WWW.PSYCHNEWS.ORG | NEWSPAPER OF THE AMERICAN PSYCHIATRIC ASSOCIATION | VOLUME 48, NUMBER 2, JANUARY 18, 2013

PSYCHIATRIC NEWS

The First and Last Word in Psychiatry

ISSN 0033-2704

AP Photo/Seth Wenig

Wooden angels are displayed as part of memorial to the shooting victims in Newtown, Conn., just days before Christmas. See article below.

Volunteer Psychiatrists Help Newtown Cope With Tragedy

Connecticut psychiatrists recount their experiences aiding a community in shock after the shooting at Sandy Hook Elementary School last month.

BY AARON LEVIN

On Saturday, December 15, 2012, the day after the mass shooting at Sandy Hook Elementary School in Newtown, Conn., Shaukat Khan, M.D., the chair of the Connecticut Psychiatric Society (CPS) Disaster Psychiatry Committee, organized the district branch's disaster team. Over the ensuing week, team members provided psychological first aid or counseling to a community suffering from the tragic event.

Mental health professionals—social workers, nurses, licensed therapists, pastoral counselors, and school counselors, as well as the psychiatrists—all volunteered to help area residents at several locations in Newtown. Some of the psychiatrists recounted their experiences to *Psychiatric News* a few days later.

"We met beautiful little children, hearing their stories, meeting the parents and teachers, supporting them as much as we could," said Khan, a psychiatrist at the VA Connecticut Health System in West Haven and a clinical assistant professor at Yale. "We are possibly making some difference in their lives."

One little boy, who was in another classroom during the shooting, arrived with his father and younger sister. He told Khan that he had a dream in which something bad was happening and he put his sister into a closet to save her. Later, speaking to Khan alone, the father broke down in tears from his own stress.

"It was a heartbreaking experience, with saddening encounters, but satisfying work," he said.

Samya Hawley, M.D., is a child and adult psychiatrist who works with children at the Village for Families and Children in Hartford.

see **Newtown** on page 12

Continuity and Changes Mark New Text Of *DSM-5*

The *DSM-5* Task Force chair discusses conceptual themes driving changes to the new manual. This is the first in a series continuing through May that will summarize the diagnostic and organizational differences between *DSM-IV* and *DSM-5*.

BY MARK MORAN

DSM-5, approved by the APA Board of Trustees in December, reflects the "state of the clinical science" in psychiatric diagnosis, incorporating important findings from genetic, neurobiological, and treatment research, while also maintaining substantial continuity for maximum clinical utility.

The latest edition of APA's *Diagnostic and Statistical Manual of Mental Disorders* will be published in May, and while clinicians will find much that is familiar, important differences—not only in criteria for individual disorders, but in the organization of the text—will be readily apparent. The changes reflect an effort begun more than a decade ago to respond to challenges posed by research and clinical experience to previous editions of the manual. Those challenges include high rates of comorbidity within and across *DSM* chapters, an excessive use of and

see **DSM-5** on page 6

PERIODICALS: TIME SENSITIVE MATERIALS

INSIDE

8 APA 2013 ELECTION

By voting in the APA election, you will help steer the Association's future.

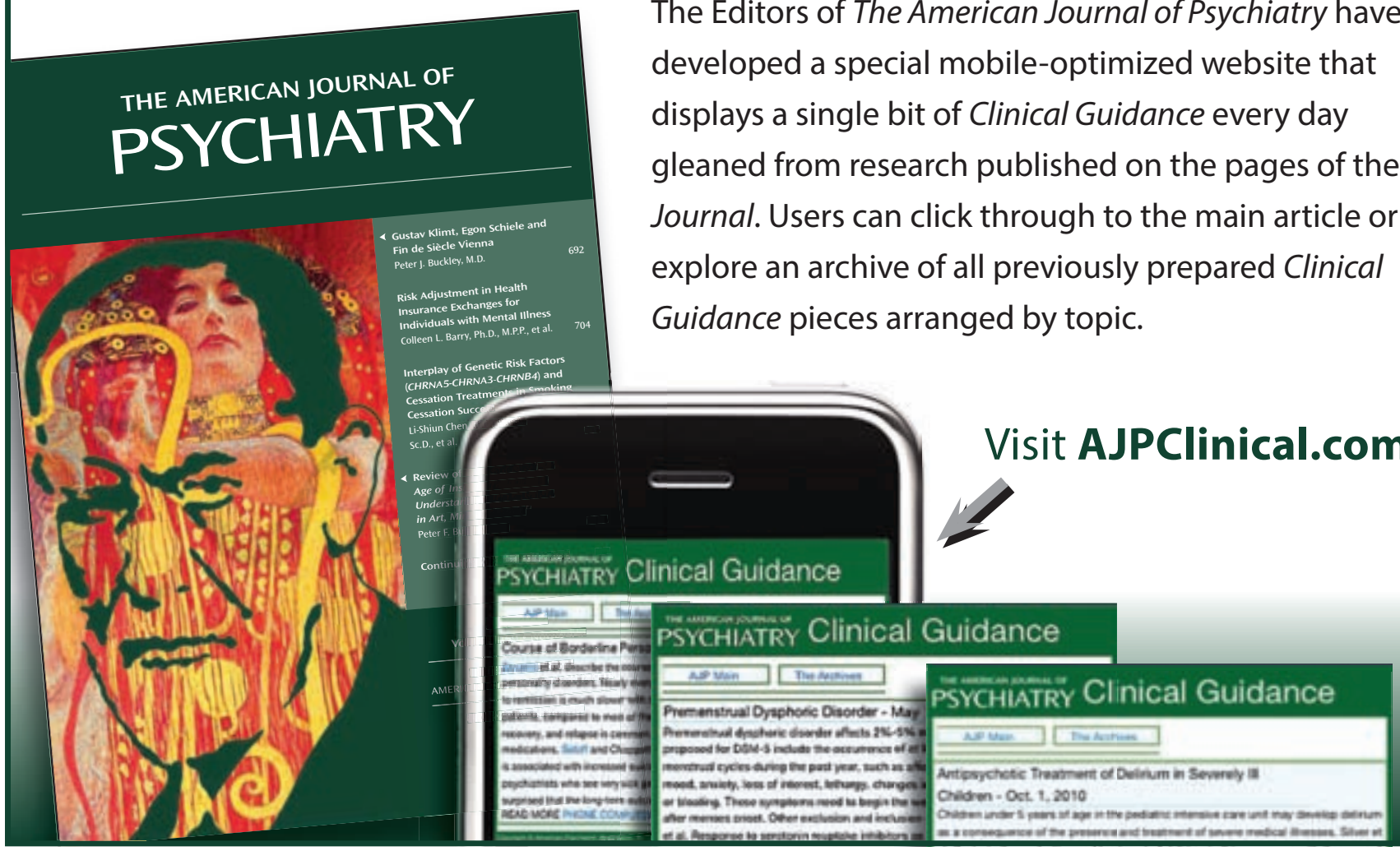
13

Sign up for annual meeting courses now, before your favorites are filled.

21

Exposure to at least one type of air pollution may be an autism risk factor.

A Daily "Pearl" is Just a Click Away!



The Editors of *The American Journal of Psychiatry* have developed a special mobile-optimized website that displays a single bit of *Clinical Guidance* every day gleaned from research published on the pages of the *Journal*. Users can click through to the main article or explore an archive of all previously prepared *Clinical Guidance* pieces arranged by topic.

Visit **AJPClinical.com**

AMERICAN PSYCHIATRIC ASSOCIATION
166TH ANNUAL MEETING
MAY 18-22, 2013 • SAN FRANCISCO, CA

This is ONE APA Annual Meeting YOU Don't Want to Miss!

Discover – Learn everything you need to know about the new *DSM-5*

Learn – Expand your knowledge base with new advances in the field of psychiatry, best practices, and clinical research

Experts – Benefit from world-renowned lecturers, including five Nobel Laureates

Value – Participate in over 400 clinical and scientific sessions; earn CME; Explore the exhibit hall; Receive special discounts on publications, journals, and CME products – all in one location

Network – Expand your peer network and meet new colleagues from around the world

Registration and housing are now open.

For more information and to register at the lowest rates available, visit **www.psychiatry.org/annualmeeting**

Reserve your housing before preferred rooms are sold out. Call Travel Planners at 800-221-3531 or 212-532-1660.

American Psychiatric Association
Chief Executive Officer/Medical Director

American Psychiatric Association
Member Driven, Science Based, Patient Focused

The American Psychiatric Association seeks an accomplished Psychiatric Physician Executive to serve as Chief Executive Officer/Medical Director.

The American Psychiatric Association (*APA*) is the medical specialty society representing 36,000 psychiatrists in the U.S. and from around the world.

APA, founded in 1844, is the largest and longest-serving psychiatric medical association. Its member physicians work together to ensure humane care and effective treatment for all persons with mental disorders, including intellectual disability and substance use disorders. *APA is the voice and conscience of modern psychiatry*.

The ideal CEO/Medical Director is a Board-certified psychiatrist with at least 10 years of progressively increasing responsibility with health care service delivery, financial and organizational management, government relations, and academic programs.

The successful candidate will have the stature to serve as a national leader and spokesperson for the psychiatric profession; absolute personal integrity; superior communication and interpersonal skills; a nuanced appreciation of the role of the CEO of a membership organization; the ability to relate well to the APA Board, Assembly, officers, and members; and the skills to manage a large and complex organization.

Heidrick & Struggles has been retained to assist with this important recruitment. Letters of application with curriculum vitae, or letters of nominations should be submitted by e-mail to: aneubauer@heidrick.com.

American Psychiatric Association is an equal opportunity, affirmative action employer.

©Copyright 2013, American Psychiatric Association

Psychiatric News, ISSN 0033-2704, is published bi-weekly on the first and third Friday of each month by the American Psychiatric Association, 1000 Wilson Boulevard, Arlington, Va. 22209-3901. Periodicals postage paid at Arlington, Va., and additional mailing offices. Postmaster: send address changes to *Psychiatric News,* APA, Suite 1825, 1000 Wilson Boulevard, Arlington, Va. 22209-3901. Online version: ISSN 1559-1255.

SUBSCRIPTIONS
U.S.: individual, $123. International: APA member, $167; nonmember, $184. Single issues: U.S., $24; international, $41. Institutional subscriptions are tier priced. For site licensing and pricing information, call (800) 368-5777 or e-mail institutions@psych.org.

OFFICERS OF THE ASSOCIATION
Dilip Jeste, M.D., President
Jeffrey Lieberman, M.D., President-elect
David Fassler, M.D., Treasurer
Roger Peele, M.D., Secretary
Scott Benson, M.D., Speaker of the Assembly
James H. Scully Jr., M.D., Medical Director

STAFF OF *PSYCHIATRIC NEWS*
Jeffrey Borenstein, M.D., **Editor in Chief**
Catherine F. Brown, **Executive Editor**
Ken Hausman, **Associate Editor**
Joan Arehart-Treichel, Mark Moran, Aaron Levin, Leslie Sinclair, **Senior Staff Writers**
B. Alma Herndon, **Production Manager**
Sergey Ivanov, **Senior Graphic Designer**
Christopher White, **Online Content Editor**
Eve Bender, Jonathan Wolfe, Jun Yan, Lynne Lamberg, **Contributors**
Lindsey Fox, **Advertising Manager**
Roger Domras, **Director of Circulation**

***PSYCHIATRIC NEWS* EDITORIAL ADVISORY BOARD**
Joseph Cerimele, M.D., Paramjit Joshi, M.D., John Luo, M.D., Molly McVoy, M.D., Claudia Reardon, M.D., Altha Stewart, M.D., and Ann Marie Sullivan, M.D.,

PUBLISHER
Rebecca Rinehart

EDITORS-IN-CHIEF EMERITI
Robert J. Campbell III, M.D.
James P. Krajeski, M.D.

EDITORIAL OFFICES
Telephone: (703) 907-7860
E-mail: PNews@psych.org
Web site: psychnews.org

ADVERTISING SALES
Frank Cox, Kathleen Harrison, Tim Wolfinger, Gina Bennicasa, Eamon Wood, Pharmaceutical Media Inc., 30 East 33rd Street, New York, N.Y. 10016; (212) 904-0379; fax: (212) 685-6126; twolfinger@pminy.com; gbennicasa@pminy.com. Nonpharmaceutical and Classified advertising: ewood@pminy.com. (212) 907-0363

CHANGES OF ADDRESS
Call the APA Answer Center at (888) 35-PSYCH in the U.S. and Canada; in other countries, call (703) 907-7300.

The content of *Psychiatric News* does not necessarily reflect the views of APA or the editors. Unless so stated, neither *Psychiatric News* nor APA guarantees, warrants, or endorses information or advertising in this newspaper. Clinical opinions are not peer reviewed and thus should be independently verified.

The information or advertising contained in this newspaper is not intended to be a substitute for professional treatment or diagnosis. Reliance on such information is at the reader's own risk; neither APA nor *Psychiatric News* shall be liable if a reader relies on information in the newspaper rather than seeking and following professional advice in a timely manner.

Those who submit letters to the editor and other types of material for *Psychiatric News* are agreeing that APA has the right, in its sole discretion, to use their submission in print, electronic, or any other media.

CONTENTS

PROFESSIONAL NEWS

5 | **Major Growth Expected in Young Field of Mental Illness Prevention**
Mental illness prevention research is rapidly expanding, with studies showing evidence of what strategies work and for what illnesses. Psychiatrists speculate on what prevention advances will emerge in the next few years.

6 | **Neurodevelopmental Disorders: What's Coming in *DSM-5***
DSM-5 will incorporate several significant changes to criteria for diagnosing neurodevelopmental disorders, including addition of social communication disorder. In addition, several autism-related disorders that were separate diagnoses in *DSM-IV* will be combined, as will several learning disorders.

8 | **Elderly Patients Often Fail to Get Effective Depression Care**
A new survey points to serious shortfalls in the quality of mental health care for older patients, particularly when treated for depression. This comes despite models that have proven they can work.

