Term, Fixed- or Flexible-Dose, Placebo-Controlled Trials in Adult Patients*

Body System or Organ Class Dictionary-derived Term	Percentage of Patients Reporting Reaction Placebo (N=587)	 FANAPT 10-16 mg/day (N=483)	 FANAPT 20-24 mg/day (N=391)
Body as a Whole			
Arthralgia	2	3	3
Fatigue	3	4	6
Musculoskeletal Stiffness	1	1	3
Weight Increased	1	1	9
Cardiac Disorders			
Tachycardia	1	3	12
Eye Disorders			
Vision Blurred	2	3	1
Gastrointestinal Disorders			
Nausea	8	7	10
Dry Mouth	1	8	10
Diarrhea	4	5	7
Abdominal Discomfort	1	1	3
Infections			
Nasopharyngitis	3	4	3
Upper Respiratory Tract Infection	1	2	3
Nervous System Disorders			
Dizziness	7	10	20
Somnolence	5	9	15
Extrapyramidal Disorder	4	5	4
Tremor	2	3	3
Lethargy	1	3	1
Reproductive System			
Ejaculation Failure	<1	2	2
Respiratory			
Nasal Congestion	2	5	8
Dyspnea	<1	2	2
Skin			
Rash	2	3	2
Vascular Disorders			
Orthostatic Hypotension	1	3	5
Hypotension	<1	<1	3

*Table includes adverse reactions that were reported in 2% or more of patients in any of the FANAPT dose groups and which occurred at greater incidence than in the placebo group. Figures rounded to the nearest integer.

Dose-Related Adverse Reactions in Clinical Trials
Based on the pooled data from four placebo-controlled, 4- or 6-week, fixed- or flexible-dose studies, adverse reactions that occurred with a greater than 2% incidence in the patients treated with FANAPT, and for which the incidence in patients treated with FANAPT 20-24 mg/day were twice than the incidence in patients treated with FANAPT 10-16 mg/day were: abdominal discomfort, dizziness, hypotension, musculoskeletal stiffness, tachycardia, and weight increased.

Common and Drug-Related Adverse Reactions in Clinical Trials
Based on the pooled data from four placebo-controlled, 4- or 6-week, fixed- or flexible-dose studies, the following adverse reactions occurred in ≥5% incidence in the patients treated with FANAPT and at least twice the placebo rate for at least one dose: dizziness, dry mouth, fatigue, nasal congestion, somnolence, tachycardia, orthostatic hypotension, and weight increased. Dizziness, tachycardia, and weight increased were at least twice as common on 20-24 mg/day as on 10-16 mg/day.

Extrapyramidal Symptoms (EPS) in Clinical Trials
Pooled data from the four placebo-controlled, 4- or 6-week, fixed- or flexible-dose studies provided information regarding treatment-emergent EPS. Adverse event data collected from those trials showed the following rates of EPS-related adverse events as shown in Table 8.

Table 8: Percentage of EPS Compared to Placebo

Adverse Event Term	Placebo (%) (N=587)	FANAPT 10-16 mg/day (%) (N=483)	FANAPT 20-24 mg/day (%) (N=391)
All EPS events	**11.6**	**13.5**	**15.1**
Akathisia	2.7	1.7	2.3
Bradykinesia	0	0.6	0.5
Dyskinesia	1.5	1.7	1.0
Dystonia	0.7	1.0	0.8
Parkinsonism	0	0.2	0.3
Tremor	1.9	2.5	3.1

Adverse Reactions Associated with Discontinuation of Treatment in Clinical Trials
Based on the pooled data from four placebo-controlled, 4- or 6-week, fixed- or flexible-dose studies, there was no difference in the incidence of discontinuation due to adverse events between FANAPT-treated (5%) and placebo-treated (5%) patients. The types of adverse events that led to discontinuation were similar for the FANAPT- and placebo-treated patients.

Demographic Differences in Adverse Reactions in Clinical Trials
An examination of population subgroups in the four placebo-controlled, 4- or 6-week, fixed- or flexible-dose studies did not reveal any evidence of differences in safety on the basis of age, gender or race *[see Warnings and Precautions (5.1)]*.

Laboratory Test Abnormalities in Clinical Trials
There were no differences between FANAPT and placebo in the incidence of discontinuation due to changes in hematology, urinalysis, or serum chemistry.

In short-term placebo-controlled trials (4- to 6-weeks), there were 1.0% (13/1342) iloperidone-treated patients with hematocrit at least one time below the extended normal range during post-randomization treatment, compared to 0.3% (2/585) on placebo. The extended normal range for lowered hematocrit was defined in each of these trials as the value 15% below the normal range for the centralized laboratory that was used in the trial.

Other Reactions During the Pre-marketing Evaluation of FANAPT
The following is a list of MedDRA terms that reflect treatment-emergent adverse reactions in patients treated with FANAPT at multiple doses ≥ 4 mg/day during any phase of a trial with the database of 3210 FANAPT-treated patients. All reported reactions are included except those already listed in Table 7, or other parts of the *Adverse Reactions (6)* section, those considered in the *Warnings and Precautions (5)*, those reaction terms which were so general as to be uninformative, reactions reported in fewer than 3 patients and which were neither serious nor life-threatening, reactions that are otherwise common as background reactions, and reactions considered unlikely to be drug related. It is important to emphasize that, although the reactions reported occurred during treatment with FANAPT, they were not necessarily caused by it.

Reactions are further categorized by MedDRA system organ class and listed in order of decreasing frequency according to the following definitions: frequent adverse events are those occurring in at least 1/100 patients (only those not listed in Table 7 appear in this listing); infrequent adverse reactions are those occurring in 1/100 to 1/1000 patients; rare events are those occurring in fewer than 1/1000 patients.

Blood and Lymphatic Disorders: Infrequent – anemia, iron deficiency anemia; *Rare* – leukopenia

Cardiac Disorders: Frequent – palpitations; *Rare* – arrhythmia, atrioventricular block first degree, cardiac failure (including congestive and acute)

Ear and Labyrinth Disorders: Infrequent – vertigo, tinnitus

Endocrine Disorders: Infrequent – hypothyroidism

Eye Disorders: Frequent - conjunctivitis (including allergic); *Infrequent* – dry eye, blepharitis, eyelid edema, eye swelling, lenticular opacities, cataract, hyperemia (including conjunctival)

Gastrointestinal Disorders: Infrequent – gastritis, salivary hypersecretion, fecal incontinence, mouth ulceration; *Rare* - aphthous stomatitis, duodenal ulcer, hiatus hernia, hyperchlorhydria, lip ulceration, reflux esophagitis, stomatitis

General Disorders and Administrative Site Conditions: Infrequent – edema (general, pitting, due to cardiac disease), difficulty in walking, thirst; *Rare* - hyperthermia

Hepatobiliary Disorders: Infrequent – cholelithiasis

Investigations: Frequent: weight decreased; *Infrequent* – hemoglobin decreased, neutrophil count increased, hematocrit decreased

Metabolism and Nutrition Disorders: Infrequent – increased appetite, dehydration, hypokalemia, fluid retention

Musculoskeletal and Connective Tissue Disorders: Frequent – myalgia, muscle spasms; *Rare* – torticollis

Nervous System Disorders: Infrequent – paresthesia, psychomotor hyperactivity, restlessness, amnesia, nystagmus; *Rare* – restless legs syndrome

Psychiatric Disorders: Frequent – restlessness, aggression, delusion; *Infrequent* – hostility, libido decreased, paranoia, anorgasmia, confusional state, mania, catatonia, mood swings, panic attack, obsessive-compulsive disorder, bulimia nervosa, delirium, polydipsia psychogenic, impulse-control disorder, major depression

Renal and Urinary Disorders: Frequent – urinary incontinence; *Infrequent* – dysuria, pollakiuria, enuresis, nephrolithiasis; *Rare* – urinary retention, renal failure acute

Reproductive System and Breast Disorders: Frequent – erectile dysfunction; *Infrequent* – testicular pain, amenorrhea, breast pain; *Rare* – menstruation irregular, gynecomastia, menorrhagia, metrorrhagia, postmenopausal hemorrhage, prostatitis.

Respiratory, Thoracic and Mediastinal Disorders: Infrequent – epistaxis, asthma, rhinorrhea, sinus congestion, nasal dryness; *Rare* – dry throat, sleep apnea syndrome, dyspnea exertional

6.2 Postmarketing Experience
The following adverse reactions have been identified during postapproval use of Fanapt: retrograde ejaculation. Because these reactions were reported voluntarily from a population of uncertain size, it is not possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

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with maladaptive aggression for whom pharmacotherapy might be appropriate, selecting a medication that has scientific evidence to support its use is recommended. However, we would also like to highlight that medication dosing matters. And it matters a lot. Treating doses that are too low may be ineffective. Doses that are too high can lead to unnecessarily high rates of side effects. In addition, although final medicine doses do matter, it is important that the correct starting dose is used, and if necessary, the correct rate at which dosing increases occur can also make the difference between a successful and unsuccessful treatment course.

In short, the approach to the pharmacotherapy of maladaptive aggression in children is similar to the one that a clinician might pursue when considering any psychopharmacological treatment for a child. Do a meticulous assessment while ensuring safety. Weigh the therapeutic options. Carefully think about the putative risks and benefits of the medications. But also thoughtfully consider the risks associated with continued dysfunction and suffering versus the possible benefits of symptom amelioration PN

The Rosato paper is posted at http://pediatrics.aappublications.org/content/129/6.toc; the Knapp paper is posted at http://pediatrics.aappublications.org/content/129/6/e1562.full.

7 DRUG INTERACTIONS

Given the primary CNS effects of FANAPT, caution should be used when it is taken in combination with other centrally acting drugs and alcohol. Due to its α1-adrenergic receptor antagonism, FANAPT has the potential to enhance the effect of certain antihypertensive agents.

7.1 Potential for Other Drugs to Affect FANAPT

Iloperidone is not a substrate for CYP1A1, CYP1A2, CYP2A6, CYP2B6, CYP2C8, CYP2C9, CYP2C19, or CYP2E1 enzymes. This suggests that an interaction of iloperidone with inhibitors or inducers of these enzymes, or other factors, like smoking, is unlikely.

Both CYP3A4 and CYP2D6 are responsible for iloperidone metabolism. Inhibitors of CYP3A4 (e.g., ketoconazole) or CYP2D6 (e.g., fluoxetine, paroxetine) can inhibit iloperidone elimination and cause increased blood levels.

Ketoconazole: Co-administration of ketoconazole (200 mg twice daily for 4 days), a potent inhibitor of CYP3A4, with a 3 mg single dose of iloperidone to 19 healthy volunteers, ages 18-45, increased the AUC of iloperidone and its metabolites P88 and P95 by 57%, 55% and 35%, respectively. Iloperidone doses should be reduced by about one-half when administered with ketoconazole or other strong inhibitors of CYP3A4 (e.g., itraconazole). Weaker inhibitors (e.g., erythromycin, grapefruit juice) have not been studied. When the CYP3A4 inhibitor is withdrawn from the combination therapy, the iloperidone dose should be returned to the previous level.

Fluoxetine: Co-administration of fluoxetine (20 mg twice daily for 21 days), a potent inhibitor of CYP2D6, with a single 3 mg dose of iloperidone to 23 healthy volunteers, ages 29-44, who were classified as CYP2D6 extensive metabolizers, increased the AUC of iloperidone and its metabolite P88, by about 2-3 fold, and decreased the AUC of its metabolite P95 by one-half. Iloperidone doses should be reduced by one-half when administered with fluoxetine. When fluoxetine is withdrawn from the combination therapy, the iloperidone dose should be returned to the previous level. Other strong inhibitors of CYP2D6 would be expected to have similar effects and would need appropriate dose reductions. When the CYP2D6 inhibitor is withdrawn from the combination therapy, iloperidone dose could then be increased to the previous level.

Paroxetine: Co-administration of paroxetine (20 mg/day for 5-8 days), a potent inhibitor of CYP2D6, with multiple doses of iloperidone (8 or 12 mg twice daily) to patients with schizophrenia ages 18-65 resulted in increased mean steady-state peak concentrations of iloperidone and its metabolite P88, by about 1.6 fold, and decreased mean steady-state peak concentrations of its metabolite P95 by one-half. Iloperidone doses should be reduced by one-half when administered with paroxetine. When paroxetine is withdrawn from the combination therapy, the iloperidone dose should be returned to the previous level. Other strong inhibitors of CYP2D6 would be expected to have similar effects and would need appropriate dose reductions. When the CYP2D6 inhibitor is withdrawn from the combination therapy, iloperidone dose could then be increased to previous levels.

Paroxetine and Ketoconazole: Co-administration of paroxetine (20 mg once daily for 10 days), a CYP2D6 inhibitor, and ketoconazole (200 mg twice daily) with multiple doses of iloperidone (8 or 12 mg twice daily) to patients with schizophrenia ages 18-65 resulted in a 1.4 fold increase in steady-state concentrations of iloperidone and its metabolite P88 and a 1.4 fold decrease in the P95 in the presence of paroxetine. So giving iloperidone with inhibitors of both of its metabolic pathways did not add to the effect of either inhibitor given alone. Iloperidone doses should therefore be reduced by about one-half if administered concomitantly with both a CYP2D6 and CYP3A4 inhibitor.

7.2 Potential for FANAPT to Affect Other Drugs

In vitro studies in human liver microsomes showed that iloperidone does not substantially inhibit the metabolism of drugs metabolized by the following cytochrome P450 isozymes: CYP1A1, CYP1A2, CYP2A6, CYP2B6, CYP2C8, CYP2C9, or CYP2E1. Based on *in vitro* studies, iloperidone is a time-dependent inhibitor of CYP3A at therapeutic exposure levels. Co-administration of iloperidone may lead to an increase in plasma levels of drugs that are predominantly eliminated by CYP3A4. Furthermore, *in vitro* studies in human liver microsomes showed that iloperidone does not have enzyme inducing properties, specifically for the following cytochrome P450 isozymes: CYP1A2, CYP2C8, CYP2C9, CYP2C19, CYP3A4 and CYP3A5.

Dextromethorphan: A study in healthy volunteers showed that changes in the pharmacokinetics of dextromethorphan (80 mg dose) when a 3 mg dose of iloperidone was co-administered resulted in a 17% increase in total exposure and a 26% increase in C_{max} of dextromethorphan. Thus, an interaction between iloperidone and other CYP2D6 substrates is unlikely.

Fluoxetine: A single 3 mg dose of iloperidone had no effect on the pharmacokinetics of fluoxetine (20 mg twice daily).

7.3 Drugs that Prolong the QT Interval

FANAPT should not be used with any other drugs that prolong the QT interval *[see Warnings and Precautions (5.2)]*.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Pregnancy Category C

FANAPT caused developmental toxicity, but was not teratogenic, in rats and rabbits.

In an embryo-fetal development study, pregnant rats were given 4, 16, or 64 mg/kg/day (1.6, 6.5, and 26 times the maximum recommended human dose [MRHD] of 24 mg/day on a mg/m^2 basis) of iloperidone orally during the period of organogenesis. The highest dose caused increased early intrauterine deaths, decreased fetal weight and length, decreased fetal skeletal ossification, and an increased incidence of minor fetal skeletal anomalies and variations; this dose also caused decreased maternal food consumption and weight gain.

In an embryo-fetal development study, pregnant rabbits were given 4, 10, or 25 mg/kg/day (3, 8, and 20 times the MRHD on a mg/m^2 basis) of iloperidone during the period of organogenesis. The highest dose caused increased early intrauterine deaths and decreased fetal viability at term; this dose also caused maternal toxicity.

In additional studies in which rats were given iloperidone at doses similar to the above beginning from either pre-conception or from day 17 of gestation and continuing through weaning, adverse reproductive effects included prolonged pregnancy and parturition, increased stillbirth rates, increased incidence of fetal visceral variations, decreased fetal and pup weights, and decreased post-partum pup survival. There were no drug effects on the neurobehavioral or reproductive development of the surviving pups. No-effect doses ranged from 4 to 12 mg/kg except for the increase in stillbirth rates which occurred at the lowest dose tested of 4 mg/kg, which is 1.6 times the MRHD on a mg/m^2 basis. Maternal toxicity was seen at the higher doses in these studies.

The iloperidone metabolite P95, which is a major circulating metabolite of iloperidone in humans but is not present in significant amounts in rats, was given to pregnant rats during the period of organogenesis at oral doses of 20, 80, or 200 mg/kg/day. No teratogenic effects were seen. Delayed skeletal ossification occurred at all doses. No significant maternal toxicity was produced. Plasma levels of P95 (AUC) at the highest dose tested were 2 times those in humans receiving the MRHD of iloperidone.

There are no adequate and well-controlled studies in pregnant women.

Non-Teratogenic Effects

Neonates exposed to antipsychotic drugs, during the third trimester of pregnancy are at risk for extrapyramidal and/or withdrawal symptoms following delivery. There have been reports of agitation, hypertonia, hypotonia, tremor, somnolence, respiratory distress and feeding disorder in these neonates. These complications have varied in severity; while in some cases symptoms have been self-limited, in other cases neonates have required intensive care unit support and prolonged hospitalization.

FANAPT should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

8.2 Labor and Delivery

The effect of FANAPT on labor and delivery in humans is unknown.

8.3 Nursing Mothers

FANAPT was excreted in milk of rats during lactation. It is not known whether FANAPT or its metabolites are excreted in human milk. It is recommended that women receiving FANAPT should not breast feed.

8.4 Pediatric Use

Safety and effectiveness in pediatric and adolescent patients have not been established.

8.5 Geriatric Use

Clinical Studies of FANAPT in the treatment of schizophrenia did not include sufficient numbers of patients aged 65 years and over to determine whether or not they respond differently than younger adult patients. Of the 3210 patients treated with FANAPT in pre-marketing trials, 25 (0.5%) were ≥65 years old and there were no patients ≥75 years old.

Studies of elderly patients with psychosis associated with Alzheimer's disease have suggested that there may be a different tolerability profile (i.e., increased risk in mortality and cerebrovascular events including stroke) in this population compared to younger patients with schizophrenia *[see Boxed Warning and Warnings and Precautions (5.1)]*. The safety and efficacy of FANAPT in the treatment of patients with psychosis associated with Alzheimer's disease has not been established. If the prescriber elects to treat such patients with FANAPT, vigilance should be exercised.

8.6 Renal Impairment

Because FANAPT is highly metabolized, with less than 1% of the drug excreted unchanged, renal impairment alone is unlikely to have a significant impact on the pharmacokinetics of FANAPT. Renal impairment (creatinine clearance <30 mL/min) had minimal effect on maximum plasma concentrations (C_{max}) of iloperidone (given in a single dose of 3 mg) and its metabolites P88 and P95 in any of the three analytes measured. $AUC_{0-\infty}$ was increased by 24%, decreased by 6%, and increased by 52% for iloperidone, P88 and P95, respectively, in subjects with renal impairment.

8.7 Hepatic Impairment

A study in mild and moderate liver impairment has not been conducted. FANAPT is not recommended for patients with hepatic impairment.

8.8 Smoking Status

Based on *in vitro* studies utilizing human liver enzymes, FANAPT is not a substrate for CYP1A2; smoking should therefore not have an effect on the pharmacokinetics of FANAPT.

LETTERS TO THE EDITOR

More Prevention Efforts Needed

On January 8, James Aune, professor and head of the Communication Department at Texas A&M University, jumped to his death off the north-side parking garage. He was warm, bright and creative and admired by students and colleagues. As the McMillan Professor of Analytical Psychology at Texas A&M for 25 years, I knew this individual and campus well.

Tragically, now two families are left without this unique, brilliant, and caring human being: his personal family (his wife, Miriam; sons Nick and Dan; and dog) and the Aggie family (thousands of students, faculty, staff, and a dog). These families are left without his tenderness and ability to teach and reach others.

As a researcher of depression and suicide, I wonder about the meaning of Prof. Aune's self-destruction. Jumping off a building onto concrete must be a horrible way to die. Even though no suicide note was found, his action speaks louder than words. So what was this scholar of communication communicating?

Having interviewed survivors of suicidal jumps off the Golden Gate Bridge, I know that no one really wants to commit suicide. All of the survivors whom I interviewed wanted a suicide barrier erected on the bridge. None of the survivors went on to commit suicide. Having survived sure death, these 10 survivors have a lot to teach us (see Scott Anderson, "The Urge to End it All," *New York Times Magazine*, July 6, 2008). They reported that the ego identity died, thus shedding the suicidal self. That's why I coined the term egocide.

Albert Camus said, "There is but one truly serious philosophical problem, and that is suicide." We need more education and therapy to assist those troubled souls, like Prof. Aune, to hold on, get help, and not choose suicide. The issue of melancholy has plagued me during stressful periods, and the subjective became the basis for objective study. The maxim of my research team is "research is me-search." William James, also a physician, who suffered from suicidal depression and transformed it, has been a major influence in my life.

It is telling that in Prof. Aune's last blog, he posted one of Rudyard Kipling's poems about holding on after being lied to and hated. Let's view what he did as a huge cry for help. A fitting legacy and tribute to this favorite professor would be the prevention of future suicides. In addition to more research, we need to emphasize that the key is in finding the courage to ask for and receive mental health care.

We in academia ought to be doing a better job to reduce the stigma of seeing counselors and psychotherapists when depressed and suicidal. There are ways to assess hopelessness, depression, and suicidal ideation, and many ways to help those who need it.

DAVID H. ROSEN, M.D.
Eugene, Ore.

Letters Invited

Readers are invited to submit letters up to 500 words long for possible publication. *Psychiatric News* reserves the right to edit letters and to publish them in all editions, print, electronic, or other media. Receipt of letters is not acknowledged. Letters should be sent by mail to *Psychiatric News*, APA, Suite 1825, 1000 Wilson Boulevard, Arlington, Va. 22209 or by e-mail to *c*brown@psych.org. Clinical opinions in letters are not peer reviewed and thus should be independently verified.

China

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have displayed during wars and the Cultural Revolution as they have struggled to survive," Tse told *Psychiatric News.*

In addition to providing community mental health services guided by a mental illness recovery philosophy, the families of individuals with severe mental illness also need to be supported and guided, Tse and colleagues maintained. "Up to 80 percent of individuals with mental illness in China (especially in rural areas) are looked after by family members at home, by choice or otherwise," they said. "This figure will increase as the National Mental Health Law is implemented."

They also pointed out that the Internet, smart phones, and social media in China can be used to "promote self-help and reduce stigma associated with severe mental illness," especially among younger Chinese.

A critical question, of course, is how much money the Chinese government will be willing to pay for such service expansions, Tse and his colleagues said. An encouraging sign, though, is that "the government is planning to increase the mental health budget from 3 to 4 percent of the total national health budget in 2010 to 7 to 8 percent by 2015."

Samuel Law, M.D., an assistant professor of psychiatry at the University of Toronto who is helping develop the first Assertive Community Treatment (ACT) team in China, commented on the report by Tse and colleagues for *Psychiatric News.*

"It is well researched," he said. "I think the information is current and that the recent mental health reforms in China have substance—they are not just another empty political campaign.... I would add that there is tremendous energy in some mental health sectors in China today. I work with some of them and am impressed by their commitment and ambition."

However, Law does have a criticism of the current thrust to create community mental health care in China. "One cannot have meaningful community mental health care without social safety-net reform. China has no unemployment security; the current health insurance is woefully not in keeping with actual medical care costs, and welfare for the indigent is still a remote idea. Thus mentally ill individuals are not likely to spend precious time and resources to seek or secure care." PN

Bartlomiej Magierowski/Shutterstock

Now that China has a national mental health law, the challenge is to make community mental health services available to villages such as this one—a village in Guanxi, an autonomous region in southern China.

"The Urgency of Now: Building a Recovery-Oriented, Community Mental Health Service in China" is posted at http://ps.psychiatryonline.org. The report also constitutes a new column in *Psychiatric Services* called "Mental Health Reforms in Asia."

Jeste

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Affordable Care Act "plus his proven leadership of large organizations will come in handy as we adapt to and take a leadership role in mental health care reform."

Jeste also noted APA's involvement in working to ensure that insurance companies comply with the federal parity law and in efforts to secure better reimbursement for psychiatrists treating Medicare and Medicaid patients.

Jeste drew attention to the traumatic events that occurred during his presidential year and that called for a response from APA. "We all have been deeply touched and saddened by the senseless gun violence in Tucson, Aurora, and Newtown," Jeste said. "APA and the district branches stepped forward to provide critical help to the local communities. There has been an unfortunate tendency in some quarters to equate mental illness with violence. But we must remind others that 96 percent of the violent crimes are unrelated to mental illness and that people with mental illnesses are far more likely to be victims than perpetrators of crime. At the same time, we must improve the access to care for people with serious mental illnesses. I recently formed an APA-led coalition of physician organizations, including the AMA, that will develop recommendations for enhancing mental health care as well as reducing the stigma of violence."

Jeste drew on his own immigrant experience to hail the diversity of the United States and of APA.

"APA is truly a microcosm of our country," he said. "The country's motto 'E pluribus unum,' meaning 'one out of many,' reflects on both its diversity and unity. America is not really a melting pot—it is more like a salad bowl or a cultural mosaic, in which different groups retain their uniqueness, but serve a common goal. I think the same applies to APA too. APA members differ in age, gender, ethnicity, subspecialty, type of practice, political views, whatever; yet we all are united around the common goal of promoting the highest-quality health care for people with mental illnesses."

He concluded his address with a reflection on his experience as a geriatric psychiatrist and his belief that successful aging is not an oxymoron but a scientific fact, emphasizing that a "positive psychiatry" of the future will be essential in an aging population.

"I am convinced that life begins at age 50," he said. "Studies show that quality of well-being follows a U-shaped curve. It is pretty high in the early 20s, then starts going down and hits rock bottom around 50—that is the time of midlife crisis. But then, people change their jobs or partners, or just their attitudes and behaviors, and the well-being starts going up progressively into their 50s, 60s, 70s, and 80s. Quality of life and psychosocial functioning depend less on physical health and more on positive psychological traits like resilience, optimism, social engagement, and wisdom. . . . Some of the most exciting neuroscience research during the past two decades has shown conclusive evidence of neuroplasticity of aging. . . . I expect that the future role of psychiatry will be much broader than treating psychiatric symptoms. It will seek to enhance the well-being of people with mental or physical illnesses. That is Positive Psychiatry. We will learn more about brain processes responsible for these traits, and we will seek new ways to promote resilience, optimism, and wisdom, through psychotherapeutic interventions." PN

Jeste was interviewed by *Psychiatric News* Editor-in-Chief Jeffrey Borenstein, M.D., during the annual meeting. To watch the video, scan the QR code at left or go to http://www.youtube.com/watch?v=frt6YYPIFEQ.

Public Policies

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ties and families, and she has attended city planning meetings with them. The Civic Arena was torn down in 2012, and today, due in part to their involvement in planning meetings, Fullilove sees a different kind of hope in the futures of remaining Hill District residents.

Annelle Primm, M.D., M.P.H., called Fullilove's work "truly groundbreaking" and noted that "through her meticulous and comprehensive study of the history of the African-American community in the Hill District of Pittsburgh, she has synthesized a narrative that reveals the succession of multiple destructive policies at the root of its decline and that of many other urban communities around the country." Primm is deputy medical director and director of the Office of Minority and National Affairs at APA.

Primm described these policies as social determinants of health that go hand in hand with poverty, segregated housing, job discrimination, and other negative forces that exact a heavy toll on community mental health and social well-being.

"As psychiatrists, we need to be concerned with treating the adverse effects of these forces on mental health and working with community residents to foster resilience. Simultaneously, psychiatrists have a role to play in collaborating with community leaders to focus on 'upstream' issues and advocate for social policies that generate a strong social fabric, healthy environments, and thriving communities." PN

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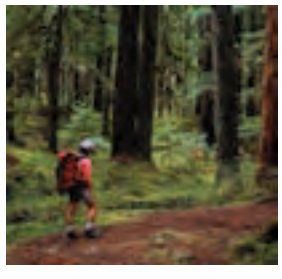

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UC DAVIS SCHOOL OF MEDICINE
DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES

Assistant/Associate Professor of Clinical Psychiatry
AREA: EARLY INTERVENTION FOR CHILDREN AND FAMILIES WITH ASD
CLINICAL LICENSE AND M.D. or PH.D. REQUIRED
START DATE: NEGOTIABLE, JULY 2014 OR LATER

A faculty position in the Department of Psychiatry and Behavioral Sciences at the University of California, Davis and the MIND Institute, at the rank of Assistant or Associate Professor of Clinical Psychiatry has been opened. The successful candidate will have both a research and clinical background in the treatment of autism spectrum disorders with a particular focus on early childhood.

Candidates must have a track record of independent funding, including NIH funds, strong research productivity, as well as clinical expertise in the treatment of young children with ASD, and their families. Candidates with a PhD in clinical psychology or an MD in child and adolescent psychiatry are required. These candidates must have current California clinical license, or be eligible for licensure in California. Candidates in other disciplines, such as occupational therapy, or speech and language pathology, would also be considered. However, they must have a PhD or equivalent doctoral degree and be licensed. All candidates, regardless of discipline, must be able to develop his/her own area of science within a larger multi-investigator program of research in early identification and treatment of ASD and other neurodevelopmental disorders.

This is primarily a research position with opportunities for a licensed candidate to provide clinical care. The candidates will also have the opportunity to teach at in-service, graduate and postgraduate levels. The position will be in the department of Psychiatry and Behavioral Sciences; however, the successful candidate will also be a member of the UC Davis MIND Institute. See www.ucdmc.ucdavis.edu/psychiatry

For full consideration, applications must be received by June 30, 2013. However, the position will remain open until filled through September 30, 2013.

Interested candidates should email a curriculum vitae and letter of interest in response to **Position #PY-05R-13 to Nicole Prine at Nicole.prine@ucdmc.ucdavis.edu**.
For more information concerning these positions, please contact the search committee chair **Dr. Leonard Abbeduto, PhD, MIND Institute Director at leonard.abbeduto@ucdmc.ucdavis.edu.**

In conformance with applicable law and University policy, the University of California, Davis, is an equal opportunity/affirmative action employer.

http://www.ucdmc.ucdavis.edu/psychiatry/

UC DAVIS SCHOOL OF MEDICINE
DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES

Health Sciences Assistant/Associate Clinical Professor
Outpatient Clinic

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For full consideration, applications must be received by September 1, 2013. However, the position will remain open until filled through November 1, 2013.

Interested candidates should email a curriculum vitae and letter of interest in response to **Nicole Prine at Nicole.prine@ucdmc.ucdavis.edu.**

For more information concerning these positions, please contact
the search committee chair, Dr. Glen Xiong at rehales@ucdavis.edu

Please make sure you reference Search #PY-06R-13 on all correspondence

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Emergency Psychiatrist
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Preferred: Clinical experience in a Comprehensive Psychiatric Emergency Program or other emergency psychiatric setting. Track record of research/teaching experience in Emergency Psychiatry.

To qualify for a senior faculty appointment, the candidate must meet the criteria established by the School of Medicine (School of Medicine's Criteria for Appointment, Promotion and Tenure) for Appointment, Promotion and Tenure.

To apply submit a cover letter and résumé/CV to: Ramin Parsey, MD, PhD, Chair
Department of Psychiatry and Behavioral Science Health Sciences Tower, T-010,
Room 020, Stony Brook University
Stony Brook, NY 11794-8101
Fax #: (631) 444-1560

For a full position description, application procedures or to apply online, visit
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Stony Brook Medicine

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Linda H. Chaudron, MD, MS
Professor of Psychiatry, Associate Chair, Clinical Services
Department of Psychiatry
University of Rochester Medical Center
300 Crittenden Boulevard
Rochester, NY 14642-8409
E-mail: Linda_Chaudron@urmc.rochester.edu
Phone: (585)273-2113; **Fax**: 585-273-1066

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- **OREGON** – Portland (Beaverton)
- **PENNSYLVANIA**–Philadelphia-Clarion
- **SOUTH CAROLINA** – Aiken - Columbia
- **TENNESSEE** - Nashville and Memphis
- **TEXAS** – Sherman – McAllen – Dallas - Austin
- **UTAH** – Salt Lake City and Provo/Orem
- **VIRGINIA** – Portsmouth - Norfolk - Virginia Beach - Leesburg
- **WASHINGTON** – Seattle area
- **WEST VIRGINIA** – Huntington

For more information about these and other locations and positions contact: **Joy Lankswert, UHS In-house Physician Recruitment @ 866-227-5415 ext: 222 or email joy.lankswert@uhsinc.com.** See all UHS positions and facilities at www.physician-practiceopportunities.com

ARKANSAS

LITTLE ROCK: Child, General & Geriatric Psychiatrists. Inpatient & Partial Services. Fulltime positions offering salary, benefits & bonus opportunity. Contact Tiffany Crawford, In-house recruiter @ 866-227-5415; OR email tiffany.crawford@uhsinc.com.

Horizon Health seeks a **Medical Director** for our 15-bed Geriatric inpatient psychiatric program our client hospital **National Park Medical Center in Hot Springs, AR**. Experience with geriatric population preferred. Excellent income and practice opportunity. For more information contact: Mark Blakeney, Voice: 972-420-7473, Fax: 972-420-8233; email: mark.blakeney@horizonhealth.com EOE.