12 | **Jeste Raises Key Issues With Congress After Newtown Shooting**
APA's president educates congressional leaders on the need for more psychiatric research and treatment funding and condemns stigmatizing remarks by the NRA's leader.

MEMBERS IN THE NEWS

18 | **Chicago Psychiatrist Treads a Path Seldom Taken**
Unlike most physicians these days, Steven Weinstein, M.D., makes house calls. He visits poor patients with serious mental illness, practicing recovery-oriented psychiatry.

CLINICAL & RESEARCH NEWS

20 | **Drug May Be Repurposed as Autism Treatment**
A diuretic medication that has been around for a long time shows promise in treating children with autism, but additional studies are needed to determine which patients would benefit most.

21 | **Could Breathing Polluted Air Contribute to Autism Development?**
New data show a relationship between traffic-related air pollution and increased risk that a child will develop autism, though the reason for this link is still speculative.

Be the First to Get *DSM-5*

APA members will have an exclusive opportunity to purchase *DSM-5* at APA's 2013 annual meeting in San Francisco before it goes on sale to the public. Also, if you register now, you can take advantage of advance registration fees. To register, go to http://annualmeeting.psychiatry.org; you will need your log-in information to receive member rates. (If you do not have this information, call [703] 907-7300.) To receive the best hotel rates near the Moscone Convention Center, contact Travel Planners, the official APA housing bureau, at (800) 221-3531 or (212) 532-1660.

Departments

4 | FROM THE PRESIDENT
19 | FROM THE EXPERTS
22 | MED CHECK

FROM THE PRESIDENT

APA Needs More Involvement by Women Members

BY DILIP JESTE, M.D.

American psychiatry has been way ahead of most other medical specialties worldwide in terms of the role of women physicians. The number of women physicians in the United States remained at a low stable rate of 4 percent to 6 percent from 1910 to the 1960s, but increased dramatically beginning in the 1970s. Psychiatry has been the second most frequently chosen specialty by women physicians (after pediatrics).

In 1972, APA appointed the Task Force on Women. In 1986, Leah Dickstein, M.D., and Carol Nadelson M.D., published *Women Physicians in Leadership Roles* (American Psychiatric Press Inc.). Probably the first book of its kind, it was a unique compilation of personal histories of women physicians as leaders in medicine, primarily from psychiatry's viewpoint. A new book edited by Donna Norris, M.D., Geetha Jayaram, M.D., and Annelle Primm, M.D., titled *Women in Psychiatry: Personal Perspectives*, which features 21 women psychiatrists, is posted at http://www.appi.org/SearchCenter/Pages/default.aspx?k=women in perspective.

APA has been fortunate in having several women psychiatrists in the highest leadership position during the past three decades. To date, there have been eight women APA presidents: Nadelson, (1985-86), Elissa Benedek, M.D. (1990-91), Mary Jane England, M.D. (1995-96), Marcia Goin, M.D. (2003-04), Michelle Riba, M.D. (2004-05), Carolyn Robinowitz, M.D. (2007-08), Nada Stotland, M.D. (2008-09), and Carol Bernstein, M.D. (2010-11). Each of them has made highly significant contributions to APA and to the field of psychiatry. Of course, leadership does not mean presidency only, but also includes positions at other levels. Currently a number of women psychiatrists are serving as chairs of councils and committees in addition to other important roles at national and district branch levels. Nonetheless, it is important to make opportunities available to all who are competent and desire to expend their creative talents in this sphere. Greater diversity in leadership is essential for organizational growth and development.

I asked Judith Kashtan, M.D., a member of APA's Assembly, Board of Trustees, and Membership Committee, to summarize issues facing women in APA and suggest some remedies. Below are her comments.

Making APA a More Welcoming 'Home' for Women

BY JUDITH KASHTAN, M.D.

Women are one of the minority/underrepresented groups in APA. While it may seem strange that a class of members consisting of half the population is considered a minority, it is true that women have been historically underrepresented in the medical profession, as Dr. Jeste notes.

In 1975, 20 percent of psychiatry residents were women, and women made up 12 percent of APA membership. By 2010 women represented 56 percent of psychiatry residents and 34 percent of APA members. This increase reflects women's changing roles in our society in general. If you'd like to read a fascinating history of that evolution, check out Gail Collins' *When Everything Changed: The Amazing Journey of American Women From 1960 to the Present*.

While more women have entered psychiatry, they are dropping out of APA at higher rates than men. This attrition is most pronounced among younger members. For APA to remain vital, we need to serve women's needs better. What is going wrong? Why do women choose to not join APA in the first place or drop out early in their careers?

While there is a wealth of resources at APA for women—mentors, colleagues, potential friends, practice resources, etc.—there also seems to be a disconnect between grassroots members and those resources. Everyone is busy, and, as a group, women with children may be the busiest of all. Even though men are doing more parenting than in the past, studies show that women still spend more of their time on household management and child care.

Since women are not underrepresented in training programs or the workplace anymore, they don't need to join APA or their district branch (DB) to have contact with other women psychiatrists—they are working with them every day.

Younger women often have limited financial resources and large educational loans to repay, so APA needs to provide clear value for money spent.

Here are some ideas we are considering—some of them are not restricted to women, but might be beneficial for us. The goal is to make APA an ever more welcoming professional "home" with easily accessible supports for our ever more multitasking members.

I set up a Web site for my practice a few years ago. It required a considerable investment of time and money, but I was amazed at the number of patients who found me through it. APA could help expedite that process by offering members templates to create such Web sites. Plans are also being considered to create a customized electronic health record for psychiatrists that APA members could purchase at a steep discount.

Younger members communicate increasingly through social media. We are giving more attention to APA's presence in that space, as well as making APA's Web site as accessible and relevant as possible.

Envision an area of the Web site like Yahoo Answers—check it out if you haven't seen it before. There, users post questions that others answer. Answers are rated by members, and the highest ranked ones migrate to the top of the list.

Such a service would be a valuable resource for time-pressed members, who could post questions about a clinical or practice issue on the fly and anticipate a quick and helpful response from a national group of peers and experts.

Similarly a mentorship area of the Web site could quickly link up women who have particular areas of expertise with younger members with similar interests.

Only 8 percent of women members belong to the APA Women's Caucus. We are looking at ways to improve our communications with all women members without requiring them to go through a complicated "opt in" process.

Studies show that women travelers often prefer hotel floors that cater to their needs. At future annual meetings, we'd like to designate one or two hotels, or floors, for women. We might provide yoga classes, discounts on spa services, and lounges where women could meet and network, for example.

In addition, a panel of women APA leaders or experts in certain areas of practice could be made available to give webinars or attend DB meetings.

Does your DB even have a women's committee? If not, they are easily formed with little overhead or time spent. If you're interested in starting one, let me know. In Minnesota we hold Saturday brunches for all the women in our DB at members' homes every four to six months, with babysitting provided.

What do you think of these suggestions? Do you have others? If so please contact me at kasht002@umn.edu. PN

Judith Kashtan, M.D., is APA's Area 4 trustee, an Assembly representative for Minnesota, a member of APA's Membership Committee, and a clinical adjunct professor at the University of Minnesota.

Medicare Pay Cut Averted

Among the provisions Congress approved at the 11th hour to keep the country from plunging over the "fiscal cliff" is one that blocks a scheduled 26.5 percent cut in Medicare physician reimbursement that was scheduled to take place January 1.

In addition to the scheduled cut, an additional 2 percent would have been taken out of physician pay because of "sequestration"—the across-the-board cuts in government spending mandated by the budget agreement last summer. The sequestration cut could still go into effect if Congress does not reach a comprehensive deficit reduction package by March 1.

The postponement of the reimbursement cut is the latest in a series of annual reprieves voted by Congress to avoid imposing reimbursement cuts on physicians resulting from the sustainable growth rate formula (SGR), which is used to determine what physicians will be paid for treating Medicare beneficiaries.

APA, the AMA, and most other physician organizations have for years lobbied Congress to devise a new way to determine Medicare's physician reimbursements.

"A postponement is preferable to a draconian Medicare payment cut, but Congress still needs to pass legislation permanently replacing the SGR itself. We can't just keep kicking the can down the road," said APA President Dilip Jeste, M.D., in a statement.

That sentiment was echoed by AMA President and psychiatrist Jeremy Lazarus, M.D. "Physicians want to work with Congress . . . to ensure access to care and the best health outcomes for patients and a stable, rewarding practice environment for physicians."

Future Looks Promising for Mental Illness Prevention

Research over the last decade shows that depression and anxiety are preventable, and psychiatrists are optimistic that advances in averting these and other mental illnesses are on the horizon.

BY JOAN AREHART-TREICHEL

Since effective treatments for mental illnesses emerged only during the 20th century, it is probably not surprising that scientifically based mental illness prevention is only now coming of age, stated George Alexopoulos, M.D., director of the Weill-Cornell Institute of Geriatric Psychiatry, in a recent interview.

Indeed, "there has been a huge explosion of work in mental illness prevention during the past decade," Carol Koplan, M.D., told *Psychiatric News*. She is a child and adolescent psychiatrist and assistant adjunct professor in health policy at Emory University, where she teaches a class in prevention of mental disorders to students in the master's-degree program in public health.

"There are probably 20 or 30 good randomized clinical trials indicating that the onset of common mental disorders like depression and anxiety can be delayed and in some cases prevented," Charles Reynolds, M.D., a professor of geriatric psychiatry at the University of Pittsburgh, said. For instance, cognitive-behavioral therapy and interpersonal therapy have been found to be effective in reducing the incidence of major depressive episodes in people who have already had mild or subsyndromal depressive symptoms. A Dutch study found a 50 percent reduction in the incidence of major depression among mildly depressed primary care patients who received a stepped-care intervention, compared with the incidence among primary care patients who received treatment as usual. Other studies showed that low-dose antidepressants or problem-solving therapy helped reduce the incidence of major and minor depression in post-stroke patients.

"A number of clinical trials," Reynolds noted, "have also supported a role for lithium in suicide prevention in people living with bipolar disorder and for clozapine for people living with schizophrenia. In addition, we performed the PROSPECT study—the Prevention of Suicide in Primary Care Elderly: Collaborative Trial study—which showed that the implementation of evidence-based depression-care guidelines in primary care practices could reduce the prevalence of suicidal ideation."

Charles Reynolds, M.D.

Charles Reynolds, M.D.: "We plan to work with colleagues in India to determine whether the depression intervention strategies we're testing in North America can be implemented and taken to scale by lay health counselors in a low- and middle-income country, namely India."

Joan Arehart-Treichel

Michael Compton, M.D., M.P.H., advises psychiatrists to promote mental health by taking part in programs that focus on preventing delinquency, bullying, unwanted teen pregnancies, child abuse, or violence in schools.

In the opinion of Michael Compton, M.D., M.P.H., a professor of psychiatry at George Washington University and a preventive medicine specialist, two recent mental illness prevention studies deserve special notice. "In 2009, Garber and colleagues published a study in *JAMA* showing that a group-based cognitive-behavioral program reduced the rate of depressive episodes in adolescent offspring of depressed parents," he said. "In 2010, Amminger and coworkers published a study in the *Archives of General Psychiatry* showing that omega-3 fatty acids, or fish oils, reduced the risk of transition to psychosis among young people deemed to be at very high risk for a psychotic disorder."

One of the most impressive mental illness prevention studies conducted to date, Koplan suggested, was designed by David Olds, Ph.D., director of the Prevention Research Center for Family and Child Health at the University of Colorado. Nurses visited high-risk mothers from lower socioeconomic backgrounds during pregnancy and for two years after to help them give their children a good start in life. Olds and his colleagues then followed the children and their mothers for several years to see whether the intervention made a difference in mental and behavioral health outcomes. It did. For example, the mothers experienced fewer arrests and convictions, engaged in less child abuse and neglect, and abused substances less than did control mothers. By 2008, Olds' program, which was called the Nurse-Family Partnership, was operating in 24 states (*Psychiatric News*, August 1, 2008). By July 2012, it was operating in 41 states, according to the Nurse-Family Partnership Web site.

see **Prevention** on page 23

How to Apply Mental Illness Prevention Findings

Several psychiatrists with an interest in mental illness prevention offer suggestions on how their colleagues might apply some of the latest research findings in this field.

- One way to help patients avert mental illness is to encourage lifestyle habits that promote mental health, such as eating a healthy diet, getting enough sleep and exercise, and avoiding substances, Frederick Langheim, M.D., Ph.D., a staff psychiatrist at Dean Health Systems in Madison, Wis., suggested. With bipolar disorder, for example, there is evidence that avoiding the use of marijuana and getting enough sleep can help prevent the resurgence of episodes, he said.
- A previous suicide attempt, recent discharge from the hospital after a suicide attempt, family history of depression, or a gun in the house can alert psychiatrists to patients who might be in danger of a suicide attempt, Carol Koplan, M.D., an assistant adjunct professor of health policy at Emory University, said. And whenever psychiatrists see patients, they should try to be prevention-minded, she suggested. For instance, a patient being treated for depression should be regularly evaluated for comorbidities such as substance abuse during times of crisis.
- Psychiatrists should take part in programs focusing on prevention of delinquency, bullying, unwanted teen pregnancies, child abuse, or violence in schools, Michael Compton, M.D., M.P.H., a professor of psychiatry at George Washington University, proposed, because such collaboration "will undoubtedly promote mental health and reduce mental illness."

A mental health prevention application that can be downloaded onto doctors' iPhones has been designed by the Agency for Healthcare Research and Quality, Christopher Oleskey, M.D., M.P.H., an assistant professor of psychiatry at Yale University, reported. It is called the Electronic Preventive Services Selector (EPSS). The way it works, he explained, is that you type in a patient's demographic information, and the EPSS then gives you evidence-based screening tools to use with the patient—tools to help detect early warning signs of a mental disorder. The EPSS can be accessed at http://epss.ahrq.gov/PDA/index.jsp.

PROFESSIONAL NEWS

DSM-5 Provides New Take on Developmental Disorders

The chapter on neurodevelopmental disorders comes first in *DSM-5's* diagnostic section, reflecting a lifespan approach to the manual's organization. See end of article for supplemental information.