CALIFORNIA

Kaweah Delta Health Care District (KDHCD) is proud to announce the ACGME accreditation of its exciting new residency program in Psychiatry www.kdgme.org/. Located in the historic Central Valley of California at the foothills of the Sequoia National Forest, KDHCD offers a low cost-of-living and family-friendly environment in the 200th largest city in the U.S. We will be accepting ERAS applications for four PGY-1 Resident positions to begin in July 2014. KDHCD Psychiatry has over 20 faculty members to provide excellent training in a highly multi-cultural environment. We are also accepting CVs for additional faculty positions that include protected research time and possible appointment to the University of California at Irvine School of Medicine. For more information, please contact the Program Coordinator at kdgme@kdhcd.org.

BEAUTIFUL NORTHERN CALIFORNIA POSITION
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- Full-time position, Monday - Friday, 8 a.m.- 5 p.m.
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For further info contact
Pamela Mayhew
Practice Administrator, at:
pmayhew@therapeuticsolutionspc.com.

ADULT PSYCHIATRISTS

County of San Diego's Health & Human Services Agency needs psychiatrists for key components in the Behavioral Health Division's continuum of care. Our Psychiatrists work with a dynamic team of medical and nursing professionals to provide outpatient treatment, telepsychiatry, inpatient and emergency services, and crisis intervention. More information about the position can be found at: www.sdcounty.ca.gov/hr.**Contact Gloria Brown at 858-505-6525 or email CV to Gloria.Brown@sdcounty.ca.gov.**

Please specify clinical area of interest.

An Outpatient Adult Psychiatrist is needed for Stanislaus County Behavioral Health & Recovery Services, in the Central Valley less than two hours from San Francisco and Yosemite. Recovery-oriented treatment provided in a multidisciplinary setting. Excellent salary scale with steps starting from 179K to 217K; additional 5% differential for board certification. No call requirements at this time. Full benefit package including medical, vision/dental, vacation, sick time. Excellent retirement package with deferred comp. plan avail.

Fax CV to Uday Mukherjee, MD at
(209) 525-6291 or
Email: umukherjee@stanbhrs.org.

Chief of Psychiatry

The Greater Los Angeles Health Care System (GLA) is seeking a full-time Chief of Psychiatry/ACOS for Mental Health (MH), to oversee inpatient and outpatient MH care provided to Veterans living in the Greater Los Angeles Area and to direct all of psychiatric care. GLA is the largest healthcare system in the VA with outstanding clinical, education, research and residency programs. This physician will serve as the Associate Chief of Staff for Mental Health and Psychiatry. The individual will participate in patient care, teaching, research and administrative activities of the Department, as assigned.

Candidate must be board certified Psychiatrist with qualification to provide leadership as Chief of Psychiatry and ACOS of MH at the Greater Los Angeles Health Care System (GLA). Candidates must also: (1)be a U.S. citizen or must have proper authorization to work in the United States (2) possess a current, full and unrestricted license to practice in a state, territory or commonwealth of the United States or District of Columbia; (3) be proficient in spoken and written English, and (4) pass a pre-employment physical. Direct Deposit is required. The position is subject to random drug testing. A recruitment incentive may be offered to secure a highly-qualified candidate.

Interested candidates must apply online at www.USAJobs.gov using announcement number 13-852956-TCM. You must submit a application VAF 10-2850 (Application for Physician and Dentist) http://www.va.gov/vaforms/medical/pdf/vha-10-2850-fill.pdf, Curriculum Vitae, and answer the questionnaire.

The Department of Veterans Affairs is an Equal Opportunity Employer.

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PSYCHIATRIST
Oakland, CA
(San Francisco Bay Area)

La Clínica de La Raza seeks a lead psychiatrist in a community based mental health clinic serving adults and children. Spanish speaking preferred but not required. Competitive salary and benefits. Federally Qualified Health Center- site eligible for **NHSC loan repayment opportunity.** Regular schedule, no nights/weekends. Position provides clinical leadership and direct services for adults with serious mental illness as well as short term outpatient stabilization. Fast paced environment, looking for innovative collaborative team leader committed to wellness and recovery. Please send letter of interest and CV to Leslie Preston at Lpreston@laclinica.org.

COLORADO

Denver Health Medical Center is recruiting for a Director of Correctional Care Behavioral Health Services for the Denver city jail and Denver County jail.

The director oversees the comprehensive behavioral health programs at the jails and provides supervision of a multidisciplinary mental health team. The Denver jails are accredited by NCCHC and ACA and were recently nominated for facility of the year by NCCHC. The director will have an academic appointment though the department of psychiatry at the University of Colorado School of Medicine and the Forensic Psychiatry fellowship. Completion of a forensic psychiatry fellowship preferred. Interested applicants should send a Curriculum Vitae to Jeanette Moore at jeanette.moore@dhha.org or call Robert M. House, MD, Director Behavioral Health at 303-602-6923 if you have questions.

Denver Health is committed to diversity and equal opportunity.

Horizon Health seeks an **Attending Psychiatrist** for a new 22-bed Senior Behavioral Health program at our client hospital **Exempla Lutheran Medical Center** in **Wheat Ridge, CO.** Excellent practice opportunity and income. For more information contact: Mark Blakeney, Voice: 972-420-7473, Fax: 972-420-8233; email: mark.blakeney@horizonhealth.com. EOE

DISTRICT OF COLUMBIA

Psychiatry Hospitalist Position

The Department of Psychiatry and Behavioral Sciences at The George Washington University Medical Faculty Associates, an independent non-profit clinical practice group affiliated with The George Washington University, is seeking an academic hospitalist psychiatrist for a full-time appointment. The position will include: 1) serving on the GWU psychiatry hospitalist team which covers the medical-surgery units, the inpatient psychiatric service, and the emergency room; 2) opportunities for medical student and resident education; 3) outpatient psychiatry and clinical research. Basic Qualifications: Applicants must be license eligible in the District of Columbia; Board Certified in General Psychiatry; and Subspecialty Board Certified in Psychosomatic Medicine. Academic rank and salary will be that of an Assistant Professor.

Review of applications begins June 21, 2013, and will continue until the position is filled. Application procedure: To be considered, please complete an online faculty application at http://www.gwu.jobs/postings/15643, and upload a cover letter and curriculum vitae. Please send three letters of recommendation (including one from the Fellowship Director, if applicable) to:

James L. Griffith, MD
Interim Chair and Professor
Department of Psychiatry and Behavioral Sciences
2120 L Street, NW, Suite 600
Washington, DC 20037

Only complete applications will be considered.

The George Washington University Medical Faculty Associates is an Equal Opportunity/Affirmative Action Employer

FLORIDA

PSYCHIATRIST; FULL TIME, FL LICENSE REQUIRED; Aventura, FL; private practice located equidistant between Miami and Ft. Lauderdale; children/adolescent/adult/geriatric pts; email CV to aventuraoffices@bellsouth.net or FAX to Dusty: 305-935-1717.

UNLIMITED INCOME. Clearwater, Destin, Jacksonville, Kissimmee, Melbourne, Sarasota, or Winter Park. Consultation practice, full or part-time. NO CALL. Great salary and benefits package based on production. We are a reputable, ethics-based practice with a team approach to nursing home patient care. Call Linda at 866-936-5250.

Private practice opportunity in a nice area, with back up of residential treatment program with partial and intensive outpatient dimensions. Sophisticated clinical team to work with you. Full time is desired. Part time will be considered. Please fax CV to (727) 441-2849. Contact Debbie Coon, RN for additional information at (727) 446-2005.

GEORGIA

The State of Georgia Department of Behavioral Health and Developmental Disabilities is currently recruiting for board-certified and board eligible psychiatrist to work at one of our six hospitals located throughout the following cities in Georgia: Atlanta, Savannah, Milledgeville, Thomasville, Columbus, Augusta. We have current openings for full-time, part-time and hourly Psychiatrists. Positions are available on both acute and chronic forensic and adult mental health units. All psychiatrists will lead a multi-disciplinary team of professionals providing quality care to both voluntary and involuntary patients. Our state facilities provide academic affiliations and promote academic collaborations, along with an excellent benefits package and competitive salary. Please forward your CV to ncnathaniel@dhr.state.ga.us

Come join our incredible behavioral health team. Come to the Peach State!!!

PSYCHIATRIST

New Horizons Community Service Board in Columbus, Georgia is seeking an Adult Psychiatrist for its Outpatient/Court Services programs. This growing community offers a pleasing climate and is situated within a short distance to Atlanta and the Gulf Coast. The qualified applicant will possess or be eligible for a valid physician's license from the state of Georgia, have completed a three-year residency in an accredited facility and be board eligible or board certified. Excellent salary with a comprehensive benefits package. Interested parties should send their curriculum vitae to:

Shannon Robertson
srobertson@newhorizonscsb.org
706/317-5001
706/317-5004 (Fax)

IDAHO

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Outpatient Psychiatry Positions

The Boise VA Medical Center seeks two full-time BC/BE outpatient psychiatrists. Ideal candidates would join our collegial staff in embracing compassionate care, clinical excellence, teamwork, and enthusiasm for teaching. In addition to an outpatient caseload, responsibilities may include telepsychiatry, integrated care collaboration, clinical research, and supervision of medical students and PGY3/4 psychiatry residents from the University of Washington (UW). On-call duties are approximately 1 in10. Come join our mission to make a difference in the lives of the veterans we serve.

Boise, Idaho has a temperate climate, affordable housing, good schools, low crime rate, a family friendly culture, world class outdoor activities, and all the amenities of a state capital and university city.

Salary and UW faculty appointment will be commensurate with credentials and experience. Recruitment/Relocation incentives and Education Debt Reduction are available.

For more information please contact Alan Hines, M.D., Chief, Psychiatry at (208) 422-1000, ext. 7256 or alan.hines@va.gov.

For further description of the outstanding benefits associated with this position and to apply online please go to http://www.usajobs.gov/GetJob/ViewDetails/337173600. EOE.

INDIANA

ADDICTIONS PSYCHIATRIST

The Indianapolis Roudebush VA Medical Center is seeking a full-time BC/BE addiction psychiatrist. It is preferred that the incumbent qualify at the Assistant Professor level or above to provide clinical, education, training, and research activities at Indianapolis Roudebush VA Medical Center which is affiliated with the Indiana University School of Medicine and is a major teaching site for residents and fellows. The candidate will be eligible for tenure or clinical track. The majority of time will involve case consultations with outpatient care staff in a large addictions program and direct outpatient care. Position also teaches and supervises medical students, residents, addiction psychiatry fellows. The addictions program includes adult outpatient services, intensive outpatient, outpatient detox, and narcotics treatment programs. The candidate will lead collaborative efforts with other physicians, nurses, and primary care coordinators.

Candidates must be BC/BE and possess strong clinical and leadership skills. Position offers competitive salary commensurate with experience and strong benefits package. Interested applicants should send their curriculum vitae, statement of clinical, teaching, and research interests plus three letters of recommendation to:

Tasha Henderson
Human Resources Specialist
Indianapolis VA Medical Center (05D)
1481 West 10th Street
Indianapolis, Indiana 46202
AA/EOE
Applications will be accepted until the position is filled.

KENTUCKY

Horizon Health seeks a Psychiatrist for our 10-bed Senior Adult, and 10-bed Adult, inpatient Behavioral Health programs our client hospital **St. Claire Regional Medical Center in Morehead, KY.** Experience with geriatric population preferred. Excellent salary, benefits and practice opportunity. For more information contact: Mark Blakeney, Voice: 972-420-7473, Fax: 972-420-8233; email: mark.blakeney@horizonhealth.com. EOE.

CLASSIFIEDS

LOUISIANA

Tulane University Health Sciences Center (TUHSC) is recruiting an adult clinical psychologist and a child clinical psychologist to serve as inpatient attendings at Northlake Behavioral Health Systems. We are seeking candidates with experience in working with adults and children with severe mental illnesses in both inpatient and outpatient treatment settings. The persons selected for these positions must be professionally competent in clinical psychology and must be eligible for psychology licensure in the State of Louisiana. In addition, candidates must be eligible for clinical privileges at Tulane University Hospital and Clinic under the appropriate staff category and must agree to abide by those privileges as outlined by the current bylaws of the institution. The Department of Psychiatry and Behavioral Sciences has an active APA Accredited clinical psychology internship. Involvement in the teaching and supervision of interns and psychiatry residents is an integral part of these faculty positions. These are full-time faculty positions – rank and salary is commensurate with experience. A competitive benefits package is included. We will continue to accept applications until suitable qualified candidates are found. All qualified candidates who are interested in these positions should forward a copy of their updated curriculum vitae and the names and complete contact information of five references to Paula Zeanah, PhD, Director of the Division of Clinical Psychology, Tulane University School of Medicine, Department of Psychiatry and Behavioral Sciences TB52, 1440 Canal Street, New Orleans, LA 70112 or pzeanah@tulane.edu. Tulane is strongly committed to policies of non-discrimination and affirmative action in student admission and in employment.

Overton Brooks VA Medical Center in Shreveport, LA is seeking full-time BE/BC staff Psychiatrists. Limited on-call duties, regular hours, malpractice insurance covered by Federal Tort Claims Act, opportunities for research in association with Louisiana State University available.

Experience what 250,000 current VA employees already have: state-of-the art practice settings, access to latest technology, a multi-disciplinary team environment and the opportunity to provide the men and women who have bravely served this country with the finest patient care, benefits and customer satisfaction.

Shreveport is quickly becoming a great place to start a business, raise a family, and explore the great outdoors. Easy driving distance to major metropolitan centers such as Dallas and New Orleans. Shreveport has an excellent quality of life, nationally rated Magnet schools, with a reasonable cost of living and warm climate. Salary is negotiable.

Candidates must be U.S./Naturalized Citizens and possess a valid and unrestricted license in any state. Duties include clinical practice (inpatient/outpatient), and supervision of fellows/residents/medical students.

Please send cover letter and CV to Sonia.Williams@va.gov.

The Department of Psychiatry and Behavioral Sciences at Tulane University School of Medicine is recruiting for a Training Program Director in Child and Adolescent Psychiatry, including the Tulane University Triple Board Training Program. This is a full-time faculty position with half-time devoted to the residency training program and half-time to other academic pursuits. An associate director is available to assist with program leadership and administration. The person selected for this position must be professionally competent and be board eligible/certified in general and child and adolescent psychiatry. She/he must be eligible for medical licensure in the State of Louisiana and have a current state and federal narcotics number. In addition, candidates must be eligible for clinical privileges at Tulane University Hospital and Clinic under the appropriate staff category and must agree to abide by those privileges as outlined by the current bylaws of the institution. This is a fully accredited child psychiatry program for 6 child and adolescent psychiatry residents and an additional 10 triple board residents. Salary will be competitive and commensurate with the level of the candidate's academic appointment. We will continue to accept applications for this position until a suitable qualified candidate is identified. Qualified applicants should send an email of interest, updated CV and list of references to Charles H. Zeanah MD, Sellars Polchow Professor and Vice Chair for Child and Adolescent Psychiatry, at czeanah@tulane.edu or a letter to the Section of Child and Adolescent Psychiatry, Tulane University School of Medicine, 1430 Tulane Avenue #8055, New Orleans LA 70112. Tulane is strongly committed to policies of non-discrimination and affirmative action in student admissions and in employment.

DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES, TULANE UNIVERSITY SCHOOL OF MEDICINE in New Orleans, LA, is recruiting for several general and forensic psychiatrists (clinical track) for our growing department, at the Assistant/Associate Professor level, salary commensurate with experience. Candidates must have completed an approved general psychiatry residency and be board certified/eligible in general psychiatry and forensic psychiatry, respectively. Responsibilities will include direct patient care, teaching of medical students and house officers, and research (clinical and basic science) at various state hospitals, state correctional institutions, the Southeast Louisiana Veterans Health Care System (Biloxi, MS) and at Tulane University Health Sciences Center. Time allocations will be based upon individual situations. Applicants must be eligible to obtain a Louisiana medical license. In addition, candidates must be eligible for clinical privileges at Tulane University Hospital and Clinic under the appropriate staff category and must agree to abide by those privileges as outlined by the current bylaws of the institution. Applications will be accepted until suitable qualified candidates are found. Email (winstead@tulane.edu) or send CV and list of references to Daniel K. Winstead, MD, Heath Professor and Chair, Department of Psychiatry and Behavioral Sciences, Tulane University School of Medicine, 1440 Canal Street TB48, New Orleans, LA 70112. For further information, you may contact Dr. Winstead, at 504-988-5246 or winstead@tulane.edu. Tulane is strongly committed to policies of non-discrimination and affirmative action in student admission and in employment.

MAINE

Dorothea Dix Psychiatric Center in Bangor, Maine seeks to fill immediate opening for a full time Board eligible/board certified Psychiatrist. On call duties are minimal. For more information on salary/benefits, call Dr. Michelle Gardner@207-941-4038. DDPC is a free-standing, publicly funded psychiatric hospital in Bangor, Maine just miles from the beautiful Downeast coast.

EEO/AAE

Liberty Healthcare anticipates an opening for a full-time attending Psychiatrist at the Riverview Psychiatric Center in Augusta, Maine. This position offers a small case load, competitive compensation package, regular 40-hour workweeks, minimal on-call, 7+ weeks off annually, liability insurance, onsite CME, relocation assistance and a collegial work environment. Psychiatrists who have an interest in providing inpatient services to adults who have serious and persistent mental illness and/or forensic patients are encouraged to apply. Details online at www.libertyhealthcare.com/upload/303.pdf. Contact Ian Castronuovo at (610) 389-7430 or ianc@libertyhealth.com.

MARYLAND

Springfield Hospital Center is seeking Board-certified or Board-eligible **general psychiatrists** for our 350-bed MHA adult inpatient facility. Salary is negotiable, within MHA guidelines. Our rural, tobacco-free campus is 22 miles west of Baltimore, convenient to the Chesapeake Bay, Washington, and a variety of cultural, historic, sports, and recreational venues. Benefits include 27 paid days off in the first year, subsidized health insurance, free parking, a generous retirement program, and a truly pleasant workplace. A Medical Services physician is always on campus to attend to patients' somatic needs. Staff psychiatrists are not expected to work after hours, but some choose to supplement their salary by providing evening and weekend/holiday coverage under contract. In addition, we offer after-hours coverage contracts to psychiatrists who are not full-time staff members. Please send CV to **Paramjit Agrawal, M.D., Clinical Director, SHC, 6655 Sykesville Road, Sykesville, MD 21784. For questions, call (410)970-7006 or e-mail paramjit.agrawal@dhmh.state.md.us.** EOE

Incredible Sunsets - Endless Waterviews - Psychiatrist needed on 24-bed adult inpatient psychiatric unit on the beautiful Eastern Shore. There is also IOP and Outpatient Addiction Program. Cambridge is located on the Choptank River in Dorchester County - a county of 1,700 miles of shoreline and is only an hour to Annapolis and Ocean City, and an hour and 45 minutes to Baltimore. Live and work in a place where many want to retire - a great quality of life. Also, seeking a Psychiatrist for one weekend per month of coverage for the unit. Please **call Terry B. Good, Horizon Health, at 1-804-684-5661,** Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

Psychiatric positions in Prince George's County

Following Part time contractual positions are available for BE & BC Psychiatrist.

1. Part time Inpatient unit practice (approximately 24 hour/week). This position is Contractual and the Payment is guaranteed. Working hours are flexible. Compensation is based on experience and number of hours worked. Minimum Annual payment for this position is guaranteed at $ 130,000.00
If the candidate is interested in providing week end coverage, additional guaranteed income is available.
The ideal candidate must possess good Pharmacotherapy skill and interest in working with the treatment team, and above all keen interest in treating individuals in Psychiatric crisis and seriously mentally ill.

2. In person and telephone coverage for walk in Psychiatric emergencies and 23 hour crisis bed. Compensation for this position is negotiable depending on the candidate's past experiences.

If you are interested in these positions, please contact me directly via phone or email. Thank you for your interest.

Noori Mirmirani, M.D.
Telephone # 703-447-7515
Email: Dr.Mirmirani@yahoo.com

Springfield Hospital Center in Sykesville, MD is accepting applications for a **Forensic Psychiatrist**. Eligible candidates must have board certification including added qualifications in forensic psychiatry (or equivalent). Duties include pretrial evaluations of competency to stand trial and criminal responsibility, competency restoration, and training of residents and students. Please forward a CV and inquiry to Erik Roskes, MD, Director, Forensic Services, Springfield Hospital Center, by fax (410.970.7105) or email (erik.roskes@maryland.gov).

MASSACHUSETTS

Lahey Health Behavioral Services

BayRidge Hospital is the largest psychiatric inpatient facility within the Lahey Health Behavioral Services continuum for psychiatric and substance abuse treatment. A full-time position is available on an inpatient unit geared toward affective disorders and dually diagnosed patients. A second, two day/week position is available in the Emergency Psychiatric Service, working up newly admitted patients. BayRidge Hospital is a teaching site for Boston University medical students; the staff and environment are physician-friendly, and for the full-time position a generous benefit package is included with the competitive salary. No required night/weekend call for either position (participation in a lucrative call system is optional). Contact Barry Ginsberg, M.D. Medical Director, BayRidge Hospital, 60 Granite Street, Lynn MA 01904. Phone (781) 477-6964, Fax (781) 477-6967, email bginsber@nhs-healthlink.org

CLASSIFIEDS

UMassMemorial
www.umassmemorial.org

Clinical/Academic Adult, Child and Geriatric Psychiatry Positions Currently Available in the Department Of Psychiatry at UMass Memorial Medical Center/University of Massachusetts Medical School

The Department of Psychiatry at UMass Memorial Health Care in Worcester, MA is currently accepting inquiries from physicians/psychologists interested in exploring affiliated clinical/academic job opportunities. The Department has a faculty of more than 300 physicians/psychologists engaged in a variety of clinical and academic pursuits. It is the largest and most highly regarded provider of psychiatric services in Central Massachusetts. Clinical, teaching and research opportunities are currently available at a wide variety of affiliated sites and programs. Below are brief descriptions of several of these attractive opportunities

- Inpatient Attending Adult Psychiatry position currently available at Marlborough Hospital, member hospital of UMass Memorial Health Care.
- Full and Part time Adult and Child positions available at our affiliated Community Mental Health Centers in Worcester, Leominster and other Central Massachusetts locations.
- Child/Adolescent Psychiatry opportunities currently available in long-term residential, community-based acute treatment and substance abuse programs. Consultation-Liaison opportunities also available, as well as a Consulting Child Psychiatry position in our Massachusetts Child Psychiatry Access Project (MCPAP).
- Geriatric Psychiatry position currently available as part of a joint venture between UMass and Fallon Community Health Plan, a well recognized provider of Senior Care Services. This partnership is intended to improve the quality and delivery of geriatric mental health care in Central Massachusetts. The position involves direct patient care, as well as consultation with PCPs, mental health clinicians and other professionals involved in providing geriatric care. Programmatic enhancement and development opportunities also exist, as does the possibility of assisting in the development of a Geriatric Psychiatry Fellowship Program at UMass.
- Moonlighting opportunities available at affiliated, new 26-bed inpatient unit.
- Palliative Care Health Psychology opportunity currently available. The position involves clinic-based consults, outpatient therapy, and possible bedside treatment. Work as a member of the Palliative Care Treatment Team. Teach psychology trainees and residents. The pursuit of research activity/interests is supported and expected.

For consideration and/or additional details, please submit your CV and Letter of Introduction to:

David DeLuca
Physician/Faculty Recruiter
UMass Memorial Medical Group
Email: psychiatryrecruitment@umassmemorial.org;
Phone: 508-334-0803

UMass Memorial Medical Center and The University of Massachusetts Medical School are equal opportunity employers.

Medical Director–Boston/Cape Cod
Pembroke Hospital is seeking a full time Medical Director to join our 115-bed psychiatric facility's Leadership Team. The ideal candidate will be Board Certified with Medical Director level experience & 5 plus years experience in an inpatient behavioral health setting. The Medical Director will oversee the PI/Quality program, Utilization Review committee, and work with the CEO in new program development. The successful candidate will have strong interpersonal, written & verbal communication skills & a passion for providing excellent care in a cost effective, changing healthcare environment. The Medical Director will supervise Physician staff and have both administrative/clinical duties. Because we have physicians on site 24/7, **there is no routine weeknight or weekend call requirement.** The Medical Director position comes with a very competitive compensation package of salary & benefits including paid time off, CME, malpractice reimbursement & opportunities to earn additional income. Pembroke Hospital is part of the Arbour Health System & a subsidiary of Universal Health Services, Inc (UHS). We are located in Pembroke, MA only 8 miles from the coast in a beautiful suburban community within easy reach of Boston & Cape Cod. **Contact Will DeCuyper, In-house Recruiter @ 866-227-5415 OR email will.decuyper@uhsinc.com.**

Berkshire Health Systems

Psychiatrist Opportunity in the Beautiful Berkshires. Top notch colleagues.

Berkshire Medical Center's Department of Psychiatry and Behavioral Science provides you the opportunity to become part of a stable, highly integrated clinical collaboration among Psychiatry, Primary Care, and Medical Specialty Services. Our Health System has an excellent opportunity for an Adult Psychiatrist to work in a highly integrated clinical collaborative at the interface of Primary Care and Behavioral Health. A clinical background in geriatric psychiatry is preferred. Our psychiatry residency program allows you to contribute to the education of the next generation of mental health specialists. Berkshire Medical Center is nationally recognized by HealthGrades and many other independent organizations for outstanding care.

Please contact Antoinette Lentine in the Physician Recruitment Department at 413-395-7866 or e-mail at mdrecruitment@bhs1.org.

Healthy Minds. Healthy Lives – a blog by the American Psychiatric Association – provides online resources and information on mental health issues.

To view this blog, visit: http://apahealthyminds.blogspot.com/

DEPARTMENT OF PSYCHIATRY MASSACHUSETTS GENERAL HOSPITAL HARVARD MEDICAL SCHOOL OUTPATIENT ATTENDING POSITION

The MGH Department of Psychiatry is recruiting for an Outpatient Attending in our Primary Care Psychiatry Program. Additional opportunities may exist in other areas, including Urgent Care. Rated among the leading psychiatry departments by US News and World Report, the Department is comprised of a staff of approximately 600 professional appointees committed to excellence in clinical care, teaching, research and community service. Candidates should be: a) board certified/board eligible in Psychiatry with expertise in the care of patients with psychiatric disorders often complicated by co-morbid medical illness; b) dedicated to excellence in the teaching of psychiatry residents, medical students and other trainees, to scholarship in psychiatry, and to clinical quality improvement; and c) qualified for an academic appointment at Harvard Medical School at the rank of Instructor or above. Fellowship training in relevant areas such as consult-liaison, addictions, geriatrics, or emergency psychiatry, as well as previous outpatient attending experience are desirable. Interested individuals should apply to Jonathan E. Alpert MD PhD, Associate Chief/Clinical Director (jalpert@partners.org). The Massachusetts General Hospital is an affirmative action/equal opportunity employer. Minorities and women are strongly urged to apply.

The Department of Psychiatry at Mount Auburn Hospital, affiliated with Harvard Medical School, is recruiting for a position in our Outpatient Psychiatry Service. Responsibilities include evaluation and treatment of adult patients with a variety of psychiatric disorders, including dual diagnosis patients, and coordination of care with other psychiatric clinicians and with primary care and specialty physicians. The department continues to develop programs integrating psychiatry with primary care. Position includes participation in the teaching activities of the Department. Academic appointment to the clinical faculty at Harvard Medical School is anticipated. Please send letter of interest and cv to: Joseph P. D'Afflitti, M.D., Chair, Department of Psychiatry, Mount Auburn Hospital, 330 Mount Auburn Street, Cambridge, MA 02138; tel: 617 499-5665, ext 4212; email: jdafflit@mah.harvard.edu

MICHIGAN

Horizon Health, together with client hospital seeks a Child/Adolescent Psychiatrist to join a behavioral health team of psychiatrists, psychologists, social workers and medical consultants. The program offers 61 licensed inpatient psychiatric beds (47 adult and 14 adolescent) and 7 licensed inpatient chemical dependency beds. Located in Saginaw, a city of Michigan and the seat of Saginaw County, located in the Flint/Tri-Cities region of Michigan. Child/Adolescent Psychiatrist will be employed by hospital. Hospital package will include competitive salary, full benefits, and insurance coverage. Interested candidates please submit CV to Mark Blakeney: mark.blakeney@horizonhealth.com ; Voice: 972-420-7473; Fax 972-420-8233. EOE

Psychiatry Opportunity Consultation Liaison and Adult Psychiatric Hospitalist

Beaumont Health System is a three-hospital regional health system with a total of 1,738 licensed beds, more than 14,000 full-time equivalent employees and 3,100 physicians in Oakland, Macomb and Wayne counties. Beaumont Hospital, Royal Oak has two immediate openings. One position is for a psychiatrist with experience as a consultation liaison, and the other has a focus on inpatient adult psychiatry as a hospitalist.

The Consultation Liaison will focus on adult medical/surgical patients with a full-time effort on inpatient work, is expected to take psychiatric ER call, will oversee the consult service and will be actively involved in teaching medical students from Oakland University William Beaumont School of Medicine on rotation for their psychiatry clinical sections.

The Adult Psychiatric Hospitalist will have experience in adult inpatient psychiatry and partial hospitalization. This is a full-time position with an expectation to take psychiatric ER call and be actively involved in teaching medical students from Oakland University William Beaumont School of Medicine on rotation for their psychiatry clinical sections.

Beaumont is the exclusive clinical teaching site for the Oakland University William Beaumont School of Medicine.

Candidates should send a curriculum vitae and cover letter to:
Diane Blackburn
Beaumont Health System
Physician Recruitment
Administration Bldg., HR Dept.
3711 West 13 Mile Rd.
Royal Oak, MI 48073
dblackburn@beaumont.edu
248.551.1565 – office;
248.551.1555 - fax
http://pathwaysplatform.com/opportunities/4899-consultation-psychiatry
http://pathwaysplatform.com/opportunities/4900-inpatient-adult-psychiatry-psychiatric-hospitalist

MISSISSIPPI

MERIDIAN: Child and/or General Psychiatrist. OLIVE BRANCH: Child Psychiatrist. Inpatient, Partial & O/P Services. Fulltime positions offering salary, benefits & bonus opportunity. Contact Tiffany Crawford, In-house recruiter @ 866-227-5415; OR email tiffany.crawford@uhsinc.com.

Horizon Health seeks a **Medical Director** for a 19-bed Adult Inpatient Psychiatric Program in **Northern MS.** Well established, busy program with full complement of support staff and administration. $200K+ Salary, Full Benefits, CME, Relocation and more. For more information contact: Mark Blakeney, Voice: 972-420-7473, Fax: 972-420-8233; email: mark.blakeney@horizonhealth.com EOE.

CLASSIFIEDS

MISSOURI

FT, PT & Per Diem Psychiatrists needed in **Bowling Green, Farmington, St Joseph & Vandalia** with MHM Services, Inc. A leader in Correctional Mental Health, we offer highly competitive, guaranteed salaries, paid malpractice insurance & excellent benefits. NHSC loan repayment is available. Join the fastest-growing segment of behavioral health today. To apply, contact **Mark Hyde: 877-861-7993** or email CV to mark@mhmcareers.com. **No locums solicitations, please.**

One of the Midwest's Best Kept Secrets - St. Joseph, MO - Close to Kansas City - Wonderful city to live and work, great schools, and so close to the metro area. Full-time salaried position with benefits & bonus on a 24-bed adult inpatient psychiatric unit based in a very impressive general hospital. Position is inpatient and outpatient. Offering attractive student loan repayment if needed. Come join our incredible behavioral health team on this growing psych service. This is a **"must see"** opportunity if you looking for a quality Psychiatry program and a wonderful place to live! Please **call Terry B. Good at 1-804-684-5661,** Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

Make An Income that Matches All the Work You Do - 20 Minutes From St. Louis - 30 Minutes To Work - Seeking a Psychiatrist for a very lucrative position with a very successful group practice in Festus. Work would be primarily inpatient work on adult & geropsych units in Farmington. Ideal opportunity for someone who wants the ability to make a very large income based on all your hard work. All billing and scheduling is done for you. Can also employ if H1 and J1 Visa is needed. Please **call Terry B. Good, Horizon Health, at 1-804-684-5661,** Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

MONTANA

Horizon Health seeks a Psychiatrist for a 24-bed (12 adult, 12 geriatric) behavioral health inpatient hospitalization program for short-term behavioral health treatment in beautiful **Helena, MT**. Helena is a charming, sophisticated and beautiful Victorian city! Offering a competitive salary and benefits. Contact: Mark Blakeney, Horizon Health, mark.blakeney@horizonhealth.com or FAX: 972-420-8233 EOE.

NEW HAMPSHIRE

Inpatient Psychiatrist: Child or Adult trained

Hampstead Hospital, Hampstead, NH (www.hampsteadhospital.com)
- Generous compensation and benefits
- Highly skilled psychiatry staff with longevity and collegial relationships
- Rural setting close to seacoast, mountains, Boston

Contact Cindy Gove at
cgove@hampsteadhospital.com or
603-329-5311, x 3226

PARTNERSHIP FOR SUCCESSFUL LIVING

Come be a change agent in Nashua, NH – twice voted the country's best place to live. Harbor Homes, Inc., a non-profit health and human service agency, seeks:
- **Psychiatrists or**
- Psychiatric ARNPs

Help change the way behavioral health care is delivered in the community. Job responsibilities include medical consultations in acute care settings, initial evaluations, and coordination with community agencies, and collaboration with primary care physicians. Competitive salary, exceptional benefits, and excellent work/life balance offered.

Qualified interested candidates please send resume and salary requirements to: Human Resources 45 High Street Nashua, NH 03060 or careers@nhpartnership.org

EOE-AAM

NEW JERSEY

GenPsych, PC is seeking FT/PT Psychiatrists and Child Psychiatrist for our Brick, Bridgewater, and Lawrenceville, NJ locations to work in our PC, IOP, and Outpatient departments. Salary is very competitive with benefits including vacation and CME. Please contact: Jessica France, 908-526-8370 ext. 135 or jessicafrance@genpsych.com.