BY MARK MORAN

A major change to the description and organization of criteria for autism and related disorders tops the major revisions clinicians can expect to see for neurodevelopmental disorders in *DSM-5*, to be published in May.

The chapter on neurodevelopmental disorders, the first set of criteria appearing in Section 2 of the manual, also includes the addition of "social communication disorder," reorganization of criteria for learning disorders, and changes to the criteria for intellectual disability (known in *DSM-IV* as mental retardation). The appearance of the chapter on neurodevelopmental disorders at the beginning of Section 2 reflects the developmental—or "lifespan"—approach taken by the *DSM-5* Task Force to the organization of the text: disorders more frequently diagnosed in childhood appear at the beginning of the manual and disorders more common to older adults (such as neurocognitive disorders) appear at the end.

Possibly the most significant change—and certainly one that received much public scrutiny—is the consolidation of *DSM-IV* criteria for autism, Asperger's, childhood disintegrative disorder, and pervasive developmental disorder-not otherwise specific (PDD-NOS)—into one diagnostic category called autism spectrum disorder (ASD). That change reflects the fact that much research has indicated a lack of concordance across clinical centers treating autism in how the four *DSM-IV* diagnoses have been applied.

"The *DSM-5* Neurodevelopmental Work Group spent a great deal of time evaluating the reliability and validity of the separate *DSM-IV* diagnoses and concluded that there was no evidence to support continued separation of the diagnoses," Susan Swedo, M.D., chair of the Work Group on Neurodevelopmental Disorders, told *Psychiatric News*.

The new criteria describe "deficits in social communication and social interaction" and "restrictive and repetitive behavior patterns"—the two principal symptoms associated with ASD—along with an expanded number of specifiers. The latter can be used by clinicians to specify features of the disorder with which some individual patients may present, such as if the autism is accompanied by intellectual impairment or is

Key Points

Major changes to criteria for neurodevelopmental disorders include the following:

- Autism spectrum disorder (ASD) replaces the four *DSM-IV* autism diagnoses and includes expanded specifiers and ratings of severity.
- Social communication disorder describes children who exhibit deficits in language and communication but do not have restrictive/repetitive behaviors necessary for ASD. These children would typically receive a *DSM-IV* diagnosis of pervasive developmental disorder–not otherwise specified.
- Specific learning disorder consolidates three *DSM-IV* learning disorders, but includes specifiers related to deficits in reading, written expression, and mathematics.
- Intellectual disability, replacing the *DSM-IV* category of "mental retardation," requires both adaptive-functioning assessments and IQ scores for diagnosis.

Other changes to criteria include the following:

- Attention deficit/hyperactivity disorder has been added to this diagnostic category and is largely unchanged from *DSM-IV*. However, age of onset was increased from 7 to 12. The subtypes of inattentive, hyperactive, and mixed were replaced with presentation specifiers. The threshold for diagnosis in adults was adjusted to five symptoms in either domain to reflect evidence-based impairments.
- Three communication disorders—language disorder, childhood onset fluency disorder (stuttering), and speech sound disorder—replace *DSM-IV* diagnoses of expressive language disorder, stuttering, and phonological disorder, respectively.
- Criteria for motor disorders are largely unchanged. *DSM-5* criteria for Tourette's syndrome and chronic motor or vocal tic disorder state that tics may "wax and wane in frequency but have persisted for more than a year." *DSM-IV* criteria had stated that "tics occur many times a day nearly every day."

DSM-5

continued from page 1

reliance on "not otherwise specified" (NOS) criteria, and a growing inability to integrate *DSM* disorders with the findings from genetic and other research.

In an interview with *Psychiatric News*, *DSM-5* Task Force Chair David Kupfer, M.D., outlined some of the overarching conceptual ideas that have informed the development of diagnostic criteria and the organization of the text. These include incorporation of a developmental approach to psychiatric disorders, recognition of the influence of culture and gender on how psychiatric illness presents in individual patients, a move toward the use of dimensional measures to rate severity and disaggregate symptoms that tend to occur across multiple disorders, harmonization of the text with *ICD*, and integration of genetic and neurobiological findings by grouping clusters of disorders that share genetic or neurobiological substrates.

DSM-5 consists of three sections: Section 1 will give an introduction to *DSM-5* with instructions on how to use the updated manual; Section 2 will outline the categorical diagnoses according to a revised chapter organization that eliminates the multiaxial system; and Section 3 will include conditions that require further research before their consideration as formal diagnoses, as well as cultural formulations and other information.

Kupfer said the classification of disorders is largely harmonized with the World Health Organization's *International Classification of Diseases (ICD)* so that the *DSM* criteria sets are more parallel with the proposed *ICD-11*. In *DSM-5* both the current *ICD-9-CM* and the future standard *ICD-10-CM* codes (scheduled for 2014) are attached to the relevant disorders in the classification.

He noted as well that Section 3 contains a detailed discussion of culture and diagnosis, including tools for in-depth cultural assessment and a description of some common cultural syndromes, idioms of distress, and causal explanations relevant to clinical practice.

Although the new manual retains a categorical listing of separate disorders, an important change to *DSM-5* is the incorporation of dimensional measures of severity for a number of disorders, reflecting what a considerable body of research—as well as clinical observation—has revealed: that the boundaries between many disorder "categories" are more fluid over the life course than was previously understood, and many symptoms assigned to a single disorder may occur, at varying levels of severity, in many other disorders. So, for instance, the criteria for autism spectrum disorder include three levels of severity for the two principal symptoms—"deficits in social communication and social interaction" and "restrictive and repetitive behavior patterns"—to indicate the level of supportive services required by an individual patient (see related article above).

While the categorical listing of personality disorders in *DSM-5* remains virtually unchanged from the previous edition, Section 3 also contains a "hybrid" model incorporating dimensional measures to guide future research.

Kupfer said the order of chapters within Section 2 reflects a "lifespan" approach, with disorders more frequently diagnosed in childhood at the beginning of the manual—hence the first chapter on neurodevelopmental disorders, including autism spectrum disorder and learning disorders—and disorders more applicable to older adulthood (such as neurocognitive disorders) at the end of the manual. Within the text, subheadings on development and course provide descriptions of how disorder presentations may change across the lifespan.

Finally, he emphasized that the revised chapter structure was informed by recent research in neuroscience and by emerging genetic linkages between diagnostic groups. Genetic and physiologic risk factors, prognostic indicators, and some putative biologic markers are highlighted in the text. "This new structure should improve clinicians' ability to identify diagnoses in a disorder spectrum based on common neurocircuitry, genetic vulnerability, and environmental stressors," he said. PN

DSM-5 may be pre-ordered at http://www.appi.org/SearchCenter/Pages/default.aspx?k=2558. APA members are eligible for a discount. Also, APA members attending the 2013 annual meeting in May will have an exclusive opportunity to purchase *DSM-5* before it goes on sale to the public. See the box on page 3 for meeting registration information.

PROFESSIONAL NEWS

associated with a known genetic/medical or environmental/acquired condition.

In addition, the criteria include three levels of severity for both principal symptoms to indicate the level of supportive services required by an individual patient. The three levels are "requiring support," "requiring substantial support," and "requiring very substantial support."

For instance, for the symptom of "deficits in social communication and social interaction," a patient requiring "very substantial support" would be one who has "severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others." Similarly, for "repetitive/restrictive behaviors" a patient requiring very substantial support would be one who exhibits inflexibility of behavior and extreme difficulty coping with change, as well as "great distress/difficulty changing focus or action."

Swedo noted also that the *DSM-5* criteria indicate that symptoms must be present in the "early developmental period," reflecting research that has shown the disorder is evident as early as age 24 months.

Learning Disorders Consolidated

Related also to recent research on autism is the inclusion of a new diagnosis, social communication disorder, designed to capture children who have severe deficits in social communication and interaction but who lack the restrictive and repetitive behavior patterns necessary for ASD. These children have typically been diagnosed with PDD-NOS. (A goal of the task force in developing the manual has been to reduce the use of NOS diagnoses to classify patients who do not fit into more explicit diagnostic categories.)

The criteria describe "persistent difficulties in the social use of verbal and nonverbal communication" in four areas: using communication for social purposes such as greeting or exchanging information; changing communication to match context or the needs of the listener; following rules for conversation or storytelling, such as taking turns in conversation; and understanding what is not explicitly stated and nonliteral or ambiguous meanings of language. The impairments result in "functional limitations in communication, social participation, social relationships, academic achievement, or occupational performance" that are not explained by the presence of ASD or another mental or general medical condition.

"We believe social communication disorder will capture those children who have in the past been diagnosed with PDD-NOS as a way of drawing attention to the patient's social communication impairments despite the absence of restrictive interests and repetitive behaviors," Swedo told *Psychiatric News*.

Also significant is the consolidation of separate learning disorders that had appeared in *DSM-IV*—reading disorder, mathematics disorder, and disorder of written expression—into one diagnosis called specific learning disorder. The criteria describe difficulties in learning and academic achievement as indicated by the presence of at least one of six symptoms persisting for six months. The new criteria now include specifiers for reading, written expression, and mathematics.

Swedo said an advantage of the *DSM-5* criteria is that they are much more comprehensive. Clinicians can use these criteria to diagnose deficits in all three areas that tend to occur together and that affect learning and academic achievement, with detailed specifiers identifying the relative deficit levels in each area.

Finally, some important changes have been made to intellectual disability (identified in *DSM-IV* as mental retardation). The name change aligns *DSM* with federal legislative language and with that used by U.S. professionals specializing in the disorder.

Moving Away From IQ Score

Most importantly, the *DSM-5* criteria mark a move away from relying exclusively on IQ scores and toward using additional measures of adaptive

see **Neurodevelopmental** on page 23

Personalized education for real-world clinical challenges

Enhance your clinical skillset, find solutions to complex conditions, and participate in high-quality education developed and led by world-renowned clinician-researchers.

The Massachusetts General Hospital Psychiatry Academy offers education for mental health clinicians of all professions in private practice, community-based facilities, and large institutions. Carefully created by accomplished researchers and clinical experts from the Massachusetts General Hospital Department of Psychiatry, our education helps you translate the latest evidence-based research into actual clinical practice and provides guidance on the toughest clinical challenges.

- **Virtual Grand Rounds Series –** free, CME/CE-certified, 20-part series on psychopharmalogical treatment strategies with live, interactive Q&A
- **Online CBT Courses** – 4-week courses on using CBT in the treatment of adults, children and couples, with role-play videos, discussion boards, and real-life case examples
- **Psychiatry Recertification Exam Update & Preparation Course** – online course that covers more than 50 clinical topics, offers 40 CME credits, is 100% mobile-friendly for smartphones and tablets, and has a companion e-book (sold separately) with 250+ questions and answers
- **Maintenance of Certification (MOC) Modules** – ABPN-approved self-assessment modules on anxiety, ADHD, psychosis, substance abuse, and more

Trust your professional development to our experience – for more than 75 years, the Massachusetts General Hospital Department of Psychiatry has been a national leader in patient care and clinical research. Each year, the department's 525 faculty train more than 100 fellows and residents and publish hundreds of articles in peer-reviewed journals.

LEARN MORE ABOUT OUR EDUCATION.
Visit www.mghcme.org/join

#1 in the Nation
U.S.News & World Report
Best Hospitals 2012-13

www.facebook.com/mghpa
www.twitter.com/MGHAcademy

Scan with smartphone to visit our site now.

Improvement Urged in Care Of Older Depressed Patients

Ten years after an effective collaborative model for treatment was developed, help for depressed elderly patients is still inadequate.

BY LESLIE SINCLAIR

Sometimes it takes more than a map to get where you're going. A new survey of Americans aged 65 and older finds that they are not getting the mental health care they need. That survey, "Silver and Blue: The Unfinished Business of Mental Health Care for Older Adults," was funded and directed by the John A. Hartford Foundation and released December 13, 2012.

Of the 1,318 older Americans surveyed, 46 percent of those who were currently receiving mental health treatment said their provider did not follow up with them within a few weeks of starting treatment to see how they were doing. And among all the respondents, very few understood the health risks of depression; only 21 percent had heard that depression is believed to double an individual's risk of developing dementia, and only 34 percent knew it can double the risk of heart disease.

What might be most discouraging about these results is that 10 years prior, the same organization funded a $10 million depression treatment project—with co-funding from the California Healthcare, Hogg, and Robert Wood Johnson foundations—that demonstrated how to double the benefits of the usual treatment of older adults for depression in primary care practices and laid out the changes needed in the process of depression care to ensure that more elderly patients get better.

But adoption of those methods has been slow. "While we found that some progress has indeed been made over the past decade, especially in the area of reducing the stigma attached to depression and other mental health conditions, we also found stark evidence of how far we still have to go to relieve the suffering of too many older adults and their families," said Christopher Langston, Ph.D., program director for the foundation.

Multiple Obstacles Limited Efforts

This fits with much of what we know about health system change in general, Langston told *Psychiatric News*. Several factors play a part in the lack of dissemination and adoption of the collaborative care management program for late-life depression that was developed in that project, known as the Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) model. Details of the randomized controlled trial that resulted in the IMPACT model were published in the December 22, 2002, *JAMA*.

Payment methods and teamwork requirements are obstacles to implementation of the model, said Langston. "While the model reduces overall spending, you don't get paid by insurance for some parts of the model. The involvement of a psychiatrist is important, but it's principally in a nondirect clinical service role. The psychiatrist reviews cases with the clinical care team and advises them, but can't bill an insurer for that service. The model also demands a strong team-oriented approach to care, and therefore a highly functioning team. You have to know who is responsible for different functions of the model and how to coordinate their work, a difficult task for many practices."

For elderly patients, depression may not make its way to the top of the list of concerns. "Elderly patients have more chronic disease, and therefore more doctor visits and more competition for time and attention," explained Langston. "If you have a patient with arthritis, congestive heart failure, high blood pressure, diabetes, and depression, it gets complicated. And during a brief primary care visit, where attention can be on these other issues, depression can get lost. Treating depression can be an effective means for changing chronic disease outcomes, but it can be hard in a busy private care practice to make it a priority. That's why you have to have a dedicated staff person in the role of depression manager."