Medical Director & Associate Position - Northern NJ - Seeking psychiatrists in private practice who want to follow inpatients on adult psych unit in Jersey City. Administrative stipends available for PT admin work that can be done while the doctor is at the hospital. Can round in the mornings or afternoons and go to practice the rest of the time. Great opportunity to grow one's practice, increase revenue. Additional income to the psychiatrist such as being paid for weekend call plus additional revenue that I would be happy to discuss with you. Please contact **Terry B. Good at 1-804-684-5661,** Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

NEW MEXICO

LAS CRUCES: General or Geriatric Psychiatrist. Inpatient & Partial Services. Full-time position offering top salary, benefits & bonus opportunity. Contact Joy Lankswert, In-house recruiter @ 866-227-5415; OR email joy.lankswert@uhsinc.com

NEW YORK CITY & AREA

Child and Adolescent Psychiatrist
P/T - 10-15 hours per week (evenings and/or weekends) in a Child and Family Mental Health Center in Brooklyn. Excellent compensation. No call. Fax resume to (718) 553-6769, or email to clinicaldirector@nypcc.org.

Director of Emergency Psychiatry STONY BROOK MEDICINE

Stony Brook University has established itself as one of America's most dynamic public universities, a center of academic excellence and a leader in health education, patient care and research. Listed among the top 1 percent of all universities in the world by the **Times Higher Education World University Rankings,** Stony Brook is home to more than 24,000 undergraduate, graduate and doctoral students and more than 13,500 faculty and staff, including those employed at Stony Brook Medicine, Long Island's premier academic medical center and teaching hospital. With 597 beds, Stony Brook Hospital is the region's only tertiary care center and Regional Trauma Center. The University is a member of the prestigious Association of American Universities and co-manager of nearby Brookhaven National Laboratory.

Stony Brook Medicine is seeking a mid-level academic psychiatrist to direct a vibrant and actively growing Comprehensive Psychiatric Emergency Program at Stony Brook Hospital. Stony Brook University is undergoing tremendous growth under a new President, Dean and Chair of Psychiatry. Our emergency psychiatry service is expanding into spacious, newly built quarters. We seek an individual who would welcome the challenge and satisfaction of providing top-notch leadership and delivery of emergency psychiatric care. Join a diverse,motivated group of clinicians, educators and researchers in enhancing current services. Includes direct clinical responsibilities and supervision of residents, NPs and medical students. Opportunities for clinical research in emergency psychiatry.

Stony Brook Medicine is located in beautiful Suffolk County on the North Shore of Long Island,approximately 40 miles east of NYC. Stony Brook is a wonderful place to live and raise children, with abundant opportunities for recreation as well as ready access to Manhattan.

Required: MD. Board Eligible/Board Certified in Adult Psychiatry. Eligible for a New York State License. Clinical experience in a Comprehensive Psychiatric Emergency Program or other emergency psychiatric setting. Provide cross-coverage of evening, night and weekend shifts. Preferred: Five years' post-residency experience in Emergency Psychiatry, including psychiatric administrative experience. Track record of research/teaching experience in Emergency Psychiatry.

To qualify for a senior faculty appointment, the candidate must meet the criteria established by the School of Medicine (School of Medicine's Criteria for Appointment, Promotion and Tenure).

To apply submit a State employment application, cover letter and CV to: Ramin Parsey, MD, PhD, Chair, Department of Psychiatry and Behavioral Science, Health Sciences Tower, T-10, Room 020, Stony Brook University, Stony Brook, NY 11794-8101; or fax #: (631) 444-7534.

For a full position description, application procedures or to apply online, visit
www.stonybrook.edu/jobs
(Ref. #: F-7690-12-12).
Stony Brook University/SUNY is an affirmative action, equal opportunity educator and employer.

Addiction Psychiatrist/ Unit Chief

Full-time position available for an Addiction Psychiatrist/ Unit Chief on the Chemical Dependency Unit at Flushing Hospital Medical Center. Supervise residents, fellows, medical students, and other trainees. Fully-staffed by Internists and PA's. Full compliment of CASACs and Social Workers. Research opportunities available. Work within the larger MediSys Health Network with extensive Psychiatric services and resources. Competitive salary, paid malpractice insurance, and full benefits. Please send your CV to Seeth Vivek, MD fax: 718-206-7169 or Email svivek@jhmc.org

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MDs & NPs needed for Psychiatry Consultation services in Long Term Care Facilities (NH, SNF). Locations: **Manhattan, Bronx & Westchester.** PT/FT Above average salaries/benefits, flexible hours. Please email CV to **manager@medcarepc.com** or via **Fax: 718-239-0032 Tel:718-239-0030**

NEW YORK STATE

Western New York-Chautauqua Region: Jamestown Psychiatric PC is seeking a Psychiatrist to join our rapidly growing Adult and Child Psychiatric team. Competitive salary and flexible growth opportunities are offered. We will offer a starting bonus to eligible candidates. Loan repayment, J1 or H1 assistance available. Please contact Mrs. Linda Jones, office manager @ lj@psychwebmd.com or Phone 716-483-2603. Fax CV and qualifications to 716-483-2828.

PSYCHIATRIST OPENINGS at CENTRAL NEW YORK PSYCHIATRIC CENTER

A State-operated, Forensic Facility, the first Office of Mental Health Facility to be recognized by the national accrediting body, The Joint Commission, as a Top Performer. Our Facility is seeking full time Psychiatrists for our Inpatient Facility in Marcy, NY, and for our Correction-based programs in various locations throughout the state. These positions are in proximity to Glens Falls, Middletown, Syracuse, Rochester, Batavia, and Utica as well as in Albany. Competitive salary range is $168,421 for NY State License to $181,790 for Board Certification plus additional compensation for some programs. NY State provides a generous and comprehensive benefits package including an outstanding Pension Plan and for NY State Regents Loan Forgiveness. Opportunities may exist for additional compensation.

Dr. Jonathan Kaplan
Clinical Director for
Outpatient Services
(Code 312)
Call at: 845-483-3443
Fax: 845-483-3455
Email: Jonathan.Kaplan@omh.ny.gov

CLASSIFIEDS

St. Lawrence Psychiatric Center
Psychiatrists
NYS Licensed or Limited Permit
(Limited Permit option – see below)**
Salary based on experience
Earn up to an additional $74,000/year through a voluntary on-call program
Fringe Benefits equal to 50.16% of your salary
Monday – Friday, 8:00A – 4:30P

St. Lawrence Psychiatric Center is seeking Licensed Psychiatrists for Adult, Children/Youth, and Sex Offender Treatment Inpatient Services and for Adult and Children/Youth Outpatient Services.

- National Health Services Corps (NHSC) student loan repayment may be available (Up to $60,000 for a 2-year FT commitment; up to $170,000 with a 5-year FT commitment, and possible total debt alleviation with 6 or more years of service)
- Doctors Across New York (DANY) loan repayment or sign-on bonuses may be available (applications are time limited and considered in the order in which they are received).
- Excellent NYS Benefits to include medical/dental/vision insurance, paid vacation, holiday and sick time, an excellent retirement plan, and educational and professional leaves.
- Our location offers quality housing prices, mild traffic, a regional airport, Clarkson University, St. Lawrence University, and 2 SUNY colleges; 1 hr drive to Ottawa; 2 hr drive to Montreal, Lake Placid, and Syracuse.

**Limited Permit Option: If you have finished your residency, but not the USLME, you may be appointed on limited permit, initially for 2 years, renewable for further 2 years.

Applications are available by calling
(315) 541-2179
or send resume to:
Personnel Office
St. Lawrence Psychiatric Center
1 Chimney Point Drive
Ogdensburg, NY 13669-2291
or to Angela Grant at
Angela.Grant@omh.ny.gov.

SLPC is a fully accredited Joint Commission program/AA/EEOE/Self-indemnified. **Affiliated with SUNY Upstate Medical University.**

NORTH CAROLINA

Now recruiting for Board Certified or Board Eligible Psychiatrists Coastal Carolina Neuropsychiatric Center, PA has multiple locations in NC. In-patient, out-patient, and a combination of both may be available. Competitive salary and benefits package.

H1 & J1 visa applicants may apply
Submit CV's to:
info@coastalcarolinapsych.com

Four beautiful seasons in North Carolina!

Candidate sought for partnership or employment in a busy private practice. Adult, 80% outpatient psychiatry practice with 1:3 call. H1b Visa physicians will be considered. Location: I-95 corridor, northeastern NC. 2.5 hours to coast, centrally located 1.5 hours from Raleigh-Durham, NC, Richmond, VA, and Norfolk, Va. Fabulous water activities. Area population: 85K.

Send letter and CV to Pam Ballew
pballew@halifaxrmc.org
www.halifaxregional.org
www.visithalifax.com

NORTH DAKOTA

Sanford Clinic North Fargo, North Dakota
Seeking BC/BE Adult Psychiatrists

Medical Director, In-Patient and Partial Hospitalization Programs—Join a team of inpatient hospitalists covering a 24 bed inpatient unit and a partial hospitalization unit with a 16 bed capacity.

General Adult Psychiatrist—This position provides the opportunity to practice outpatient and in-patient psychiatry.

Sanford's Behavioral Health Sciences Department is staffed by more than 30 psychiatrists, clinical nurse specialists, doctorate-level psychologists and master's-level psychologists offering a continuum of care, from inpatient hospitalization and partial hospitalization programs, to outpatient individual and group therapy including eating disorders at the highly regarded Eating Disorders Institute. Responsibilities include teaching psychiatry resident and medical students through the University of North Dakota School of Medicine.

Sanford Health is the largest, rural, not-for-profit, health care system in the nation, serving 126 communities in seven states plus children's clinic services expanding into several countries.

Fargo, ND, a community of 190,000, offers excellent schools, a wonderful blend of cultural and recreational activities, low crime and affordable and upscale living.

Jean Keller, Physician Recruiter
Phone: (701) 280-4853
Email: Jean.Keller@sanfordhealth.org
www.sanfordhealth.org

OHIO

Southern OH - Hospital Named 10th in the Top 100 Best Places to Work - Outpatient Position with some on-call duties for the geropsych unit. Enjoy small town living; laid-back, wonderful quality of life. Great place to raise a family. An easy drive to Huntington, WV and Cincinnati, OH. Salaried position with production & performance bonuses; medical school loan repayment plan up to $200k. Join our top notch team at this truly impressive hospital and enjoy where you live & work every day. Please **call Terry B. Good, Horizon Health, at 1-804-684-5661,** Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

OKLAHOMA

Horizon Health seeks a **Medical Director** for our 10-bed Geriatric, and 20-bed Adult, inpatient Behavioral Health programs our client hospital **Eastar Health Systems, in Muskogee, OK.** Experience with geriatric population preferred. Excellent income and practice opportunity. For more information contact: Mark Blakeney, Voice: 972-420-7473, Fax: 972-420-8233; email: mark.blakeney@horizonhealth.com. EOE

OREGON

Horizon Health seeks a Medical Director for a NEW 10 bed IP general Older Adult / Geriatric Psych program. At the center of healthcare in the **Yamhill Valley** and surrounding areas located in **McMinnville, OR.** The award-winning, modern facility houses state-of-the-art services. Client hospital provides all the latest technology to provide the best healthcare available. Responsibilities include attending Medical Director duties for inpatient program and routine MD administrative duties. Offering an attractive income package and located in the heart of Willamette Valley's wine country, midway between the coast and Portland and 30 miles from the capital city of Salem. McMinnville is a wonderful place to live! Contact: Mark Blakeney, email: mark.blakeney@horizonhealth.com or fax: 972-420-8233 EOE.

PENNSYLVANIA

We have exciting full and part-time positions in our five-hospital system close to Philadelphia and Wilmington. There are immediate openings in our outpatient psychotherapy practice which includes the **Women's Behavioral Health Program, Child/Adolescent, and General Adult.** Psychiatrists provide both psychotherapy and medication management. We also seek psychiatric leadership of our Pain Management Program.

Excellent salaries and benefit package. Send CV to Kevin Caputo, MD, Chairman Department of Psychiatry, Crozer-Keystone Health System, One Medical Center Blvd., Upland, PA 19013 or call 610-874-5257.

Join our team of 10 psychiatrists and five extenders in a community based mental health program in the scenic Laurel Highlands of Southwestern Pennsylvania (one hour south of Pittsburgh). Immediate openings providing Outpatient, Partial Hospitalization and Residential psychiatric services. Also Tele-psychiatry Opportunities! Full / Part time positions, with NO On-Call. Easy commute and flexible schedules. Current PA license required. Competitive salary and excellent benefits. J-1/H-1 positions available. NHSC approved. Forward CV to Ronald Lobo, MD, Medical Director, 100 New Salem Rd. Uniontown, PA 15401. hr@crcsi.org. To learn more about Chestnut Ridge Counseling Services, please visit our website at www.crcsi.org.

The Penn State Department of Psychiatry is recruiting in-patient and consultation-liaison psychiatrists for its growing faculty. With our clinical partner, Pennsylvania Psychiatric Institute, the Department staffs three clinics, with outpatient and partial hospital programs for children and adults, 58 adult and 16 child/adolescent beds, ECT and other neuromodulation services, specialty sleep and eating-disorders programs, and expanding psychiatric consultation for Penn State Hershey Medical Center. Our current psychiatry faculty numbers 52, with planned increases, plus 24 residents and fellows, also likely to expand. We are about to start a new Psychology Internship. We have a growing research portfolio and new research groups about to join us, with basic and clinical science and close collaboration with allied neuroscience disciplines at several Penn State campuses.

Successful candidates should have strong clinical and teaching skills and, optimally, potential for scientific and scholarly achievement. We offer a very attractive compensation package commensurate with qualifications.

Central Pennsylvania fosters a delightful quality of life, with ready access to major metropolitan areas like D.C., Baltimore, Philadelphia, and NYC, while placing you in a picturesque and historic environment, with superb schools and varied recreation.

Candidates with interest and skills in these areas should send a curriculum vitae and cover letter to:

Alan J. Gelenberg, M.D.
Shivley/Tan Professor and Chair
Penn State Hershey Medical Center
Department of Psychiatry, H073
500 University Drive, P.O. Box 850
Hershey, PA 17033
Phone: 717.531.8516
Fax: 717.531.6491
agelenberg@hmc.psu.edu

Penn State Hershey Medical Center is committed to affirmative action, equal opportunity and the diversity of its workforce.

MEDICAL DIRECTOR & ASSOCIATE POSITIONS – Employment or Contractor Positions in Lancaster, PA – VERY attractive compensation packages available; PT work is also available. Involves inpatient work on adult & geropsych units. A beautiful area in eastern PA; strong medical community; an easy drive to several metro areas. Please call Terry B. Good at 1-804-684-5661, Fax #: 804-684-5663; Email: terry.good@horizonhealth.com

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Langhorne, PA – Independent Contractor Position - Seeking psychiatrist in private practice who wants to follow inpatients on geropsychiatric unit in Langhorne, PA. Can round in the mornings or afternoons and go to practice the rest of the time. Great opportunity to grow one's practice, increase revenue. Please contact **Terry B. Good at 1-804-684-5661,** Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

CLASSIFIEDS

RHODE ISLAND

Rhode Island Hospital
A Lifespan Partner
Affiliated Hospitals of the
Warren Alpert Medical School of
Brown University
Positions in Psychiatry

1) Adult Partial Hospital: Full time psychiatrist positions available. This acute care program is an innovative, evidence-based practice, specializing in biopsychosocial models of treatment. Candidates with an interest in program leadership and development are particularly encouraged to apply.

These positions are eligible to be considered for Faculty teaching appointments at Brown University. Scholarly and academic capabilities can be accommodated depending on the qualifications of the candidate. There are also opportunities for research participation.

Applicants must be Board Certified in Psychiatry or Board eligible (within three years of training completion). Salary and benefits are competitive and commensurate with level of training and experience. To learn more, visit www.lifespan.org. Please send CV's along with a letter of interest to Richard J. Goldberg, M.D., Psychiatrist-in-Chief, APC-9, Rhode Island Hospital, 593 Eddy Street, Providence, RI 02903 and/or email: rjgoldberg@lifespan.org

SOUTH CAROLINA

Medical Director Position - Make A Difference in This Community/Hospital - Head up an 8-bed inpatient Geropsychiatric Unit; salaried with benefits or practice opportunity for those who prefer independent contract. Weekend call is 1 in 3 or 4. Rounding on weekends is not necessary unless there is an admission on Friday or Saturday. Great group of people to work with; huge amount of support. Located in northeast SC, easy drive to Florence, SC. Please **call Terry B. Good at 1-804-684-5661,** Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

Horizon Health seeks a **Psychiatrist** for part-time, weekend coverage for a 15-bed Geriatric Inpatient Psychiatric Program in **Spartanburg, SC.** 2 or 3 weekends per month. For more information contact: Mark Blakeney, Voice: 972-420-7473, Fax: 972-420-8233; email: mark.blakeney@horizonhealth.com. EOE.