Lisa F. Young/Shutterstock

Survey results indicate that elements of quality care for elderly patients with depression are still lacking.

Answer Is Better, Not More, Treatment

But that's not to say that an effort to address patients' depression is not being made: "The rates of people getting prescriptions are high; the patients are not better, but they have been prescribed medications. The problem seems to be not one of initiation of treatment, but of better treatment. The care team needs to follow up, reassess, remeasure the level of depression, and make changes to the treatment plan."

"The 'Silver and Blue' survey shows us that there's still a lot of room for these effective practices to become common practice," said Langston. "We can, and must, provide better mental health care for older Americans."

APA President Dilip Jeste, M.D., the Estelle and Edgar Levi Chair in Aging and director of the Sam and Rose Stein Institute for Research on Aging at the University of California, San Diego, agreed that the survey shows that older adults are not getting the quality of care they need.

"This survey clearly highlights a major problem with our mental health care system," Jeste said. "Today there are more effective treatments available for depression and many other psychiatric disorders in later life than was the case even a decade ago; yet most patients aren't receiving adequate treatment. The current training of primary care clinicians as well as other mental health care providers in geriatric psychiatry is embarrassingly limited. The number of specialists in this field is woefully inadequate, and the shortage is only getting worse, with growing numbers of older people."

Jeste pointed out as well that "considerable research has shown that early treatment and even prevention are not only feasible but also effective in reducing morbidity and mortality in older adults. As a society, it is our responsibility to provide the needed care to older people with mental illnesses—one of the most disenfranchised groups. The good news is that help is available, and we must strive to ensure that the patients receive it." PN

A summary of the survey's findings is posted at http://www.jhartfound.org/file/MjQ2/Hartford_MH_Poll_Memo_FINAL_121211%20(2).pdf. An abstract of the publication of the initial study and model design is posted at http://www.ncbi.nlm.nih.gov/pubmed/12472325.

IMPACT Help Available

A Web site providing information and materials to help clinicians and organizations implement IMPACT in a variety of settings is maintained by the IMPACT Implementation Center, a division of the Advancing Integrated Mental Health Solutions (AIMS) Center in the Department of Psychiatry and Behavioral Sciences at the University of Washington. Among other resources available are a free 13-module online IMPACT training program, a video describing IMPACT implementation in Minnesota (where nine health plans, 25 medical groups, and more than 80 primary care clinics have collaborated to implement and study integrated care for depression based on the IMPACT model), and a webinar by Jürgen Unützer, M.D., M.P.H., and Virna Little, L.C.S.W.-R., Psy.D., describing IMPACT and its implementation at the Institute for Family Health in New York. With support from the John A. Hartford Foundation, AIMS provides materials, training, and technical assistance to aid the adoption and implementation of IMPACT in diverse practice settings. The center says that it has trained about 5,000 individuals and supported implementation of this program in more than 500 clinical settings.

Time to Elect Your Leaders

Voting opened on January 2 in the 2013 APA election. On that date, online voting became available and paper ballots were mailed to members for whom APA does not have a valid e-mail address. Eligible voters without an electronic or paper ballot can vote online through the APA Web site by using their member login. Extensive information about this year's election is posted at http://www.psychiatry.org/network/board-of-trustees/apa-national-elections. Ballots must be received by 5 p.m. Eastern time on January 31.

NOW AVAILABLE

Keep It Simple

New Forfivo™ XL provides a once-daily, bupropion 450 mg dose in a single tablet:

- Indicated for the treatment of major depressive disorder
- Forfivo XL is bioequivalent to three 150 mg tablets of Wellbutrin XL®[1]
- Rx Savings Program will automatically limit 30-day Rx cost to $28 for most commercial drug plan patients[2]

Do not initiate bupropion therapy with Forfivo XL because the 450 mg tablet is the only available dosage strength. Use a lower-dose bupropion product for therapy initiation and dose titration.

NEW! ONCE-DAILY 450 MG

Forfivo™ XL

(bupropion hydrochloride extended-release tablets)

Visit ForfivoXL.com to download Rx savings cards.

IMPORTANT SAFETY INFORMATION FOR FORFIVO XL

WARNING: SUICIDALITY and ANTIDEPRESSANT DRUGS; PSYCHIATRIC EVENTS and SMOKING CESSATION
SUICIDALITY and ANTIDEPRESSANT DRUGS: Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of major depressive disorder (MDD) and other psychiatric disorders. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. FORFIVO XL is not approved for use in pediatric patients.
PSYCHIATRIC EVENTS and SMOKING CESSATION: FORFIVO XL is not approved for smoking cessation treatment, but bupropion under the name ZYBAN® is approved for this use. Serious neuropsychiatric events, including but not limited to depression, suicidal ideation, suicide attempt, and completed suicide have been reported in patients taking bupropion for smoking cessation. Advise patients and caregivers that the patient using bupropion for smoking cessation should stop taking bupropion and contact a healthcare provider immediately if agitation, hostility, depressed mood, or changes in thinking or behavior that are not typical for the patient are observed, or if the patient develops suicidal ideation or suicidal behavior.

CONTRAINDICATIONS
FORFIVO XL is contraindicated in:
- Seizure disorder, because these patients may have a lower seizure threshold
- Patients treated currently with other bupropion products, because seizure incidence is dose-dependent
- A current or prior diagnosis of bulimia or anorexia nervosa
- Patients undergoing abrupt discontinuation of alcohol or sedatives
- Concurrent administration of monoamine oxidase (MAO) inhibitors. At least 14 days should elapse between discontinuation of an MAO inhibitor and initiation of treatment with FORFIVO XL.
- Known hypersensitivity to bupropion or the other ingredients of FORFIVO XL

WARNINGS AND PRECAUTIONS
Activation of Mania/Hypomania A major depressive episode may be the initial presentation of bipolar disorder. 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 FORFIVO XL is not approved for use in treating bipolar depression. **Seizures** Bupropion is associated with a dose-related risk of seizures. The risk of seizures is also related to patient factors, clinical situations, and concomitant medications, which must be considered in selection of patients for therapy with FORFIVO XL. FORFIVO XL should be discontinued and not restarted in patients who experience a seizure while on treatment. Retrospective analysis of clinical experience gained during the development of bupropion suggests that the risk of seizure may be minimized if the total daily dose of bupropion does not exceed 450 mg and the rate of incrementation of the bupropion dose is gradual. **Psychosis and Other Neuropsychiatric Events** Depressed patients treated with bupropion have been reported to show a variety of neuropsychiatric signs and symptoms, including delusions, hallucinations, psychosis, concentration disturbance, paranoia, and confusion. In some cases, these symptoms abated upon dose reduction and/or withdrawal of treatment. It is recommended stopping bupropion when the symptoms occur. **Severe Hypertension** In clinical practice, hypertension, in some cases severe, requiring acute treatment, has been reported in patients receiving bupropion alone and in combination with nicotine replacement therapy. These reactions have been observed in both patients with and without evidence of preexisting hypertension. Monitoring of blood pressure is recommended in patients who receive the combination of bupropion and nicotine replacement. **Agitation and Insomnia** Increased restlessness, agitation, anxiety, and insomnia, especially shortly after initiation of treatment, have been associated with treatment with bupropion. In clinical studies of MDD, these symptoms (see **Table 2** of the full prescribing information) were sometimes of sufficient magnitude to require treatment with sedative/hypnotic drugs. Symptoms in these studies were sufficiently severe to require discontinuation of treatment in 1% and 2.6% of patients treated with 300 and 400 mg/day, respectively, of bupropion hydrochloride sustained-release tablets and 0.8% of patients treated with placebo. **Altered Appetite and Weight** In placebo-controlled short-term studies of MDD using the sustained-release formulation of bupropion hydrochloride, patients experienced weight gain or weight loss (see **Table 3** of the full prescribing information). In studies conducted with the immediate-release formulation of bupropion hydrochloride, 35% of patients receiving tricyclic antidepressants gained weight, compared to 9% of patients treated with the immediate-release formulation of bupropion hydrochloride. If weight loss is a major presenting sign of a patient's depressive illness, the anorectic and/or weight-reducing potential of FORFIVO XL tablets should be considered. **Hypersensitivity Reactions** Anaphylactoid/anaphylactic reactions characterized by symptoms such as pruritus, urticaria, angioedema, and dyspnea requiring medical treatment have been reported in clinical trials with bupropion. In addition, there have been rare spontaneous postmarketing reports of erythema multiforme, Stevens-Johnson syndrome, and anaphylactic shock associated with bupropion. A patient should stop taking FORFIVO XL and consult a doctor if experiencing allergic or anaphylactoid/anaphylactic reactions (e.g., skin rash, pruritus, hives, chest pain, edema, and shortness of breath) during treatment. Arthralgia, myalgia, and fever with rash and other symptoms suggestive of delayed hypersensitivity have been reported in association with bupropion. These symptoms may resemble serum sickness [see ***Contraindications*** in the full prescribing information].

ADVERSE REACTIONS
Clinical Trials Experience: Commonly Observed Adverse Reactions in Controlled Clinical Trials The most common adverse reactions were (incidence ≥ 5%; ≥ 2 times placebo rate): Dry mouth, nausea, insomnia, dizziness, pharyngitis, abdominal pain, agitation, anxiety, tremor, palpitation, sweating, tinnitus, myalgia, anorexia, urinary frequency, and rash.

Please see brief summary of Prescribing Information, including complete Boxed Warnings, on the following pages.

[1]Wellbutrin XL is a registered trademark of GlaxoSmithKline.

[2]Maximum savings benefit per Rx is $35. Certain patient groups are not eligible for this Rx Savings Program (e.g., federal healthcare programs, including Medicare or Medicaid, Medicare Part D prescription drug plans, or by any similar federal or state program, including a state pharmaceutical assistance program, etc.). Cash-paying patients and Massachusetts patients are eligible but will require a physical Rx savings card.

EDGEMONT® PHARMACEUTICALS

©2012 Edgemont Pharmaceuticals, LLC. All rights reserved.
Intended for US audiences only.

FF0070_JA

FORFIVO XL (bupropion hydrochloride extended-release tablets), for oral use
Brief Summary: Consult package insert for full prescribing information

WARNING: SUICIDALITY and ANTIDEPRESSANT DRUGS; PSYCHIATRIC EVENTS and SMOKING CESSATION
SUICIDALITY and ANTIDEPRESSANT DRUGS: Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of FORFIVO XL or any other antidepressant in a child, adolescent, or young adult must balance this risk with the clinical need. 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 in risk with antidepressants compared to placebo in adults aged 65 and older. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. FORFIVO XL is not approved for use in pediatric patients *[see Warnings and Precautions]*.
PSYCHIATRIC EVENTS and SMOKING CESSATION: FORFIVO XL is not approved for smoking cessation treatment, but bupropion under the name ZYBAN® is approved for this use. Serious neuropsychiatric events, including but not limited to depression, suicidal ideation, suicide attempt, and completed suicide have been reported in patients taking bupropion for smoking cessation. Some cases may have been complicated by the symptoms of nicotine withdrawal in patients who stopped smoking. Depressed mood may be a symptom of nicotine withdrawal. Depression, rarely including suicidal ideation, has been reported in smokers undergoing a smoking cessation attempt without medication. However, some of these symptoms have occurred in patients taking bupropion who continued to smoke. All patients being treated with bupropion for smoking cessation treatment should be observed for neuropsychiatric symptoms including changes in behavior, hostility, agitation, depressed mood, and suicide-related events, including ideation, behavior, and attempted suicide. These symptoms, as well as worsening of pre-existing psychiatric illness and completed suicide have been reported in some patients attempting to quit smoking while taking ZYBAN in the postmarketing experience. When symptoms were reported, most were during treatment with ZYBAN, but some were following discontinuation of treatment with ZYBAN. These events have occurred in patients with and without pre-existing psychiatric disease; some have experienced worsening of their psychiatric illnesses. Patients with serious psychiatric illness such as schizophrenia, bipolar disorder, and major depressive disorder did not participate in the premarketing studies of ZYBAN. Advise patients and caregivers that the patient using bupropion for smoking cessation should stop taking bupropion and contact a healthcare provider immediately if agitation, hostility, depressed mood, or changes in thinking or behavior that are not typical for the patient are observed, or if the patient develops suicidal ideation or suicidal behavior. In many postmarketing cases, resolution of symptoms after discontinuation of ZYBAN was reported, although in some cases the symptoms persisted; therefore, ongoing monitoring and supportive care should be provided until symptoms resolve. The risks of using bupropion for smoking cessation should be weighed against the benefits of its use. ZYBAN has been demonstrated to increase the likelihood of abstinence from smoking for as long as 6 months compared to treatment with placebo. The health benefits of quitting smoking are immediate and substantial *[see Warnings and Precautions and Patient Counseling Information]*.