TENNESSEE

Horizon Health, in partnership with **Livingston Regional Hospital** in **Livingston, TN**, near beautiful **Dale Hollow Lake,** has an exciting opportunity for a **Medical Director** at our 10-bed Geriatric Inpatient Psychiatric Program. Excellent income with great quality of life! 2 hours from Nashville and Knoxville and one of the lowest costs of living in the U.S. For more information contact: Mark Blakeney, Voice: 972-420-7473, Fax: 972-420-8233; email: mark.blakeney@horizonhealth.com. EOE

EAST TENNESSEE STATE UNIVERSITY
JAMES H. QUILLEN
COLLEGE OF MEDICINE
DEPARTMENT OF PSYCHIATRY & BEHAVIORAL SCIENCES

ADULT PSYCHIATRIST
CHILD PSYCHIATRIST
GERIATRIC PSYCHIATRIST

Three full-time positions available for Adult Psychiatrist, Child Psychiatrist and Geriatric Psychiatrist. The department seeks Adult Psychiatrist who is BE/BC (at time of hire), Child Psychiatrist who is BE/BC (at the time of hire) in the subspecialty of Child and Adolescent Psychiatry, and Geriatric Psychiatrist who is BE/BC (at the time of hire) in the subspecialty of geriatric psychiatry and will become involved in the development of a Geriatric Psychiatry Fellowship. Positions may include inpatient and/or outpatient. Program activities include clinical care of patients combined with teaching and supervision of residents and medical students. Adult or Child position may be considered for Director of Outpatient Clinic Programs. Research is encouraged but not essential. Salary and academic rank are commensurate with experience and qualifications. Salary is competitive with funding available through the Medical School, faculty private practice and extramural contracts.

ETSU is located in Johnson City which is the perfect blend of four mild and beautiful seasons, gentle mountains and a symphony orchestra. Come explore this ideal family location of college/urban sophistication surrounded by national forests and serene pastures. No state income tax, low cost-of-living, low crime rate, lots of parks, golf courses, and lakes. Apply to this position at https://jobs.etsu.edu. Telephone inquiries should be made at (423) 439-2235 or e-mail at lovedayc@etsu.edu. AA/EOE.

TEXAS

Interested in working from home, office, ANYWHERE?
Psychiatric Telemedicine Openings with ETBHN are available

Telepsychiatry, or telemedicine, "is a specifically defined form of video conferencing that can provide psychiatric services to patients living in remote locations or otherwise underserved areas." Required: Current unrestricted Texas license to practice medicine; Board Eligible-Board Certified in Child and Adolescent Psychiatry. Board Certified in General Psychiatry. HOURS: 8:00 a.m. to 5:00 p.m., Monday through Friday. SALARY: Negotiable. Send Vitaes to angieh@etbhn.org or contact Angie Hardy 936-229-0994.

UTAH

SALT LAKE CITY and OREM/PROVO: Inpatient & partial programs. General and Military specialty services. Staff and Directorship opportunities. Top salary, benefits and more. Contact Joy Lankswert, In-house recruiter @ 866-227-5415; OR email joy.lankswert@uhsinc.com.

VIRGINIA

VIRGINIA BEACH: Addiction Psychiatrist – Inpatient Services. **LEESBURG, PORTSMOUTH & KEMPSVILLE:** Child Psychiatrists for Residential Treatment and/or Inpatient Services. All positions are fulltime offering salary, benefits and bonus opportunity. **Contact Will DeCuyper, In-house Recruiter @ 866-227-5415 OR email will.decuyper@uhsinc.com.**

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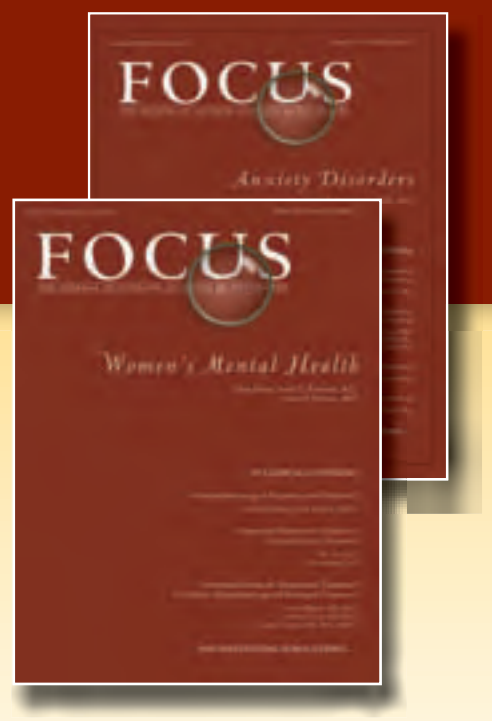

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BRIEF SUMMARY. See package insert for full Prescribing Information. For further product information and current package insert, please visit www.pristiqhcp.com or call Pfizer US Medical Information toll-free at (800) 438-1985.

WARNING: SUICIDAL THOUGHTS AND BEHAVIORS

Antidepressants increased the risk of suicidal thoughts and behavior in children, adolescents, and young adults in short-term studies. These studies did not show an increase in the risk of suicidal thoughts and behavior with antidepressant use in patients over age 24; there was a reduction in risk with antidepressant use in patients aged 65 and older *[see Warnings and Precautions (5.1) in the full prescribing information]*.

In patients of all ages who are started on antidepressant therapy, monitor closely for worsening, and for emergence of suicidal thoughts and behaviors. Advise families and caregivers of the need for close observation and communication with the prescriber *[see Warnings and Precautions (5.1) in the full prescribing information]*.

PRISTIQ is not approved for use in pediatric patients *[see Use in Specific Populations (8.4) in the full prescribing information]*.

INDICATIONS AND USAGE: PRISTIQ, a serotonin and norepinephrine reuptake inhibitor (SNRI), is indicated for the treatment of major depressive disorder (MDD) *[see Clinical Studies (14) and Dosage and Administration (2.1) in the full prescribing information]*. The efficacy of PRISTIQ has been established in four short-term (8-week, placebo-controlled studies) and two maintenance studies in adult outpatients who met DSM-IV criteria for major depressive disorder.

CONTRAINDICATIONS: Hypersensitivity—Hypersensitivity to desvenlafaxine succinate, venlafaxine hydrochloride or to any excipients in the PRISTIQ formulation. Angioedema has been reported in patients treated with PRISTIQ *[see Adverse Reactions (6.1) in the full prescribing information]*. **Monoamine Oxidase Inhibitors**—The use of monoamine oxidase inhibitors (MAOIs) intended to treat psychiatric disorders with PRISTIQ or within 7 days of stopping treatment with PRISTIQ is contraindicated because of an increased risk of serotonin syndrome. The use of PRISTIQ within 14 days of stopping an MAOI intended to treat psychiatric disorders is also contraindicated *[see Dosage and Administration (2.6) and Warnings and Precautions (5.2) in the full prescribing information]*. Starting PRISTIQ in a patient who is being treated with MAOIs such as linezolid or intravenous methylene blue is also contraindicated because of an increased risk of serotonin syndrome *[see Dosage and Administration (2.6) and Warnings and Precautions (5.2) in the full prescribing information]*.

WARNINGS AND PRECAUTIONS: Suicidal Thoughts and Behaviors in Adolescents and Young Adults—Patients with major depressive disorder (MDD), both adult and pediatric, may experience worsening of their depression and/or the emergence of suicidal ideation and behavior (suicidality) or unusual changes in behavior, whether or not they are taking antidepressant medications, and this risk may persist until significant remission occurs. Suicide is a known risk of depression and certain other psychiatric disorders, and these disorders themselves are the strongest predictors of suicide. There has been a long-standing concern, however, that antidepressants may have a role in inducing worsening of depression and the emergence of suicidality in certain patients during the early phases of treatment. Pooled analyses of short-term placebo-controlled studies of antidepressant drugs (SSRIs and others) showed that these drugs increase the risk of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults (ages 18 to 24) with major depressive disorder (MDD) and other psychiatric disorders. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction with antidepressants compared to placebo in adults aged 65 and older. The pooled analyses of placebo-controlled studies in children and adolescents with MDD, obsessive compulsive disorder (OCD), or other psychiatric disorders included a total of 24 short-term studies of 9 antidepressant drugs in over 4,400 patients. The pooled analyses of placebo-controlled studies in adults with MDD or other psychiatric disorders included a total of 295 short-term studies (median duration of 2 months) of 11 antidepressant drugs in over 77,000 patients. There was considerable variation in risk of suicidality among drugs, but a tendency toward an increase in the younger patients for almost all drugs studied. There were differences in absolute risk of suicidality across the different indications, with the highest incidence in MDD. The risk differences (drug vs. placebo), however, were relatively stable within age strata and across indications. These risk differences (drug-placebo difference in the number of cases of suicidality per 1,000 patients treated) included 14 additional cases of increases among those aged <18, 5 additional cases of increases among those aged 18 to 24, 1 fewer case of decrease among those aged 25 to 64, and 6 fewer cases of decrease among those aged ≥65.

No suicides occurred in any of the pediatric studies. There were suicides in the adult studies, but the number was not sufficient to reach any conclusion about drug effect on suicide. It is unknown whether the suicidality risk extends to longer-term use, i.e., beyond several months. However, there is substantial evidence from placebo-controlled maintenance studies in adults with depression that the use of antidepressants can delay the recurrence of depression. **All patients being treated with antidepressants for any indication should be monitored appropriately and observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases.** The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adult and pediatric patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and nonpsychiatric. Although a causal link between the emergence of such symptoms and either the worsening of depression and/or the emergence of suicidal impulses has not been established, there is concern that such symptoms may represent precursors to emerging suicidality. Consideration should be given to changing the therapeutic regimen, including possibly discontinuing the medication, in patients whose depression is persistently worse, or who are experiencing emergent suicidality or symptoms that might be precursors to worsening depression or suicidality, especially if these symptoms are severe, abrupt in onset, or were not part of the patient's presenting symptoms. If the decision has been made to discontinue treatment, medication should be tapered, as rapidly as is feasible, but with recognition that abrupt discontinuation can be associated with certain symptoms *[see Dosage and Administration (2.4) and Warnings and Precautions (5.7) in the full prescribing information for a description of the risks of discontinuation of PRISTIQ]*. **Families and caregivers of patients being treated with antidepressants for major depressive disorder or other indications, both psychiatric and nonpsychiatric, should be alerted about the need to monitor patients for the emergence of agitation, irritability, unusual changes in behavior, and the other symptoms described above, as well as the emergence of suicidality, and to report such symptoms immediately to healthcare providers. Such monitoring should include daily observation by families and caregivers.** Prescriptions for PRISTIQ should be written for the smallest quantity of tablets consistent with good patient management, in order to reduce the risk of overdose. Screening patients for bipolar disorder—A major depressive episode may be the initial presentation of bipolar disorder. It is generally believed (though not established in controlled studies) that treating such an episode with an antidepressant alone may increase the likelihood of precipitation of a mixed/manic episode in patients at risk for bipolar disorder. Whether any of the symptoms described above represent such a conversion is unknown. However, prior to initiating treatment with an antidepressant, patients with depressive symptoms should be adequately screened to determine if they are at risk for bipolar disorder; such screening should include a detailed psychiatric history, including a family history of suicide, bipolar disorder, and depression. It should be noted that PRISTIQ is not approved for use in treating bipolar depression. **Serotonin Syndrome:** The development of a potentially life-threatening serotonin syndrome has been reported with SNRIs and SSRIs, including PRISTIQ, alone but particularly with concomitant use of other serotonergic drugs (including triptans, tricyclic antidepressants, fentanyl, lithium, tramadol, tryptophan, buspirone, and St. John's Wort), and with drugs that impair metabolism of serotonin (in particular, MAOIs, both those intended to treat psychiatric disorders and also others, such as linezolid and intravenous methylene blue). Serotonin syndrome symptoms may include mental status changes (e.g., agitation, hallucinations, delirium, and coma), autonomic instability (e.g., tachycardia, labile blood pressure, dizziness, diaphoresis, flushing, hyperthermia), neuromuscular symptoms (e.g., tremor, rigidity, myoclonus, hyperreflexia, incoordination), seizures, and/or gastrointestinal symptoms (e.g., nausea, vomiting, diarrhea). Patients should be monitored for the emergence of serotonin syndrome. The concomitant use of PRISTIQ with MAOIs intended to treat psychiatric disorders is contraindicated. PRISTIQ should also not be started in a patient who is being treated with MAOIs such as linezolid or intravenous methylene blue. All reports with methylene blue that provided information on the route of administration involved intravenous administration in the dose range of 1 mg/kg to 8 mg/kg. No reports involved the administration of methylene blue by other routes (such as oral tablets or local tissue injection) or at lower doses. There may be circumstances when it is necessary to initiate treatment with a MAOI such as linezolid or intravenous methylene blue in a patient taking PRISTIQ. PRISTIQ should be discontinued before initiating treatment with the MAOI *[see Contraindications (4.2) and Dosage and Administration (2.6) in the full prescribing information]*. If concomitant use of PRISTIQ with other serotonergic drugs, including triptans, tricyclic antidepressants, fentanyl, lithium, tramadol, buspirone, tryptophan, and St. John's Wort is clinically warranted, patients should be made aware of a potential increased risk for serotonin syndrome, particularly during treatment initiation and dose increases. Treatment with PRISTIQ and any concomitant serotonergic agents should be discontinued immediately if the above events occur and supportive symptomatic treatment should be initiated. **Elevated Blood Pressure:** Patients receiving PRISTIQ should have regular monitoring of blood pressure since increases in blood pressure were observed in clinical studies *[see Adverse Reactions (6.1) in the full prescribing information]*. Pre-existing hypertension should be controlled before initiating treatment with PRISTIQ. Caution should be exercised in treating patients with pre-existing hypertension, cardiovascular, or cerebrovascular conditions that might be compromised by increases in blood pressure. Cases of elevated blood pressure requiring immediate treatment have been reported with PRISTIQ. Sustained blood pressure increases could have adverse consequences. For patients who experience a sustained increase in blood pressure while receiving PRISTIQ, either dose reduction or discontinuation should be considered *[see Adverse Reactions (6.1) in the full prescribing information]*. **Abnormal Bleeding:** SSRIs and SNRIs, including PRISTIQ, may increase the risk of bleeding events. Concomitant use of aspirin, nonsteroidal anti-inflammatory drugs, warfarin, and other anticoagulants may add to this risk. Case reports and epidemiological studies (case-control and cohort design) have demonstrated an association between use of drugs that interfere with serotonin reuptake and the occurrence of gastrointestinal bleeding. Bleeding events related to SSRIs and SNRIs have ranged from ecchymosis, hematoma, epistaxis, and petechiae to life-threatening hemorrhages. Patients should be cautioned about the risk of bleeding associated with the concomitant use of PRISTIQ and NSAIDs, aspirin, or other drugs that affect coagulation or bleeding. **Narrow-angle Glaucoma**: Mydriasis has been reported in association with PRISTIQ; therefore, patients with raised intraocular pressure or those at risk of acute narrow-angle glaucoma (angle-closure glaucoma) should be monitored. **Activation of Mania/Hypomania:** During all MDD phase 2 and phase 3 studies, mania was reported for approximately 0.02% of patients treated with PRISTIQ. Activation of mania/hypomania has also been reported in a small proportion of patients with major affective disorder who were treated with other marketed antidepressants. As with all antidepressants, PRISTIQ should be used cautiously in patients with a history or family history of mania or hypomania. **Discontinuation Syndrome:** Discontinuation symptoms have been systematically and prospectively evaluated in patients treated with PRISTIQ during clinical studies in Major Depressive Disorder. Abrupt discontinuation or dose reduction has been associated with the appearance of new symptoms that include dizziness, nausea, headache, irritability, insomnia, diarrhea, anxiety, fatigue, abnormal dreams, and hyperhidrosis. In general, discontinuation events occurred more frequently with longer duration of therapy. During marketing of SNRIs (Serotonin and Norepinephrine Reuptake Inhibitors), and SSRIs (Selective Serotonin Reuptake Inhibitors), there have been spontaneous reports of adverse events occurring upon discontinuation of these drugs, particularly when abrupt, including the following: dysphoric mood, irritability, agitation, dizziness, sensory disturbances (e.g., paresthesia, such as electric shock sensations), anxiety, confusion, headache, lethargy, emotional lability, insomnia, hypomania, tinnitus, and seizures. While these events are generally self-limiting, there have been reports of serious discontinuation symptoms. Patients should be monitored for these symptoms when discontinuing treatment with PRISTIQ. A gradual reduction in the dose rather than abrupt cessation is recommended whenever possible. If intolerable symptoms occur following a decrease in the dose or upon discontinuation of treatment, then resuming the previously prescribed dose may be considered. Subsequently, the physician may continue decreasing the dose, but at a more gradual rate *[see Dosage and Administration (2.4) and Adverse Reactions (6.1) in the full prescribing information]*. **Seizure:** Cases of seizure have been reported in pre-marketing clinical studies with PRISTIQ. PRISTIQ has not been systematically evaluated in patients with a seizure disorder. Patients with a history of seizures were excluded from pre-marketing clinical studies. PRISTIQ should be prescribed with caution in patients with a seizure disorder. **Hyponatremia:** Hyponatremia may occur as a result of treatment with SSRIs and SNRIs, including PRISTIQ. In many cases, this hyponatremia appears to be the result of the syndrome of inappropriate antidiuretic hormone secretion (SIADH). Cases with serum sodium lower than 110 mmol/L have been reported. Elderly patients may be at greater risk of developing hyponatremia with SSRIs and SNRIs. Also, patients taking diuretics or who are otherwise volume depleted can be at greater risk *[see Use in Specific Populations (8.5) and Clinical Pharmacology (12.6) in the full prescribing information]*. Discontinuation of PRISTIQ should be considered in patients with symptomatic hyponatremia and appropriate medical intervention should be instituted. Signs and symptoms of hyponatremia include headache, difficulty concentrating, memory impairment, confusion, weakness, and unsteadiness, which can lead to falls. Signs and symptoms associated with more severe and/or acute cases have included hallucination, syncope, seizure, coma, respiratory arrest, and death. **Interstitial Lung Disease and Eosinophilic Pneumonia:** Interstitial lung disease and eosinophilic pneumonia associated with venlafaxine (the parent drug of PRISTIQ) therapy have been rarely reported. The possibility of these adverse events should be considered in patients treated with PRISTIQ who present with progressive dyspnea, cough, or chest discomfort. Such patients should undergo a prompt medical evaluation, and discontinuation of PRISTIQ should be considered.

ADVERSE REACTIONS: The following adverse reactions are discussed in greater detail in other sections of the label: Hypersensitivity *[see Contraindications (4)]*, Suicidal Thoughts and Behaviors in Adolescents and Young Adults *[see Warnings and Precautions (5.1)]*, Serotonin Syndrome *[see Warnings and Precautions (5.2)]*, Elevated Blood Pressure *[see Warnings and Precautions (5.3)]*, Abnormal Bleeding *[see Warnings and Precautions (5.4)]*, Narrow-Angle Glaucoma *[see Warnings and Precautions (5.5)]*, Activation of Mania/Hypomania *[see Warnings and Precautions (5.6)]*, Discontinuation Syndrome *[see Warnings and Precautions (5.7)]*, Seizure *[see Warnings and Precautions (5.8)]*, Hyponatremia *[see Warnings and Precautions (5.9)]*, Interstitial Lung Disease and Eosinophilic Pneumonia *[see Warnings and Precautions (5.10)]*. **Clinical Studies Experience:** Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical studies of another drug and may not reflect the rates observed in clinical practice. Patient exposure—PRISTIQ was evaluated for safety in 4,158 patients diagnosed with major depressive disorder who participated in multiple-dose pre-marketing studies, representing 1,677 patient-years of exposure. Among these 4,158 PRISTIQ treated patients; 1,834 patients were exposed to PRISTIQ in 8-week, placebo-controlled studies at doses ranging from 50 to 400 mg/day. Out of the 1,834 patients, 687 PRISTIQ treated patients continued into a 10-month open-label study. Of the total 4,158 patients exposed to at least one dose of PRISTIQ; 1,320 were exposed to PRISTIQ for 6 months, representing 1,058 patient-years of exposure, and 274 were exposed for one year, representing 241 patient-years of exposure. Adverse reactions reported as reasons for discontinuation of treatment—In the pooled 8-week placebo-controlled studies in patients with MDD, 12% of the 1,834 patients who received PRISTIQ (50 to 400 mg) discontinued treatment due to an adverse reaction, compared with 3% of the 1,116 placebo-treated patients. At the recommended dose of 50 mg, the discontinuation rate due to an adverse reaction for PRISTIQ (4.1%) was similar to the rate for placebo (3.8%). For the 100 mg dose of PRISTIQ the discontinuation rate due to an adverse reaction was 8.7%. The most common adverse reactions leading to discontinuation in at least 2% and at a rate greater than placebo of the PRISTIQ treated patients in the short-term studies, up to 8 weeks, were: nausea (4%); dizziness, headache and vomiting (2% each); in the longer-term studies, up to 11 months, the most common was vomiting (2%). Common adverse reactions in placebo-controlled MDD studies—The most commonly observed adverse reactions in PRISTIQ treated MDD patients in short-term fixed-dose studies (incidence ≥ 5% and at least twice the rate of placebo in the 50 or 100 mg dose groups) were: nausea, dizziness, insomnia, hyperhidrosis, constipation, somnolence, decreased appetite, anxiety, and specific male sexual function disorders. The incidence of common adverse reactions that occurred in ≥2% of PRISTIQ-treated MDD patients and twice the rate of placebo at any dose in the pooled 8-week, placebo-controlled, fixed-dose clinical studies (placebo, n=636; PRISTIQ 50 mg, n=317; PRISTIQ 100 mg, n=424; PRISTIQ 200 mg, n=307; PRISTIQ 400 mg, n=317) included Cardiac disorders: Blood pressure increased (1% placebo, 1% PRISTIQ 50 mg, 1% PRISTIQ 100 mg, 2% PRISTIQ 200 mg, 2% PRISTIQ 400 mg); Gastrointestinal disorders: Nausea (10% placebo, 22% PRISTIQ 50 mg, 26% PRISTIQ 100 mg, 36% PRISTIQ 200 mg, 41% PRISTIQ 400 mg), Dry mouth (9% placebo, 11% PRISTIQ 50 mg, 17% PRISTIQ 100 mg, 21% PRISTIQ 200 mg, 25% PRISTIQ 400 mg), Constipation (4% placebo, 9% PRISTIQ 50 mg, 9% PRISTIQ 100 mg, 10% PRISTIQ 200 mg, 14% PRISTIQ 400 mg), Vomiting (3% placebo, 3% PRISTIQ 50 mg, 4% PRISTIQ 100 mg, 6% PRISTIQ 200 mg, 9% PRISTIQ 400 mg); General disorders and administration site conditions: Fatigue (4% placebo, 7% PRISTIQ 50 mg, 7% PRISTIQ 100 mg, 10% PRISTIQ 200 mg, 11% PRISTIQ 400 mg), Chills (1% placebo, 1% PRISTIQ 50 mg, <1% PRISTIQ 100 mg, 3% PRISTIQ 200 mg, 4% PRISTIQ 400 mg), Feeling jittery (1% placebo, 1% PRISTIQ 50 mg, 2% PRISTIQ 100 mg, 3% PRISTIQ 200 mg, 3% PRISTIQ 400 mg); Metabolism and nutrition disorders: Decreased appetite (2% placebo, 5% PRISTIQ 50 mg, 8% PRISTIQ 100 mg, 10% PRISTIQ 200 mg, 10% PRISTIQ 400 mg); Nervous system disorders: Dizziness (5% placebo, 13% PRISTIQ 50 mg, 10% PRISTIQ 100 mg, 15% PRISTIQ 200 mg, 16% PRISTIQ 400 mg), Somnolence (4% placebo, 4% PRISTIQ 50 mg, 9% PRISTIQ 100 mg, 12% PRISTIQ 200 mg, 12% PRISTIQ 400 mg), Tremor (2% placebo, 2% PRISTIQ 50 mg, 3% PRISTIQ 100 mg, 9% PRISTIQ 200 mg, 9% PRISTIQ 400 mg), Disturbance in attention (<1% placebo, <1% PRISTIQ 50 mg, 1% PRISTIQ 100 mg, 2% PRISTIQ 200 mg, 1% PRISTIQ 400 mg); Psychiatric disorders: Insomnia (6% placebo, 9% PRISTIQ 50 mg, 12% PRISTIQ 100 mg, 14% PRISTIQ 200 mg, 15% PRISTIQ 400 mg), Anxiety (2% placebo, 3% PRISTIQ 50 mg, 5% PRISTIQ 100 mg, 4% PRISTIQ 200 mg, 4% PRISTIQ 400 mg), Nervousness (1% placebo, <1% PRISTIQ 50 mg, 1% PRISTIQ 100 mg, 2% PRISTIQ 200 mg, 2% PRISTIQ 400 mg), Abnormal dreams (1% placebo, 2% PRISTIQ 50 mg, 3% PRISTIQ 100 mg, 2% PRISTIQ 200 mg, 4% PRISTIQ 400 mg); Renal and urinary disorders: Urinary hesitation (0% placebo, <1% PRISTIQ 50 mg, 1% PRISTIQ 100 mg, 2% PRISTIQ 200 mg, 2% PRISTIQ 400 mg); Respiratory, thoracic and mediastinal disorders: Yawning (<1% placebo, 1% PRISTIQ 50 mg, 1% PRISTIQ 100 mg, 4% PRISTIQ 200 mg, 3% PRISTIQ 400 mg); Skin and subcutaneous tissue disorders: Hyperhidrosis (4% placebo, 10% PRISTIQ 50 mg, 11% PRISTIQ 100 mg, 18% PRISTIQ 200 mg, 21% PRISTIQ 400 mg); Special Senses: Vision blurred (1% placebo, 3% PRISTIQ 50 mg, 4% PRISTIQ 100 mg, 4% PRISTIQ 200 mg, 4% PRISTIQ 400 mg), Mydriasis (<1% placebo, 2% PRISTIQ 50 mg, 2% PRISTIQ 100 mg, 6% PRISTIQ 200 mg, 6% PRISTIQ 400 mg), Vertigo (1% placebo, 2% PRISTIQ 50 mg, 1% PRISTIQ 100 mg, 5% PRISTIQ 200 mg, 3% PRISTIQ 400 mg), Tinnitus (1% placebo, 2% PRISTIQ 50 mg, 1% PRISTIQ 100 mg, 1% PRISTIQ 200 mg, 2% PRISTIQ 400 mg), Dysgeusia (1% placebo, 1% PRISTIQ 50 mg, 1% PRISTIQ 100 mg, 1% PRISTIQ 200 mg, 2% PRISTIQ 400 mg); Vascular disorders: Hot flush (<1% placebo, 1% PRISTIQ 50 mg, 1% PRISTIQ 100 mg, 2% PRISTIQ 200 mg, 2% PRISTIQ 400 mg).

Sexual function adverse reactions—The incidence of sexual function adverse reactions that occurred in ≥ 2% of PRISTIQ treated MDD patients in any fixed-dose group (pooled 8-week, placebo-controlled, fixed and flexible-dose, clinical studies) included Men only (placebo, n=239; PRISTIQ 50 mg, n=108; PRISTIQ 100 mg, n=157; PRISTIQ 200 mg, n=131; PRISTIQ 400 mg, n=154): Anorgasmia (0% placebo, 0% PRISTIQ 50 mg, 3% PRISTIQ 100 mg, 5% PRISTIQ 200 mg, 8% PRISTIQ 400 mg), Libido decreased (1% placebo, 4% PRISTIQ 50 mg, 5% PRISTIQ 100 mg, 6% PRISTIQ 200 mg, 3% PRISTIQ 400 mg), Orgasm abnormal (0% placebo, 0% PRISTIQ 50 mg, 1% PRISTIQ 100 mg, 2% PRISTIQ 200 mg, 3% PRISTIQ 400 mg), Ejaculation delayed (<1% placebo, 1% PRISTIQ 50 mg, 5% PRISTIQ 100 mg, 7% PRISTIQ 200 mg, 6% PRISTIQ 400 mg), Erectile dysfunction (1% placebo, 3% PRISTIQ 50 mg, 6% PRISTIQ 100 mg, 8% PRISTIQ 200 mg, 11% PRISTIQ 400 mg), Ejaculation disorder (0% placebo, 0% PRISTIQ 50 mg, 1% PRISTIQ 100 mg, 2% PRISTIQ 200 mg, 5% PRISTIQ 400 mg), Ejaculation failure (0% placebo, 1% PRISTIQ 50 mg, 0% PRISTIQ 100 mg, 2% PRISTIQ 200 mg, 2% PRISTIQ 400 mg), Sexual dysfunction (0% placebo, 1% PRISTIQ 50 mg, 0% PRISTIQ 100 mg, 0% PRISTIQ 200 mg, 2% PRISTIQ 400 mg); Women only (placebo, n=397; PRISTIQ 50 mg, n=209; PRISTIQ 100 mg, n=267; PRISTIQ 200 mg, n=176; PRISTIQ 400 mg, n=163): Anorgasmia (0% placebo, 1% PRISTIQ 50 mg, 1% PRISTIQ 100 mg, 0% PRISTIQ 200 mg, 3% PRISTIQ 400 mg).

Other adverse reactions observed in clinical studies: Other infrequent adverse reactions, not described elsewhere in the label, occurring at an incidence of <2% in MDD patients treated with PRISTIQ were: *Cardiac disorders*—Tachycardia; *General disorders and administration site conditions*—Asthenia; *Investigations*—Weight increased, liver function test abnormal, blood prolactin increased; *Musculoskeletal and connective tissue disorders*—Musculoskeletal stiffness; *Nervous system disorders*—Syncope, convulsion, dystonia; *Psychiatric disorders*—Depersonalization, bruxism; *Renal and urinary disorders*—Urinary retention; *Skin and subcutaneous tissue disorders*—Rash, alopecia, photosensitivity reaction, angioedema. In clinical studies, there were uncommon reports of ischemic cardiac adverse reactions, including myocardial ischemia, myocardial infarction, and coronary occlusion requiring revascularization; these patients had multiple underlying cardiac risk factors. More patients experienced these events during PRISTIQ treatment as compared to placebo.

Laboratory, ECG and vital sign changes observed in MDD clinical studies—The following changes were observed in placebo-controlled, short-term MDD studies with PRISTIQ. *Lipids*—Elevations in fasting serum total cholesterol, LDL (low density lipoproteins) cholesterol, and triglycerides occurred in the controlled studies. Some of these abnormalities were considered potentially clinically significant. The percentage of patients who exceeded a predetermined threshold value included: Total Cholesterol increase of ≥50 mg/dl and an absolute value of ≥261 mg/dl (2% placebo, 3% PRISTIQ 50 mg, 4% PRISTIQ 100 mg, 4% PRISTIQ 200 mg, 10% PRISTIQ 400 mg), LDL Cholesterol increase ≥50 mg/dl and an absolute value of ≥190 mg/dl (0% placebo, 1% PRISTIQ 50 mg, 0% PRISTIQ 100 mg, 1% PRISTIQ 200 mg, 2% PRISTIQ 400 mg), Triglycerides, fasting, ≥327 mg/dl (3% placebo, 2% PRISTIQ 50 mg, 1% PRISTIQ 100 mg, 4% PRISTIQ 200 mg, 6% PRISTIQ 400 mg).

Proteinuria—Proteinuria, greater than or equal to trace, was observed in the fixed-dose controlled studies. This proteinuria was not associated with increases in BUN or creatinine and was generally transient. The percentage of patients with proteinuria in the fixed-dose clinical studies were 4% placebo, 6% PRISTIQ 50 mg, 8% PRISTIQ 100 mg, 5% PRISTIQ 200 mg, 7% PRISTIQ 400 mg.

Vital sign changes—Mean changes observed in placebo-controlled, short-term, fixed-dose, pre-marketing, controlled studies with PRISTIQ in patients with MDD included Blood pressure: Supine systolic bp (-1.4 mm Hg placebo, 1.2 mm Hg PRISTIQ 50 mg, 2.0 mm Hg PRISTIQ 100 mg, 2.5 mm Hg PRISTIQ 200 mg, 2.1 mm Hg PRISTIQ 400 mg); Supine diastolic bp (-0.6 mm Hg placebo, 0.7 mm Hg PRISTIQ 50 mg, 0.8 mm Hg PRISTIQ 100 mg, 1.8 mm Hg PRISTIQ 200 mg, 2.3 mm Hg PRISTIQ 400 mg); Pulse rate: Supine pulse (-0.3 bpm placebo, 1.3 bpm PRISTIQ 50 mg, 1.3 bpm PRISTIQ 100 mg, 0.9 bpm PRISTIQ 200 mg, 4.1 bpm PRISTIQ 400 mg); Weight: (0.0 kg placebo, -0.4 kg PRISTIQ 50 mg, -0.6 kg PRISTIQ 100 mg, -0.9 kg PRISTIQ 200 mg, -1.1 kg PRISTIQ 400 mg).