INDICATIONS AND USAGE: FORFIVO XL (bupropion hydrochloride extended-release tablets) is indicated for the treatment of major depressive disorder (MDD). The efficacy in the treatment of MDD was established in two 4-week and one 6-week and one maintenance trial in adult patients whose diagnoses corresponded most closely to the Major Depression category of the APA Diagnostic and Statistical Manual (DSM) *[see Clinical Studies]*. A major depressive episode (DSM-IV) implies the presence of 1) depressed mood or 2) loss of interest or pleasure; in addition, at least 5 of the following symptoms have been present during the same 2-week period and represent a change from previous functioning: depressed mood, markedly diminished interest or pleasure in usual activities, significant change in weight and/or appetite, insomnia or hypersomnia, psychomotor agitation or retardation, increased fatigue, feelings of guilt or worthlessness, slowed thinking or impaired concentration, a suicide attempt, or suicidal ideation. The efficacy of bupropion in pediatric population has not been established. The physician who elects to use FORFIVO XL for extended periods should periodically reevaluate the long-term usefulness of the drug for the individual patient. **CONTRAINDICATIONS:** FORFIVO XL is contraindicated in patients with the following: seizure disorder because these patients may have a lower seizure threshold; patients treated currently with other bupropion products because the incidence of seizure is dose dependent; a current or prior diagnosis of bulimia or anorexia nervosa because of a higher incidence of seizures noted in patients treated for bulimia with the immediate-release formulation of bupropion in a pre-marketing clinical trial; patients undergoing abrupt discontinuation of alcohol or sedatives because of a lower seizure threshold in these conditions; concurrent administration of monoamine oxidase (MAO) inhibitors because MAOIs potentially can enhance the CNS toxicity, at least 14 days should elapse between discontinuation of an MAO inhibitor and initiation of treatment with FORFIVO XL; and known hypersensitivity to bupropion or the other ingredients of FORFIVO XL tablets. Anaphylactoid/anaphylactic reactions and Stevens-Johnson syndrome have been reported *[see Warnings and Precautions]*.
WARNINGS AND PRECAUTIONS: Clinical Worsening and Suicide Risk in Treating Psychiatric Disorder Patients with 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 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 trials of antidepressant drugs (SSRIs and others) show that these drugs increase the risk of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults (ages 18-24) with 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 trials in children and adolescents with MDD, obsessive compulsive disorder (OCD), or other psychiatric disorders included a total of 24 short-term trials of 9 antidepressant drugs in over 4,400 patients. The pooled analyses of placebo-controlled trials in adults with MDD or other psychiatric disorders included a total of 295 short-term trials (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) are provided in Table 1.

Table 1. Drug-Placebo Difference in Number of Cases of Suicidality per 1000 Patients Treated

Age Range	
Increases Compared to Placebo	
<18	14 additional cases
18–24	5 additional cases
Decreases Compared to Placebo	
25–64	1 fewer case
≥65	6 fewer cases

No suicides occurred in any of the pediatric trials. There were suicides in the adult trials, 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 trials 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 *[see Boxed Warning and Use in Specific Populations]*. 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 MDD 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. Families and caregivers of patients being treated with antidepressants for MDD 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 health care providers. Such monitoring should include daily observation by families and caregivers *[see Patient Counseling Information]*. Prescriptions for FORFIVO XL should be written for the smallest quantity of tablets consistent with good patient management, in order to reduce the risk of overdose. **Neuropsychiatric Symptoms and Suicide Risk in Smoking Cessation Treatment** FORFIVO XL is not approved for smoking cessation treatment, but bupropion under the name ZYBAN is approved for this use. Serious neuropsychiatric symptoms have been reported in patients taking bupropion for smoking cessation *[see Boxed Warning and Adverse Reactions]*. These have included changes in mood (including depression and mania), psychosis, hallucinations, paranoia, delusions, homicidal ideation, hostility, agitation, aggression, anxiety, and panic, as well as suicidal ideation, suicide attempt, and completed suicide *[see Patient Counseling Information]*. **Activation of Mania/Hypomania** A major depressive episode may be the initial presentation of bipolar disorder. It is generally believed (though not established in controlled trials) 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. 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 FORFIVO XL is not approved for use in treating bipolar depression. **Seizures** Bupropion is associated with a dose-related risk of seizures. The risk of seizures is also related to patient factors, clinical situations, and concomitant medications, which must be considered in selection of patients for therapy with FORFIVO XL. FORFIVO XL should be discontinued and not restarted in patients who experience a seizure while on treatment. Dose: At doses up to 300 mg/day of the sustained-release formulation of bupropion hydrochloride (WELLBUTRIN SR®), the incidence of seizure is approximately 0.1% (1/1,000). Data for the immediate-release formulation of bupropion hydrochloride revealed a seizure incidence of approximately 0.4% (i.e., 13 of 3,200 patients followed prospectively) in patients treated at doses in a range of 300 to 450 mg/day. This seizure incidence (0.4%) may exceed that of some other marketed antidepressants. Additional data accumulated for the immediate-release formulation of bupropion hydrochloride suggested that the estimated seizure incidence increases almost tenfold between 450 and 600 mg/day. The 600 mg dose is twice the usual adult dose and one and one-third the maximum recommended daily dose (450 mg) of FORFIVO XL. This disproportionate increase in seizure incidence with dose incrementation calls for caution in dosing. Patient Factors: Predisposing factors that may increase the risk of seizure with bupropion use include history of head trauma or prior seizure, central nervous system (CNS) tumor, the presence of severe hepatic cirrhosis, and concomitant medications that lower seizure threshold. Clinical Situations: Circumstances associated with an increased seizure risk include, among others, excessive use of alcohol or sedatives; addiction to opiates, cocaine, or stimulants; use of over-the-counter stimulants and anorectics; and diabetes treated with oral hypoglycemics or insulin. Concomitant Medications: Many medications (e.g., antipsychotics, antidepressants, theophylline, and systemic steroids) are known to lower seizure threshold. Recommendations for Reducing the Risk of Seizure: Retrospective analysis of clinical experience gained during the development of bupropion suggests that the risk of seizure may be minimized if the total daily dose of bupropion does not exceed 450 mg, the rate of incrementation of the bupropion dose is gradual. **Psychosis and Other Neuropsychiatric Events** Depressed patients treated with bupropion have been reported to show a variety of neuropsychiatric signs and symptoms, including delusions, hallucinations, psychosis, concentration disturbance, paranoia, and confusion. In some cases, these symptoms abated upon dose reduction and/or withdrawal of treatment. It is recommended stopping bupropion when the symptoms occurred. **Severe Hypertension** In clinical practice, hypertension, in some cases severe, requiring acute treatment, has been reported in patients receiving bupropion alone and in combination with nicotine replacement therapy. These reactions have been observed in both patients with and without evidence of preexisting hypertension. Data from a comparative study of the sustained-release formulation of bupropion hydrochloride (ZYBAN® Sustained-Release Tablets), nicotine transdermal system (NTS), the combination of sustained-release bupropion hydrochloride plus NTS, and placebo as an aid to smoking cessation suggest a higher incidence of treatment-emergent hypertension in patients treated with the combination of sustained-release bupropion hydrochloride and NTS. Monitoring of blood pressure is recommended in patients who receive the combination of bupropion and nicotine replacement. There is no clinical experience establishing the safety of FORFIVO XL tablets in patients with a recent history of myocardial infarction or unstable heart disease. Therefore, care should be exercised if it is used in these groups. Bupropion was well tolerated in depressed patients who had previously developed orthostatic hypotension while receiving tricyclic antidepressants, and was also generally well tolerated in a group of 36 depressed inpatients with stable congestive heart failure (CHF). However, bupropion was associated with a rise in supine blood pressure in the study of patients with CHF, resulting in discontinuation of treatment in 2 patients for exacerbation of baseline hypertension. **Agitation and Insomnia** Increased restlessness, agitation, anxiety, and insomnia, especially shortly after initiation of treatment, have been associated with treatment with bupropion. Patients in placebo-controlled trials of MDD with sustained-release formulation of bupropion hydrochloride, experienced agitation, anxiety, and insomnia as shown in Table 2.

Table 2. Incidence of Agitation, Anxiety, and Insomnia in Placebo-Controlled Trials of Bupropion HCl Sustained-release Tablets for Major Depressive Disorder

Adverse Reactions Term	Bupropion HCl 300 mg/day (n = 376)	Bupropion HCl 400 mg/day (n = 114)	Placebo (n = 385)
Agitation	3%	9%	2%
Anxiety	5%	6%	3%
Insomnia	11%	16%	6%

In clinical studies of MDD, these symptoms were sometimes of sufficient magnitude to require treatment with sedative/hypnotic drugs. Symptoms in these studies were sufficiently severe to require discontinuation of treatment in 1% and 2.6% of patients treated with 300 and 400 mg/day, respectively, of bupropion hydrochloride sustained-release tablets and 0.8% of patients treated with placebo. **Altered Appetite and Weight** In placebo-controlled short-term studies of MDD using the sustained-release formulation of bupropion hydrochloride, patients experienced weight gain or weight loss as shown in Table 3.

Table 3. Incidence of Weight Gain and Weight Loss in Placebo-Controlled Trials of Bupropion Hydrochloride Sustained-release tablets for Major Depressive Disorder

Weight Change	Bupropion HCl 300 mg/day (n = 339)	Bupropion HCl 400 mg/day (n = 112)	Placebo (n = 347)
Gained >5 lbs	3%	2%	4%
Lost >5 lbs	14%	19%	6%

In studies conducted with the immediate-release formulation of bupropion hydrochloride, 35% of patients receiving tricyclic antidepressants gained weight, compared to 9% of patients treated with the immediate-release formulation of bupropion hydrochloride. If weight loss is a major presenting sign of a patient's depressive illness, the anorectic and/or weight-reducing potential of FORFIVO XL tablets should be considered. **Hypersensitivity Reactions** Anaphylactoid/anaphylactic reactions characterized by symptoms such as pruritus, urticaria, angioedema, and dyspnea requiring medical treatment have been reported in clinical trials with bupropion. In addition, there have been rare spontaneous postmarketing reports of erythema multiforme, Stevens-Johnson syndrome, and anaphylactic shock associated with bupropion. A patient should stop taking FORFIVO XL and consult a doctor if experiencing allergic or anaphylactoid/anaphylactic reactions (e.g., skin rash, pruritus, hives, chest pain, edema, and shortness of breath) during treatment. Arthralgia, myalgia, and fever with rash and other symptoms suggestive of delayed hypersensitivity have been reported in association with bupropion. These symptoms may resemble serum sickness *[see Contraindications]*.
ADVERSE REACTIONS: The following risks are discussed in greater detail in other sections of the full prescribing information *[see Warnings and Precautions]*: clinical worsening and suicide risk, neuropsychiatric symptoms and suicide risk in smoking cessation treatment, activation of mania or hypomania, seizures, psychosis, and other neuropsychiatric events, severe hypertension, agitation and insomnia, altered appetite and weight, hypersensitivity reactions. **Clinical Trials Experience** Commonly Observed Adverse Reactions in Controlled Clinical Trials. 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 trials of another drug and may not reflect the rates observed in clinical practice. Adverse reactions from Table 5 occurring in at least 5% of patients treated with the sustained-release formulation of bupropion hydrochloride and at a rate at least twice the placebo rate are listed below for the 300- and 400-mg/day dose groups. 300 mg/day of bupropion sustained release: anorexia, dry mouth, rash, sweating, tinnitus, and tremor. 400 mg/day of bupropion sustained release: abdominal pain, agitation, anxiety, dizziness, dry mouth, insomnia, myalgia, nausea, palpitation, pharyngitis, sweating, tinnitus, and urinary frequency. FORFIVO XL is bioequivalent to three 150 mg tablets of WELLBUTRIN XL®, which has been demonstrated to have similar bioavailability both to the immediate-release formulation of bupropion and to the sustained-release formulation of bupropion. The information included under this subsection and under subsections 6.2 and 6.3 of the full prescribing information is based primarily on data from controlled clinical trials with the sustained-release formulation of bupropion hydrochloride. Adverse Reactions Leading to Discontinuation of Treatment with Bupropion Immediate Release or Bupropion Sustained Release. In placebo-controlled clinical trials, 9% and 11% of patients treated with 300 and 400 mg/day, respectively, of the sustained-release formulation of bupropion hydrochloride and 4% of patients treated with placebo discontinued treatment due to adverse reactions. The specific adverse reactions in these trials that led to discontinuation in at least 1% of patients treated with either 300 mg/day or 400 mg/day of the sustained-release formulation of bupropion hydrochloride, and at a rate at least twice the placebo rate are listed in Table 4.

Table 4. Treatment Discontinuations Due to Adverse Reactions in Placebo-Controlled Trials for Major Depressive Disorder using Bupropion Hydrochloride Sustained Release Formulation

Adverse Reaction	Bupropion HCl 300 mg/day (n = 376)	Bupropion HCl 400 mg/day (n = 114)	Placebo (n = 385)
Rash	2.4%	0.9%	0.0%
Nausea	0.8%	1.8%	0.3%
Agitation	0.3%	1.8%	0.3%
Migraine	0.0%	1.8%	0.3%

In clinical trials with the immediate-release formulation of bupropion, 10% of patients and volunteers discontinued due to an adverse reaction. Reactions resulting in discontinuation, in addition to those listed above for the sustained-release formulation of bupropion hydrochloride, include vomiting, seizures, and sleep disturbances. Adverse Reactions Occurring at an Incidence of 1% or More Among Patients Treated With Bupropion Immediate Release or Bupropion Sustained Release. Table 5 enumerates adverse reactions that occurred among patients treated with 300 and 400 mg/day of the sustained-release formulation of bupropion hydrochloride and with placebo in controlled trials. Reactions that occurred in either the 300- or 400-mg/day group at an incidence of 1% or more and were more frequent than in the placebo group are included. Reported adverse reactions were classified using a COSTART-based Dictionary. Accurate estimates of the incidence of adverse reactions associated with the use of any drug are difficult to obtain. Estimates are influenced by drug dose, detection technique, setting, physician judgments, etc. The figures cited cannot be used to predict precisely the incidence of untoward reactions in the course of usual medical practice where patient characteristics and other factors differ from those that prevailed in the clinical trials. These incidence figures also cannot be compared with those obtained from other clinical studies involving related drug products as each group of drug trials is conducted under a different set of conditions. Finally, it is important to emphasize that the tabulation does not reflect the relative severity and/or clinical importance of the reactions. A better perspective on the serious adverse reactions associated with the use of bupropion is provided in the **Warnings and Precautions**.