Treatment with PRISTIQ at all doses from 50 mg/day to 400 mg/day in controlled studies was associated with sustained hypertension, defined as treatment-emergent supine diastolic blood pressure (SDBP) ≥90 mm Hg and ≥10 mm Hg above baseline for 3 consecutive on-therapy visits. The proportion of patients with sustained elevation of supine diastolic blood pressure included 0.5% placebo, 1.3% PRISTIQ 50 mg, 0.7% PRISTIQ 100 mg, 1.1% PRISTIQ 200 mg, 2.3% PRISTIQ 400 mg. Analyses of patients in PRISTIQ short-term controlled studies who met criteria for sustained hypertension revealed a consistent increase in the proportion of patients who developed sustained hypertension. This was seen at all doses with a suggestion of a higher rate at 400 mg/day.

Orthostatic hypotension—In the short-term, placebo-controlled clinical studies with doses of 50 to 400 mg, systolic orthostatic hypotension (decrease ≥30 mm Hg from supine to standing position) occurred more frequently in patients ≥65 years of age receiving PRISTIQ (8%, 7/87) versus placebo (2.5%, 1/40), compared to patients <65 years of age receiving PRISTIQ (0.9%, 18/1,937) versus placebo (0.7%, 8/1,218). **Postmarketing Experience**—The following adverse reaction has been identified during post-approval use of PRISTIQ. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure: *Skin and subcutaneous tissue disorders*—Stevens-Johnson syndrome. **DRUG INTERACTIONS: Monoamine Oxidase Inhibitors (MAOI)**—*[see Dosage and Administration (2.6), Contraindications (4) and Warnings and Precautions (5.2) in the full prescribing information]*. **Serotonergic Drugs**—*[see Dosage and Administration (2.6), Contraindications (4) and Warnings and Precautions (5.2) in the full prescribing information]*. **Drugs that Interfere with Hemostasis (e.g., NSAIDs, Aspirin, and Warfarin)**—Serotonin release by platelets plays an important role in hemostasis. Epidemiological studies of case-control and cohort design that have demonstrated an association between use of psychotropic drugs that interfere with serotonin reuptake and the occurrence of upper gastrointestinal bleeding. These studies have also shown that concurrent use of an NSAID or aspirin may potentiate this risk of bleeding. Altered anticoagulant effects, including increased bleeding, have been reported when SSRIs and SNRIs are co-administered with warfarin. Patients receiving warfarin therapy should be carefully monitored when PRISTIQ is initiated or discontinued *[see Warnings and Precautions (5.4) in the full prescribing information]*. **Potential for Desvenlafaxine to Affect Other Drugs**—Clinical studies have shown that desvenlafaxine does not have a clinically relevant effect on CYP2D6 metabolism at the dose of 100 mg daily. Substrates primarily metabolized by CYP2D6 (e.g., desipramine, atomoxetine, dextromethorphan, metoprolol, nebivolol, perphenazine, tolterodine) should be dosed at the original level when co-administered with PRISTIQ 100 mg or lower. Reduce the dose of these substrates by one-half if co-administered with 400 mg of PRISTIQ. The substrate dose should be increased to the original level when 400 mg of PRISTIQ is discontinued. **Other Drugs Containing Desvenlafaxine or Venlafaxine**—Avoid use of PRISTIQ with other desvenlafaxine-containing products or venlafaxine products. The concomitant use of PRISTIQ with other desvenlafaxine-containing products or venlafaxine will increase desvenlafaxine blood levels and increase dose-related adverse reactions *[see Adverse Reactions (6) in the full prescribing information]*. **Ethanol**—A clinical study has shown that PRISTIQ does not increase the impairment of mental and motor skills caused by ethanol. However, as with all CNS-active drugs, patients should be advised to avoid alcohol consumption while taking PRISTIQ.

USE IN SPECIFIC POPULATIONS: Pregnancy—Pregnancy Category C: *Risk summary*—There are no adequate and well-controlled studies of PRISTIQ in pregnant women. In reproductive developmental studies in rats and rabbits with desvenlafaxine succinate, evidence of teratogenicity was not observed at doses up to 30 times a human dose of 100 mg/day (on a mg/m^2 basis) in rats, and up to 15 times a human dose of 100 mg/day (on a mg/m^2 basis) in rabbits. An increase in rat pup deaths was seen during the first 4 days of lactation when dosing occurred during gestation and lactation, at doses greater than 10 times a human dose of 100 mg/day (on a mg/m^2 basis). PRISTIQ should be used during pregnancy only if the potential benefits justify the potential risks to the fetus. *Clinical considerations*—A prospective longitudinal study of 201 women with history of major depression who were euthymic at the beginning of pregnancy, showed women who discontinued antidepressant medication during pregnancy were more likely to experience a relapse of major depression than women who continued antidepressant medication. *Human data*—Neonates exposed to SNRIs (Serotonin and Norepinephrine Reuptake Inhibitors), or SSRIs (Selective Serotonin Reuptake Inhibitors), late in the third trimester have developed complications requiring prolonged hospitalization, respiratory support, and tube feeding. Such complications can arise immediately upon delivery. Reported clinical findings have included respiratory distress, cyanosis, apnea, seizures, temperature instability, feeding difficulty, vomiting, hypoglycemia, hypotonia, hypertonia, hyperreflexia, tremor, jitteriness, irritability, and constant crying. These features are consistent with either a direct toxic effect of SSRIs and SNRIs or, possibly, a drug discontinuation syndrome. It should be noted that, in some cases, the clinical picture is consistent with serotonin syndrome *[see Warnings and Precautions (5.2) in the full prescribing information]*. *Animal data*—When desvenlafaxine succinate was administered orally to pregnant rats and rabbits during the period of organogenesis at doses up to 300 mg/kg/day and 75 mg/kg/day, respectively, no teratogenic effects were observed. These doses are 30 times a human dose of 100 mg/day (on a mg/m^2 basis) in rats and 15 times a human dose of 100 mg/day (on a mg/m^2 basis) in rabbits. However, fetal weights were decreased and skeletal ossification was delayed in rats in association with maternal toxicity at the highest dose, with a no-effect dose 10 times a human dose of 100 mg/day (on a mg/m^2 basis). **When desvenlafaxine succinate was administered orally to pregnant rats throughout gestation and lactation, there was a decrease in pup weights and an increase in pup deaths during the first four days of lactation at the highest dose of 300 mg/kg/day. The cause of these deaths is not known. The no-effect dose for rat pup mortality was 10 times a human dose of 100 mg/day (on a mg/m^2 basis). Post-weaning growth and reproductive performance of the progeny were not affected by maternal treatment with desvenlafaxine succinate at a dose 30 times a human dose of 100 mg/day (on a mg/m^2 basis). Nursing Mothers**—Desvenlafaxine (O-desmethylvenlafaxine) is excreted in human milk. Because of the potential for serious adverse reactions in nursing infants from PRISTIQ, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. **Pediatric Use**—Safety and effectiveness in pediatric patients have not been established *[see Boxed Warning and Warnings and Precautions (5.1) in the full prescribing information]*. Anyone considering the use of PRISTIQ in a child or adolescent must balance the potential risks with the clinical need. **Geriatric Use**—Of the 4,158 patients in clinical studies with PRISTIQ, 6% were 65 years of age or older. No overall differences in safety or efficacy were observed between these patients and younger patients; however, in the short-term placebo-controlled studies, there was a higher incidence of systolic orthostatic hypotension in patients ≥65 years of age compared to patients <65 years of age treated with PRISTIQ *[see Adverse Reactions (6) in the full prescribing information]*. For elderly patients, possible reduced renal clearance of PRISTIQ should be considered when determining dose *[see Dosage and Administration (2.2) and Clinical Pharmacology (12.3) in the full prescribing information]*. SSRIs and SNRIs, including PRISTIQ, have been associated with cases of clinically significant hyponatremia in elderly patients, who may be at greater risk for this adverse event *[see Warnings and Precautions (5.9) in the full prescribing information]*. **Renal Impairment**—In subjects with renal impairment the clearance of PRISTIQ was decreased. In subjects with severe renal impairment (24-hr CrCl <30 mL/min, Cockcroft-Gault) and end-stage renal disease, elimination half-lives were significantly prolonged, increasing exposures to PRISTIQ; therefore, dosage adjustment is recommended in these patients *[see Dosage and Administration (2.2) and Clinical Pharmacology (12.3) in the full prescribing information]*. **Hepatic Impairment**—The mean terminal half life ($t_{1/2}$) changed from approximately 10 hours in healthy subjects and subjects with mild hepatic impairment to 13 and 14 hours in moderate and severe hepatic impairment, respectively. The recommended dose in patients with moderate to severe hepatic impairment is 50 mg/day. Dose escalation above 100 mg/day is not recommended *[see Clinical Pharmacology (12.3) in the full prescribing information]*.

DRUG ABUSE AND DEPENDENCE: Controlled Substance—PRISTIQ is not a controlled substance.

OVERDOSAGE: Human Experience with Overdosage—There is limited clinical trial experience with desvenlafaxine succinate overdosage in humans. However, desvenlafaxine (PRISTIQ) is the major active metabolite of venlafaxine. Overdose experience reported with venlafaxine (the parent drug of PRISTIQ) is presented below; the identical information can be found in the *Overdosage* section of the venlafaxine package insert. In postmarketing experience, overdose with venlafaxine (the parent drug of PRISTIQ) has occurred predominantly in combination with alcohol and/or other drugs. The most commonly reported events in overdosage include tachycardia, changes in level of consciousness (ranging from somnolence to coma), mydriasis, seizures, and vomiting. Electrocardiogram changes (e.g., prolongation of QT interval, bundle branch block, QRS prolongation), sinus and ventricular tachycardia, bradycardia, hypotension, rhabdomyolysis, vertigo, liver necrosis, serotonin syndrome, and death have been reported. Published retrospective studies report that venlafaxine overdosage may be associated with an increased risk of fatal outcomes compared to that observed with SSRI antidepressant products, but lower than that for tricyclic antidepressants. Epidemiological studies have shown that venlafaxine-treated patients have a higher pre-existing burden of suicide risk factors than SSRI-treated patients. The extent to which the finding of an increased risk of fatal outcomes can be attributed to the toxicity of venlafaxine in overdosage, as opposed to some characteristic(s) of venlafaxine-treated patients, is not clear. **Management of Overdosage**—No specific antidotes for PRISTIQ are known. In managing over dosage, consider the possibility of multiple drug involvement. In case of overdose, call Poison Control Center at 1-800-222-1222 for latest recommendations.

This brief summary is based on PRISTIQ Prescribing Information LAB-0452-8.0, revised February 2013.

Major Depressive Disorder (MDD) can make it all feel overwhelming.

Consider PRISTIQ® (desvenlafaxine) 50 mg for your adult MDD patients

An SNRI with a starting dose that is the proven effective dose* and a low discontinuation rate due to adverse reactions[1]

- Discontinuation rate due to adverse reactions comparable to placebo (4.1% vs 3.8%)[2]
- Most commonly observed adverse reactions vs placebo include nausea (22% vs 10%), dizziness (13% vs 5%), hyperhidrosis (10% vs 4%), constipation (9% vs 4%), and decreased appetite (5% vs 2%)

*50 mg per day is the recommended dose for most patients. The maximum recommended dose in patients with severe renal impairment (24-hr CrCl less than 30 mL/min, C-G) or end-stage renal disease (ESRD) is 50 mg every other day. Supplemental doses should not be given to patients after dialysis.

Important Safety Information for PRISTIQ

WARNING: SUICIDAL THOUGHTS AND BEHAVIORS

Antidepressants increased the risk of suicidal thoughts and behavior in children, adolescents, and young adults in short-term studies. These studies did not show an increase in the risk of suicidal thoughts and behavior with antidepressant use in patients over age 24; there was a reduction in risk with antidepressant use in patients aged 65 and older.

In patients of all ages who are started on antidepressant therapy, monitor closely for worsening, and for emergence of suicidal thoughts and behaviors. Advise families and caregivers of the need for close observation and communication with the prescriber.

PRISTIQ is not approved for use in pediatric patients.

Contraindications

- PRISTIQ is contraindicated in patients with a known hypersensitivity to PRISTIQ or venlafaxine. Angioedema has been reported in patients treated with PRISTIQ.
- **Serotonin syndrome and MAOIs:** Do not use MAOIs intended to treat psychiatric disorders with PRISTIQ or within 7 days of stopping treatment with PRISTIQ. Do not use PRISTIQ within 14 days of stopping an MAOI intended to treat psychiatric disorders. In addition, do not start PRISTIQ in a patient who is being treated with an MAOI such as linezolid or intravenous methylene blue.

Selected Warnings and Precautions

- **All patients treated with antidepressants should be monitored appropriately and observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially during the first few months of treatment and when changing the dose.** Consider changing the therapeutic regimen, including possibly discontinuing the medication, in patients whose depression is persistently worse or includes symptoms of anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia, hypomania, mania, or suicidality that are severe, abrupt in onset, or were not part of the patient's presenting symptoms. **Families and caregivers of patients being treated with antidepressants should be alerted about the need to monitor patients.**
- The development of a potentially life-threatening serotonin syndrome has been reported with SSRIs and SNRIs, including with PRISTIQ, both when taken alone, but especially when co-administered with other serotonergic agents (including triptans, tricyclic antidepressants, fentanyl, lithium, tramadol, tryptophan, buspirone, and St. John's Wort) and with drugs that impair metabolism of serotonin (in particular, MAOIs, both those intended to treat psychiatric disorders and also others, such as linezolid and intravenous methylene blue). If such events occur, immediately discontinue PRISTIQ and any concomitant serotonergic agents, and initiate supportive treatment. If concomitant use of PRISTIQ with other serotonergic drugs is clinically warranted, patients should be made aware of a potential increased risk for serotonin syndrome, particularly during treatment initiation and dose increase.
- Patients receiving PRISTIQ should have regular monitoring of blood pressure, since increases in blood pressure were observed in clinical studies. Pre-existing hypertension should be controlled before starting PRISTIQ. Caution should be exercised in treating patients with pre-existing hypertension, cardiovascular or cerebrovascular conditions that might be compromised by increases in blood pressure. Cases of elevated blood pressure requiring immediate treatment have been reported. For patients who experience a sustained increase in blood pressure, either dose reduction or discontinuation should be considered.
- SSRIs and SNRIs, including PRISTIQ, may increase the risk of bleeding events. Concomitant use of aspirin, NSAIDs, warfarin, and other anticoagulants may add to this risk.
- Mydriasis has been reported in association with PRISTIQ; therefore, patients with raised intraocular pressure or those at risk of acute narrow-angle glaucoma (angle-closure glaucoma) should be monitored.
- PRISTIQ is not approved for use in bipolar depression. Prior to initiating treatment with an antidepressant, patients should be adequately screened to determine the risk of bipolar disorder.
- PRISTIQ should be used cautiously in patients with a history or family history of mania or hypomania or with a history of seizure disorder.
- On discontinuation, adverse events, some of which may be serious, have been reported with PRISTIQ and other SSRIs and SNRIs. Abrupt discontinuation of PRISTIQ has been associated with the appearance of new symptoms. Patients should be monitored for symptoms when discontinuing treatment. A gradual reduction in dose rather than abrupt cessation is recommended whenever possible.
- Hyponatremia may occur as a result of treatment with SSRIs and SNRIs, including PRISTIQ. Discontinuation of PRISTIQ should be considered in patients with symptomatic hyponatremia.
- Interstitial lung disease and eosinophilic pneumonia associated with venlafaxine (the parent drug of PRISTIQ) therapy have been rarely reported.

Adverse Reactions

- The most commonly observed adverse reactions in patients taking PRISTIQ vs placebo for MDD in short-term fixed-dose premarketing studies (incidence ≥5% and at least twice the rate of placebo in the 50-mg dose group) were nausea (22% vs 10%), dizziness (13% vs 5%), hyperhidrosis (10% vs 4%), constipation (9% vs 4%), and decreased appetite (5% vs 2%).

Indication

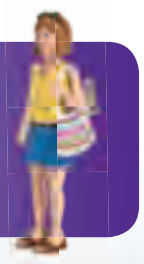
PRISTIQ Extended-Release Tablets are indicated for the treatment of major depressive disorder in adults.

References: 1. Thase ME, Kornstein SG, Germain JM, Jiang Q, Guico-Pabia C, Ninan PT. An integrated analysis of the efficacy of desvenlafaxine compared with placebo in patients with major depressive disorder. *CNS Spectr.* 2009;14(3):144-154. **2.** Clayton AH, Kornstein SG, Rosas G, Guico-Pabia C, Tourian KA. An integrated analysis of the safety and tolerability of desvenlafaxine compared with placebo in the treatment of major depressive disorder. *CNS Spectr.* 2009;14(4):183-195. **3.** Data on file. Pfizer Inc, New York, NY.

Please see brief summary of full Prescribing Information on adjacent page.

Pristiq® desvenlafaxine 50 mg EXTENDED-RELEASE TABLETS

MORE THAN 14 MILLION PRESCRIPTIONS FILLED[3†]



To learn more about PRISTIQ, go to **www.pristiqhcp.com**

†IMS Health data, February 2013; total prescriptions filled year-to-date 2013. Includes data for 50-mg and 100-mg tablets.

Pfizer