Table 5. Adverse Reactions in Placebo-Controlled Trials* for Major Depressive Disorder

Body System/Adverse Reaction	Bupropion HCl 300 mg/day (n = 376)	Bupropion HCl 400 mg/day (n = 114)	Placebo (n = 385)
Body (General)			
Headache	26%	25%	23%
Infection	8%	9%	6%
Abdominal pain	3%	9%	2%
Asthenia	2%	4%	2%

Chest pain	3%	4%	1%
Pain	2%	3%	2%
Fever	1%	2%	–
Cardiovascular			
Palpitation	2%	6%	2%
Flushing	1%	4%	–
Migraine	1%	4%	1%
Hot flashes	1%	3%	1%
Digestive			
Dry mouth	17%	24%	7%
Nausea	13%	18%	8%
Constipation	10%	5%	7%
Diarrhea	5%	7%	6%
Anorexia	5%	3%	2%
Vomiting	4%	2%	2%
Dysphagia	0%	2%	0%
Musculoskeletal			
Myalgia	2%	6%	3%
Arthralgia	1%	4%	1%
Arthritis	0%	2%	0%
Twitch	1%	2%	–
Nervous System			
Insomnia	11%	16%	6%
Dizziness	7%	11%	5%
Agitation	3%	9%	2%
Anxiety	5%	6%	3%
Tremor	6%	3%	1%
Nervousness	5%	3%	3%
Somnolence	2%	3%	2%
Irritability	3%	2%	2%
Memory decreased	–	3%	1%
Paresthesia	1%	2%	1%
Central nervous system stimulation	2%	1%	1%
Respiratory			
Pharyngitis	3%	11%	2%
Sinusitis	3%	1%	2%
Increased cough	1%	2%	1%
Skin			
Sweating	6%	5%	2%
Rash	5%	4%	1%
Pruritus	2%	4%	2%
Urticaria	2%	1%	0%
Special Senses			
Tinnitus	6%	6%	2%
Taste perversion	2%	4%	–
Blurred vision or diplopia	3%	2%	2%
Urogenital			
Urinary frequency	2%	5%	2%
Urinary urgency	–	2%	0%
Vaginal hemorrhage†	0%	2%	–
Urinary tract infection	1%	0%	–

* Adverse reactions that occurred in at least 1% of patients treated with either 300 or 400 mg/day of the sustained-release formulation of bupropion hydrochloride, but equally or more frequently in the placebo group, were: abnormal dreams, accidental injury, acne, appetite increased, back pain, bronchitis, dysmenorrhea, dyspepsia, flatulence, flu syndrome, hypertension, neck pain, respiratory disorder, rhinitis, and tooth disorder.

† Incidence based on the number of female patients.

— Hyphen denotes adverse reactions occurring in greater than 0 but less than 0.5% of patients.

Additional reactions to those listed in Table 5 that occurred at an incidence of at least 1% in controlled clinical trials of the immediate-release formulation of bupropion hydrochloride (300 to 600 mg/day) and that were numerically more frequent than placebo were: cardiac arrhythmias (5% vs. 4%), hypertension (4% vs. 2%), hypotension (3% vs. 2%), tachycardia (11% vs. 9%), appetite increase (4% vs. 2%), dyspepsia (3% vs. 2%), menstrual complaints (5% vs. 1%), akathisia (2% vs. 1%), impaired sleep quality (4% vs. 2%), sensory disturbance (4% vs. 3%), confusion (8% vs. 5%), decreased libido (3% vs. 2%), hostility (6% vs. 4%), auditory disturbance (5% vs. 3%), and gustatory disturbance (3% vs. 1%). Other adverse reactions occurring < 1% in clinical trials: Chills, facial edema, postural hypotension, stroke, syncope, bruxism, gastric reflux, gingivitis, glossitis, increased salivation, mouth ulcers, stomatitis, edema of tongue, ecchymosis, edema, abnormal coordination, decreased libido, depersonalization, emotional lability, hyperkinesia, hypertonia, hypesthesia, ataxia, and derealization, bronchospasm, accommodation abnormality, dry eye, impotence, and prostate disorder. **Postmarketing Experience** The following adverse reactions have been identified during post-approval use of bupropion hydrochloride. 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. Only those adverse reactions not previously listed for bupropion are included. The extent to which these reactions may be associated with FORFIVO XL is unknown. **Cardiovascular**—complete atrioventricular block, extrasystoles, myocardial infarction, phlebitis, and pulmonary embolism. **Gastrointestinal**—colitis, esophagitis, gastrointestinal hemorrhage, gum hemorrhage, intestinal perforation, pancreatitis, and stomach ulcer. **Endocrine**—hyperglycemia, hypoglycemia, and syndrome of inappropriate antidiuretic hormone. **Hemic and Lymphatic**—anemia, leukocytosis, leukopenia, lymphadenopathy, pancytopenia, and thrombocytopenia. **Metabolic and Nutritional**—glycosuria. **Musculoskeletal**—muscle rigidity/fever/rhabdomyolysis and muscle weakness. **Nervous System**—abnormal electroencephalogram (EEG), aggression, akinesia, aphasia, coma, delirium, dysarthria, dyskinesia, dystonia, extrapyramidal syndrome, hypokinesia, increased libido, neuralgia, neuropathy, and unmasking tardive dyskinesia. **Skin**—alopecia, exfoliative dermatitis, and hirsutism. **Eye**—mydriasis. **Urogenital**—abnormal ejaculation, cystitis, dyspareunia, dysuria, gynecomastia, painful erection, salpingitis, urinary incontinence, and urinary retention.

DRUG INTERACTIONS: Few systemic data have been collected on the metabolism of bupropion following concomitant administration with other drugs or, alternatively, the effect of concomitant administration of bupropion on the metabolism of other drugs. **Potential for Other Drugs to Affect FORFIVO XL** Because bupropion is extensively metabolized, the coadministration of other drugs may affect its clinical activity. Substrates or Inhibitors/Inducers of Cytochrome P450IIB6 (CYP2B6): In vitro studies indicate that bupropion is primarily metabolized to hydroxybupropion by the CYP2B6 isoenzyme. Therefore, the potential exists for a drug interaction between FORFIVO XL and drugs that are substrates or inhibitors/inducers of the CYP2B6 isoenzyme (e.g., orphenadrine, thiotepa, cyclophosphamide, ticlopidine and clopidogrel). In addition, in vitro studies suggest that paroxetine, sertraline, norfluoxetine, and fluvoxamine as well as nelfinavir, inhibit the hydroxylation of bupropion. *Ticlopidine, Clopidogrel:* In a study in healthy male volunteers, 75 mg clopidogrel once daily or 250 mg ticlopidine twice daily increased exposures (C_{max} and AUC) of bupropion by 40% and 60% for clopidogrel, by 38% and 85% for ticlopidine, respectively. The exposures of hydroxybupropion were decreased. This effect is thought to be due to the inhibition of the CYP2B6-catalyzed bupropion hydroxylation. Coadministration of FORFIVO XL with ticlopidine or clopidogrel is not recommended. *Prasugrel:* Prasugrel is a weak inhibitor of CYP2B6. In healthy subjects, prasugrel increased C_{max} and AUC values of bupropion by 14% and 18%, respectively, and decreased C_{max} and AUC values of hydroxybupropion, an active metabolite of bupropion, by 32% and 24%, respectively. The inhibition of prasugrel on bupropion metabolism is not considered clinically significant. *Ritonavir, Lopinavir, Efavirenz:* In a series of studies in healthy volunteers, ritonavir (100 mg twice daily or 600 mg twice daily) or ritonavir 100 mg plus lopinavir (KALETRA) 400 mg twice daily reduced the exposure of bupropion and its major metabolites in a dose dependent manner by approximately 20% to 80%. Similarly, efavirenz 600 mg once daily for 2 weeks reduced the exposure of bupropion by approximately 55%. This effect is thought to be due to the induction of bupropion metabolism. Patients receiving any of these drugs with bupropion may need increased doses of bupropion, but the maximum recommended dose of bupropion should not be exceeded *[see Clinical Pharmacology]*. *Cimetidine:* The threohydrobupropion metabolite of bupropion does not appear to be produced by the cytochrome P450 isoenzymes. The effects of concomitant administration of cimetidine on the pharmacokinetics of bupropion and its active metabolites were studied in 24 healthy young male volunteers. Following oral administration of two 150-mg tablets of the sustained-release formulation of bupropion hydrochloride with and without 800 mg of cimetidine, the pharmacokinetics of bupropion and hydroxybupropion were unaffected. However, there were 16% and 32% increases in the AUC and C_{max}, respectively, of the combined moieties of threohydrobupropion and erythrohydrobupropion. *Carbamazepine, Phenobarbital, Phenytoin:* While not systematically studied, these drugs may induce the metabolism of bupropion. **Potential for FORFIVO XL to Affect Other Drugs** Animal data indicated that bupropion may be an inducer of drug-metabolizing enzymes in humans. In one study, following chronic administration of bupropion hydrochloride, 100 mg 3 times daily to 8 healthy male volunteers for 14 days, there was no evidence of induction of its own metabolism. Nevertheless, there may be the potential for clinically important alterations of blood levels of coadministered drugs. Lamotrigine: Multiple oral doses of bupropion had no statistically significant effects on the single dose pharmacokinetics of lamotrigine in 12 healthy volunteers. Drugs Metabolized by Cytochrome P450IID6 (CYP2D6). Many drugs, including most antidepressants (SSRIs, many tricyclics), beta-blockers, antiarrhythmics, and antipsychotics are metabolized by the CYP2D6 isoenzyme. Although bupropion is not metabolized by this isoenzyme, bupropion and hydroxybupropion are inhibitors of the CYP2D6 isoenzyme in vitro. In a study of 15 male subjects (ages 19 to 35 years) who were extensive metabolizers of the CYP2D6 isoenzyme, daily doses of bupropion hydrochloride given as 150 mg twice daily followed by a single dose of 50 mg desipramine increased the C_{max}, AUC, and $t_{1/2}$ of desipramine by an average of approximately 2-, 5-, and 2-fold, respectively. The effect was present for at least 7 days after the last dose of bupropion. Concomitant use of bupropion with other drugs metabolized by CYP2D6 has not been formally studied. Therefore, coadministration of bupropion with drugs that are metabolized by the CYP2D6 isoenzyme including certain antidepressants (e.g., venlafaxine, nortriptyline, imipramine, desipramine, paroxetine, fluoxetine, and sertraline), antipsychotics (e.g., haloperidol, risperidone, and thioridazine), beta-blockers (e.g., metoprolol), and Type 1C antiarrhythmics (e.g., propafenone and flecainide), should be approached with caution and should be initiated at the lower end of the dose range of the concomitant medication. If bupropion is added to the treatment regimen of a patient already receiving a drug metabolized by CYP2D6, the need to decrease the dose of the original medication should be considered, particularly for those concomitant medications with a narrow therapeutic index. CYP2D6 in order to be effective (e.g., tamoxifen) theoretically could have reduced efficacy when administered concomitantly with inhibitors of CYP2D6 such as bupropion. Although citalopram is not primarily metabolized by CYP2D6, in one study bupropion increased the C_{max} and AUC of citalopram by 30% and 40%, respectively. Citalopram did not affect the pharmacokinetics of bupropion and its three metabolites. **Nicotine Transdermal System** Data from a smoking cessation study suggest that a higher incidence of hypertension in patients who received the combination of sustained-release bupropion hydrochloride and NTS. Monitoring of blood pressure is recommended in patients who receive the combination of bupropion and nicotine replacement *[see Warnings and Precautions]*. **Drug Laboratory Test Interactions** False-positive urine immunoassay screening tests for amphetamines have been reported in patients taking bupropion. This is due to lack of specificity of some screening tests. False-positive test results may result even following discontinuation of bupropion therapy. Confirmatory test such as gas chromatography/mass spectrometry, will distinguish bupropion from amphetamines. **MAO Inhibitors** Studies in animals demonstrate that the acute toxicity of bupropion is enhanced by the MAO inhibitor phenelzine *[see Contraindications]*. **Drugs that Lower Seizure Threshold** Since there is no lower strength for FORFIVO XL, concurrent administration of FORFIVO XL tablets and agents (e.g., antipsychotics, other antidepressants, theophylline, systemic steroids, etc.) that lower seizure threshold should be undertaken only with caution *[see Warnings and Precautions]*. **Alcohol** In postmarketing experience, there have been rare reports of adverse neuropsychiatric events or reduced alcohol tolerance in patients who were drinking alcohol during treatment with bupropion. Alcohol increased the release rate of FORFIVO XL in vitro. The consumption of alcohol during treatment with FORFIVO XL should be avoided. **Levodopa and Amantadine** Limited clinical data suggest a higher incidence of adverse experiences in patients receiving bupropion concurrently with either levodopa or amantadine. Since there is no lower strength for FORFIVO XL, administration of FORFIVO XL tablets to patients receiving either levodopa or amantadine concurrently should be undertaken with caution.

USE IN SPECIFIC POPULATIONS: Pregnancy Teratogenic Effects: **Pregnancy Category C.** In studies conducted in rats and rabbits, bupropion hydrochloride was administered orally at doses up to 450 and 150 mg/kg/day, respectively (approximately 11 and 7 times the maximum recommended human dose [MRHD], respectively, on a mg/m^2 basis), during the period of organogenesis. No clear evidence of teratogenic activity was found in either species; however, in rabbits, slightly increased incidences of fetal malformations and skeletal variations were observed at the lowest dose tested (25 mg/kg/day, approximately equal to the MRHD on a mg/m^2 basis) and greater. Decreased fetal weights were seen at 50 mg/kg and greater. When rats were administered bupropion hydrochloride at oral doses of up to 300 mg/kg/day (approximately 7 times the MRHD on a mg/m^2 basis) prior to mating and throughout pregnancy and lactation, there were no apparent adverse effects on offspring development. One study has been conducted in pregnant women. This retrospective, managed-care database study assessed the risk of congenital malformations overall, and cardiovascular malformations specifically, following exposure to bupropion in the first trimester compared to the risk of these malformations following exposure to other antidepressants in the first trimester and bupropion outside of the first trimester. This study included 7,005 infants with antidepressant exposure during pregnancy, 1,213 of whom were exposed to bupropion in the first trimester. The study showed no greater risk for congenital malformations overall, or cardiovascular malformations specifically, following first trimester bupropion exposure compared to exposure to all other antidepressants in the first trimester, or bupropion outside of the first trimester. The results of this study have not been corroborated. FORFIVO XL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. **Nursing Mothers** Like many other drugs, bupropion and its metabolites are secreted in human milk. Because of the potential for serious adverse reactions in nursing infants from FORFIVO XL tablets, 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. Anyone considering the use of FORFIVO XL in a child or adolescent must balance the potential risks with the clinical need. **Geriatric Use** Of the approximately 6,000 patients who participated in clinical trials with bupropion hydrochloride sustained-release tablets (depression and smoking cessation studies), 275 were 65 years old and over and 47 were 75 years old and over. In addition, several hundred patients 65 and over participated in clinical trials using the immediate-release formulation of bupropion hydrochloride (depression studies). No overall differences in safety or effectiveness were observed between these subjects and younger subjects. Reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out. A single-dose pharmacokinetic study demonstrated that the disposition of bupropion and its metabolites in elderly subjects was similar to that of younger subjects; however, another pharmacokinetic study, single and multiple dose, has suggested that the elderly are at increased risk for accumulation of bupropion and its metabolites *[see Clinical Pharmacology]*. Bupropion is extensively metabolized in the liver to active metabolites, which are further metabolized and excreted by the kidneys. The risk of toxic reaction to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection, and it may be useful to monitor renal function *[see Dosage and Administration and Use in Specific Populations]*. **Renal Impairment** Since there is no lower dose strength for FORFIVO XL, FORFIVO XL is not recommended in patients with renal impairment *[see Clinical Pharmacology]*. **Hepatic Impairment** Since there is no lower dose strength for FORFIVO XL, FORFIVO XL is not recommended in patients with hepatic impairment *[see Clinical Pharmacology]*.

DRUG ABUSE AND DEPENDENCE: Controlled Substance Bupropion is not a controlled substance. **Abuse** Humans: Controlled clinical studies of bupropion hydrochloride (immediate-release formulation) conducted in normal volunteers, in subjects with a history of multiple drug abuse, and in depressed patients showed some increase in motor activity and agitation/excitement. In a population of individuals experienced with drugs of abuse, a single dose of 400 mg of bupropion hydrochloride produced mild amphetamine-like activity as compared to placebo on the Morphine-Benzedrine Subscale of the Addiction Research Center Inventories (ARCI), and a score intermediate between placebo and amphetamine on the Liking Scale of the ARCI. These scales measure general feelings of euphoria and drug desirability. Findings in clinical trials, however, are not known to reliably predict the abuse potential of drugs. Nonetheless, evidence from single-dose studies does suggest that the recommended daily dosage of bupropion when administered in divided doses is not likely to be especially reinforcing to amphetamine or stimulant abusers. However, higher doses that could not be tested because of the risk of seizure might be modestly attractive to those who abuse stimulant drugs. Animals: Studies in rodents and primates have shown that bupropion exhibits some pharmacologic actions common to psychostimulants. In rodents, it has been shown to increase locomotor activity, elicit a mild stereotyped behavioral response, and increase rates of responding in several schedule-controlled behavior paradigms. In primate models to assess the positive reinforcing effects of psychoactive drugs, bupropion was self-administered intravenously. In rats, bupropion produced amphetamine-like and cocaine-like discriminative stimulus effects in drug discrimination paradigms used to characterize the subjective effects of psychoactive drugs.

OVERDOSAGE: Human Overdose Experience Overdoses of up to 30 g or more of bupropion have been reported. Seizure was reported in approximately one third of all cases. Other serious reactions reported with overdoses of bupropion alone included hallucinations, loss of consciousness, sinus tachycardia, and ECG changes such as conduction disturbances or arrhythmias. Fever, muscle rigidity, rhabdomyolysis, hypotension, stupor, coma, and respiratory failure have been reported mainly when bupropion was part of multiple drug overdoses. Although most patients recovered without sequelae, deaths associated with overdoses of bupropion alone have been reported in patients ingesting large doses of the drug. Multiple uncontrolled seizures, bradycardia, cardiac failure, and cardiac arrest prior to death were reported in these patients. **Overdosage Management** Ensure an adequate airway, oxygenation, and ventilation. Monitor cardiac rhythm and vital signs. EEG monitoring is also recommended for the first 48 hours post-ingestion. General supportive and symptomatic measures are also recommended. Induction of emesis is not recommended. Gastric lavage with a large-bore orogastric tube with appropriate airway protection, if needed, may be indicated if performed soon after ingestion or in symptomatic patients. Activated charcoal should be administered. There is no experience with the use of forced diuresis, dialysis, hemoperfusion, or exchange transfusion in the management of bupropion overdoses. No specific antidotes for bupropion are known. Due to the dose-related risk of seizures with FORFIVO XL, hospitalization following suspected overdose should be considered. Based on studies in animals, it is recommended that seizures be treated with intravenous benzodiazepine administration and other supportive measures, as appropriate. In managing overdosage, consider the possibility of multiple drug involvement. The physician should consider contacting a poison control center for additional information on the treatment of any overdose. Telephone numbers for certified poison control centers are listed in the Physicians' Desk Reference (PDR).

Manufactured for: Edgemont Pharmaceuticals, LLC, Austin, TX 78731
By: Pillar5 Pharma Inc., Arnprior, Ontario, K7S 0C9, Canada

©2012 Edgemont Pharmaceuticals, LLC. All rights reserved.
Intended for US audiences only.

NEW! ONCE-DAILY **450 MG**

Forfivo™ XL

(bupropion hydrochloride extended-release tablets)

EDGEMONT® PHARMACEUTICALS

APA Educates Congress After Newtown Tragedy

APA urges Congress to provide funding for public mental health research and treatment, and disputes the NRA's remarks in the wake of the Connecticut tragedy.

BY LESLIE SINCLAIR

APA President Dilip Jeste, M.D., sent a letter in late December on behalf of the Association to leaders of both the Senate and House of Representatives responding to the massacre in Newtown, Conn., and emphasizing that psychiatrists "stand ready to do whatever we can to help alleviate the suffering caused by the tragedy and to help the survivors cope with life after a trauma of this unimaginable magnitude."

Jeste also expressed APA's concern about some proposals to identify people with mental illness by placing them on special registries and about media accounts that inaccurately portray people with mental illness.

"Stigma remains one of the greatest barriers to early identification, intervention, and treatment for Americans seeking help for mental illness, and we hope that Congress will avoid making generalized assumptions about persons now in or seeking treatment for mental illness," he told congressional leaders. "The vast majority of violence in our society is not perpetrated by persons with serious mental disorders. Research suggests that individuals with mental illness engaged in regular treatment are considerably less likely to commit violent acts than those in need of, but not engaged in, appropriate mental health treatment."

Highlighting the effectiveness of psychiatric treatment, Jeste urged policymakers to focus on the fact that access to comprehensive, effective psychiatric treatment works. "Yet at the very time of the Newtown tragedy, federal and state funding of critical mental health services is under siege," he said, pointing out that 29 states have eliminated a total of more than 3,200 psychiatric inpatient beds since 2008.

Jeste also called on Congress to address the abundance and easy availability of guns, saying that APA believes "any discussion on fostering a robust mental health delivery system must not be isolated from discussions of strategies to reduce gun violence." He condemned laws to bar physicians from asking about the presence of guns in a patient's home and pointed out that APA has expressed support for "appropriately targeted proposals such as mental health registries and modified access to firearms as meaningful ways to curb gun violence."

Four days later, in the wake of comments about people with mental illness by the head of the National Rifle Association (NRA), APA expressed its severe disappointment in comments made by Wayne LaPierre, the NRA executive vice president and CEO. APA took issue with LaPierre's inaccurate assumption that horrendous crimes are commonly perpetrated by people with mental illness. "Only 4 percent to 5 percent of violent crimes are committed by people with mental illness," said Jeste in a press release responding to the NRA's comments. "About one-quarter of all Americans have a mental disorder in any given year, and only a very small percentage of them will ever commit violent crimes."

> "Any discussion on fostering a robust mental health delivery system must not be isolated from discussions of strateties to reduce gun violence."

APA Medical Director James H. Scully Jr., M.D., said that LaPierre's statements serve only to increase the stigma around mental illness and further the misconception that those with mental disorders are likely to be dangerous.

In an interview with *Psychiatric News*, Jeste expressed hope for a constructive outcome to the debate about the etiology of the Newtown tragedy: "There have been several examples in history when shocking events led to a meaningful and rational evaluation of the circumstances and resulted in the development and implementation of long-term solutions. We can hope that the unimaginable tragedy in Newtown will cause national soul searching and produce changes, not only in markedly improved mental health care, but also in reducing various other risk factors that promote senseless violence. Nothing else will bring justice to the innocent children and brave teachers who lost their lives in Newtown." PN

Jeste's letter to Congress is posted on APA's Web site at http://www.psychiatry.org/advocacy--newsroom/advocacy/apa-sends-letter-to-congress-regarding-recent-shooting-in-newtownct. APA's response to the NRA's comments is posted at http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Press%20Releases/2012%20Releases/12-45-APA-Repsonse-to-NRA-Comments.pdf.

Newtown

continued from page 1

She responded to an e-mail request for volunteers from the Connecticut chapter of the American Academy of Child and Adolescent Psychiatry and worked a 10 a.m. to 1 p.m. shift at Newtown's town hall, talking to whoever walked in the door.

These were brief encounters, she said. They were "more supportive and reflective, just letting people know that they were not alone and that in the community, people were there for each other."

"In Newtown, everyone is two or three degrees removed from someone directly affected by the shooting," said Sohrab Zahedi, M.D., another volunteer who worked a three-hour shift at the Reed Intermediate School on the Sunday after the attack.

The psychiatrists, psychologists, social workers, and others there did more than counseling, said Zahedi, a forensic psychiatrist at the Hartford Correctional Center.

"Often, we were offering guidance about what adults can do and how they could talk to their children about the event," he explained. "These kids need to feel safe, and that means a return to a normal routine."

He advised people to acknowledge the extraordinary nature of the crime. They should expect to cry or feel weird or angry and would likely see children expressing their emotions with occasional outbursts.

"Mainly, I listened," said Zahedi. "Just having someone there to talk to was the most important thing for them."

On a Sunday shift the weekend after the shooting, child psychiatrists worked with both children and adults, said Carolyn Drazinic, M.D., Ph.D., president-elect of the CPS and an assistant professor of psychiatry at the University of Connecticut School of Medicine.

"It was a whole community pouring in to get help and counseling," she said. "People all knew somebody affected by the tragedy."

When people asked her how to talk to children, she suggested talking to them on their developmental level, speaking the truth, but not going into unneeded detail about the crime. Use of medications was generally discouraged, she said.

A training course in disaster psychiatry led by Khan and others and held just a month before the school shooting proved helpful, she noted. "We coordinated with the Red Cross," she said. "That was essential for having the response be organized and helpful."

The psychiatrists' first week in Newtown was only the beginning, said Khan. "We'll need to figure out how the CPS can help with follow-up and continuing care."

Based on this experience, Khan hopes that APA will support more psychiatric disaster training for its district branches and push for greater inclusion of the topic in medical school and residency training. PN

Scully to Resign as CEO/Medical Director

James H. Scully Jr., M.D., will step down as APA medical director and CEO at the end of 2013 after a little more than a decade of serving APA in that capacity. A search committee chaired by former APA President Paul Appelbaum, M.D., has been appointed to identify a successor.

Said Appelbaum, "Jay Scully, like the stalwart former Naval officer that he is, has steered APA through difficult waters while staying focused on the ultimate mission of serving our members and their patients. In identifying candidates to succeed him, the Search Committee is looking for someone who has the personal integrity that Jay has exemplified, the stature to serve as a national leader and spokesperson for the psychiatric profession, and the skills to run this complex organization." (See advertisement on page 2.)

In addition to Appelbaum, the members of the Search Committee are Rahn Bailey, M.D., R. Scott Benson, M.D., David Fassler, M.D., Garry Gottlieb, M.D., Anand Pandya, M.D., Herbert Pardes, M.D., Claudia Reardon, M.D., Carolyn Robinowitz, M.D., Pedro Ruiz, M.D., Alan Schatzberg, M.D., Ann Marie Sullivan, M.D., and Melinda Louise Young, M.D.

The Search Committee is staffed by Margaret Dewar, director of APA's Department of Governance, and Jessica Hopey, senior governance coordinator. More information is available by contacting Dewar at mdewar@psych.org.

APA 166TH ANNUAL MEETING COURSE GUIDE

HOW TO REGISTER

There are three easy ways to register for APA's 2013 annual meeting and courses. The deadline for advance registration is **APRIL 19.**

Annual meeting information can be accessed from APA's Web site at http://annualmeeting.psychiatry.org.

REGISTER ONLINE: Go to the URL above and go to the "Registration" menu on the right.

FAX REGISTRATION FORM: Fax your completed registration form with credit card information to (703) 907-1097. There is a $10 processing fee for faxed forms.

MAIL REGISTRATION FORM: Mail your completed registration form and payment (by credit card or check made payable to APA) to American Psychiatric Association Annual Meeting, P.O. Box 418237, Boston, Mass. 02241-8237. There is a $10 processing fee for mailed forms.

After April 19, you may register online only (on-site fees apply), not by mail or fax. You can also register on site.

SAN FRANCISCO, MAY 18-22, 2013

BY CATHY CRONE, M.D.
Chair, Scientific Program Subcommittee on Courses

YOU MIGHT ask yourself, "Why take a course at the APA annual meeting?" Whether you wish to prepare for certification exams, enhance your clinical skills, or remain abreast of exciting uses of technology and research advances in psychiatry, the APA Subcommittee on Courses has planned something for you!

Over the years, exceptional continuing medical education courses have become a tradition at APA's annual meeting. Courses are offered in half-day (four hours) and full-day (six or eight hours) formats. This year's courses encompass new offerings, highly evaluated repeat courses directed by national and international experts, and improved versions of courses given in the past. We will be covering a wide variety of topics this year, including cognitive-behavior therapy, personality disorders, ADHD, and neuropsychiatry.

In addition to me, serving on the Subcommittee on Courses are my vice chair, Josepha Cheong, M.D., and committee members Michael Myers, M.D., Arnaldo Moreno, M.D., and Lucy Hutner, M.D. Along with Isabel Mahoney, course services coordinator, we have worked hard to evaluate course submissions critically to provide an exceptional, in-depth educational experience for all.

The Subcommittee on Courses limits course enrollment size to maximize opportunities for participant-faculty interaction. To secure your place in a course, register early! The courses sell out quickly. Registration and enrollment information and forms can be accessed at APA's Web site at http://annualmeeting.psychiatry.org. Links for online meeting and housing registration can also be accessed from this site.

All mailed and faxed registration and pre-enrollment forms must be received at APA on or before **April 19.** After this date, on-site fees are in effect for meeting and course registration. The course enrollment area is located in the Moscone Convention Center. Only those who have registered for the annual meeting may purchase course tickets.

SEE YOU THERE!

MASTER COURSE 07

DSM-5: What You Need to Know

SATURDAY, MAY 18, 9 A.M.-4 P.M

Director: Darrel A. Regier, M.D., M.P.H. **Co-Director:** David J. Kupfer, M.D.

DSM-5 marks the first major revision to the classification of and diagnostic criteria for mental disorders since 1994. The course will educate learners on the major changes from *DSM-IV* to *DSM-5*, including diagnosis-specific changes and broader, manual-wide changes. Primary emphasis is on ensuring clinicians understand these changes and how to implement these changes in their practice. Convention Center; advance: $350; on site: $380

MASTER COURSE 02

Update on Pediatric Psychopharmacology

SATURDAY, MAY 18, 9 A.M.-4 P.M.

Director: Glen O. Gabbard, M.D. **Faculty:** Mantosh Dewan, M.D., Valdesha Ball, M.D., Gabrielle Hobday, M.D., Holly Crisp-Han, M.D.

This course will provide practical information on the use of psychotropic medications in the treatment of children and adolescents. Topics include an overview and discussion of recent data in pediatric psychopharmacology, with a focus on mood disorders, attention-deficit/hyperactivity disorder, anxiety disorders, and autism spectrum disorders. Convention Center; advance: $350; on site: $380

MASTER COURSE 03

Sex, Drugs, and Social Media: Professionalism and Ethics Put to the Test

SUNDAY, MAY 19, 9 A.M.-4 P.M.

Director: Glen O. Gabbard, M.D. **Faculty:** Gabrielle Hobday, M.D.; Holly Crisp-Han, M.D.; Valdesha Ball, M.D.; Laura Roberts, M.D.

This course will engage learners with clinical dilemmas encountered in practice and make ethics and professionalism clinically relevant and practical. Major areas covered include the problems of maintaining professional boundaries, dual relationships, intercolleague relationships, complicated issues around race, culture, gender, sexuality, religion, and social media. Convention Center; advance: $350; on site: $380

MASTER COURSE 06

Psychiatry Review 2013

TUESDAY, MAY 21, 9 A.M.-4 P.M.

Director: Arden D. Dingle, M.D. **Co-Director:** Robert Boland, M.D. **Faculty:** Richard Balon, M.D.; Sandra M. DeJong, M.D., M.Sc.; Natalie Lester, M.D.,M.P.H.; Avram H. Mack, M.D.; Vishal Madaan, M.D.; Anthony Rostain, M.D.; Mark Servis, M.D.; Marcy Verduin, M.D.

Essential psychiatric and neurology topics will be discussed using multiple-choice questions. Audience members will use an audience-response system to respond before correct answers, full explanations, and references are given. Convention Center; advance: $350; on site: $380

ATTEND a master course at APA's 2013 annual meeting and receive an accompanying reference as part of your admission! The deadline for advance registration is **April 19.**

MASTER COURSE 01

Treating the LGBT Patient

SATURDAY, MAY 18, 9 A.M.-4 P.M.

Director: Christopher Kratochvil, M.D. **Faculty:** John T. Walkup, M.D.; Karen Dineen Wagner, M.D., Ph.D.; Christopher J. McDougle, M.D.

Clinicians must be sensitive to the diverse range of problems facing their patients. This course covers basic concerns facing LGBT populations, including coming out, heterosexist attitudes, the "don't ask, don't tell" mentality, legal issues, gay parenting, and sexual identity in patient-therapist relationships. The course presents case studies with different *DSM* diagnoses, illuminating the impact of LGBT identity and illustrating effectively working with patients. Convention Center; advance: $350; on site: $380

MASTER COURSE 04

Practical Cognitive-Behavior Therapy

SUNDAY, MAY 19, 9 A.M.- 4 P.M.

Director: Jesse H. Wright, M.D., Ph.D. **Faculty:** Donna Sudak, M.D.; Robert Michael Goisman, M.D.; Judith Beck, Ph.D.

Clinicians will learn the fundamentals of cognitive-behavior therapy, including the basic cognitive-behavioral model, the collaborative empirical relationship, methods of structuring and educating, techniques for changing dysfunctional automatic thoughts and schemas, behavioral interventions for anxiety and depression, and strategies of improving medication adherence. The price includes a copy of Learning Cognitive-Behavior Therapy: An Illustrated Guide. Convention Center; advance: $350; on site: $380

MASTER COURSE 08

Update on the *Manual of Clinical Psychopharmacology*

TUESDAY, MAY 21, 9 A.M.-4 P.M.

Director: Alan F. Schatzberg, M.D. **Co-Director:** Charles DeBattista, M.D. **Faculty:** Antonio Hardan, M.D.; Rona Hu, M.D.; Charles Nemeroff, M.D., Ph.D.; Terence Arthur Ketter, M.D.

This course, designed for psychiatric clinicians, will focus on the cutting-edge issues every clinician needs to know to ensure quality care. Advances over the last year will be highlighted, with a particular focus on depression and anxiety, bipolar disorder, child/adolescent disorders, ECT, and schizophrenia. Convention Center; advance: $350; on site: $380

APA 166TH ANNUAL MEETING COURSE GUIDE

SATURDAY, MAY 18

COURSE 01

STREET DRUGS AND MENTAL DISORDERS: OVERVIEW AND TREATMENT OF DUAL-DIAGNOSIS PATIENTS

Director: John Tsuang, M.D. **Faculty:** Reef Karim, D.O.; Larissa Mooney, M.D.; Timothy W. Fong, M.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) understand the issues relating to the treatment of dual-diagnosis patients; (2) be aware of popular street drugs and club drugs; (3) be familiar with available pharmacological agents for treatment of dual-diagnosis patients; and (4) understand the harm-reduction versus the abstinence model for dual-diagnosis patients. **Saturday, May 18, 8-noon; 4 hours; Moscone Convention Center; advance: $165; on site: $190; spaces available: 80**

COURSE 02

MENTALIZATION-BASED TREATMENT FOR BORDERLINE PERSONALITY DISORDER (BPD): INTRODUCTION TO CLINICAL PRACTICE

Director: Anthony Bateman, M.D. **Co-Director:** Peter Fonagy, Ph.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) demonstrate an understanding of the mentalizing problems of borderline personality disorder; (2) recognize mentalizing and nonmentalizing interventions; (3) develop and maintain a mentalizing therapeutic stance; and (4) use some basic mentalizing techniques in everyday clinical work. **Saturday, May 18, 8-noon; 4 hours; Moscone Convention Center; advance: $165; on site: $190; spaces available: 100**

COURSE 03

INTERPERSONAL PSYCHOTHERAPY (IPT)

Director: John C. Markowitz, M.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) understand the basic rationale and techniques of IPT; (2) understand its application to the treatment of major depressive disorder and other conditions; and (3) understand the basic research supporting its use and treatment indications. **Saturday, May 18, 8-noon; 4 hours; Moscone Convention Center; advance: $165; on site: $190; spaces available: 45**

COURSE 04

HEALTHY BRAIN AGING: EVIDENCE-BASED METHODS TO PRESERVE AND IMPROVE BRAIN FUNCTION

Director: Abhilash Desai, M.D. **Co-Director:** George Thomas Grossberg, M.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) describe research clarifying different trajectories of cognitive health in older adults; (2) discuss evidence supporting modifiable factors associated with reduced risk of dementia in older adults; and (3) describe specific lifestyle modification strategies that promote cognitive health in older adults. **Saturday, May 18, 8-noon; 4 hours; Moscone Convention Center; advance: $165; on site: $190; spaces available: 150**

COURSE 05

BASIC CONCEPTS IN ADMINISTRATIVE PSYCHIATRY

Director: Geetha Jayaram, M.D., M.B.A. **Co-Director:** John Elgin Wilkaitis, M.B.A., M.D. **Faculty:** Mark Russakoff, M.D.; Barry Herman, M.D.; Robert Atkins, M.D., M.P.H.; Shivkumar Hatti, M.D., M.B.A. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) demonstrate a working knowledge of the basic concepts for the theoretical, fiscal, and information technology concepts of administration in psychiatry; (2) apply these concepts to psychiatric service systems; and (3) recognize gaps in services systems, use a collaborative service model, and recognize future trends in health delivery systems. **Saturday, May 18, 9-4; 6 hours; Moscone Convention Center; advance: $300; on site: $340; spaces available: 85**

COURSE 06

MELATONIN AND LIGHT TREATMENT OF SAD, SLEEP, AND OTHER BODY CLOCK DISORDERS

Director: Alfred Lewy, M.D., Ph.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) use the salivary dim light melatonin onset and sleep time to phase type circadian sleep and mood disorders as to whether they are phase advanced or phase delayed; (2) treat a patient with appropriately timed bright light exposure (evening or morning) and/or low-dose melatonin administration (morning or afternoon) using the patient's phase type; and (3) monitor treatment response using the DLMO/mid-sleep interval, targeting six hours. **Saturday, May 18, 1-5; 4 hours; Moscone Convention Center; advance: $165; on site: $190; spaces available: 80**

COURSE 07

THE PSYCHIATRIST AS EXPERT WITNESS

Director: Phillip Resnick, M.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) give more effective expert-witness testimony; (2) understand rules of evidence and courtroom privilege; and (3) understand issues of power and control in the witness/cross-examiner relationship. **(APA Members Only) Saturday, May 18, 1-5; 4 hours; Moscone Convention Center; advance: $165; on site: $190; spaces available: 100**

COURSE 08

MANAGEMENT OF PSYCHIATRIC DISORDERS IN PREGNANT AND POSTPARTUM WOMEN

Director: Shaila Misri, M.D. **Co-Director:** Diana Carter, M.D. **Faculty:** Deirdre Ryan, M.D.; Shari Lusskin, M.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) have an increased awareness about psychiatric disorders that occur in pregnancy and postpartum; (2) have an improved ability to identify psychiatric disorders that occur in pregnancy and postpartum; and (3) have an improved ability to treat psychiatric disorders that occur in pregnancy and postpartum. **Saturday, May 18, 1-5; 4 hours; Moscone Convention Center; advance: $165; on site: $190; spaces available: 150**

SUNDAY, MAY 19

COURSE 09

GOOD PSYCHIATRIC MANAGEMENT FOR BPD: WHAT EVERY PSYCHIATRIST SHOULD KNOW

Director: John Gunderson, M.D. **Faculty:** Paul Links, M.D.; Brian Palmer, M.D., M.P.H. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) explain the diagnosis to patients and families and establish reasonable expectations for change (psychoeducation); (2) manage the problem of recurrent suicidality and self-harm while limiting personal burden and liability; and (3) expedite alliance-building via use of medications and homework. **Sunday, May 19, 8-noon; 4 hours; Moscone Convention Center; advance: $165; on site: $190; spaces available: 100**

COURSE 10

NEUROANATOMY OF EMOTIONS

Director: Ricardo Vela, M.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) describe the functional neuroanatomical interrelationships of the hypothalamus, amygdala, septal nuclei, hippocampus, and anterior cingulate gyrus; (2) identify the major limbic fiber pathways, their trajectories, and their specific targets; describe how each limbic structure contributes to the specific expression of emotions and attachment behavior; (3) discuss neuroanatomical-emotional correlates in autism; and (4) discuss neurodevelopmental abnormalities of migrating neurons in schizophrenia. **Sunday, May 19, 8-noon; 4 hours; Moscone Convention Center; advance: $165; on site: $190; spaces available: 150**

COURSE 11

MOOD DISORDERS IN LATER LIFE

Director: James Michael Ellison, M.D., M.P.H. **Co-Director:** Yusuf Sivrioglu, M.D. **Faculty:** Patricia Anne Arean, Ph.D.; Donald Davidoff, Ph.D.; Brent Forester, M.D., M.Sc. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) implement an evidence-based approach to the diagnosis of mood disorders in older adults; (2) describe and discuss the characteristics of "normal cognitive aging," "major depressive disorder," and the "dementia syndrome of depression"; (3) apply an evidence-based approach to using somatic therapies in the treatment of older adults with mood disorders, including treatment-resistant mood disorders; and (4) discuss psychotherapy's evidence-based role in treating older adults with mood disorders and to describe special issues that arise in treating this population. **Sunday, May 19, 8-noon; 4 hours; Moscone Convention Center; advance: $165; on site: $190; spaces available: 100**

COURSE 12

YOGA OF THE EAST AND WEST EXPERIENTIAL FOR STRESS, ANXIETY, PTSD, MASS DISASTERS, STRESS-RELATED MEDICAL CONDITIONS, AND MORE

Director: Patricia L. Gerbarg, M.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) understand how Heart Rate Variability, sympatho-vagal balance, and cardiopulmonary resonance contribute to stress-resilience; Experience Coherent Breathing for stress reduction and learn how it is used in the treatment of anxiety disorders, insomnia, PTSD, depression, and stress-related medical conditions; (2) experience Open Focus meditation for stress reduction, improved attention, and relief of physical and psychological distress; (3) employ Coherent Breathing to relieve personal stress and professional burnout; and (4) acquire the tools to teach Coherent Breathing for stress relief to individual patients in their clinical practice. **Sunday, May 19, 9-4; 6 hours; Moscone Convention Center; advance: $300; on site: $340; spaces available: 80**

COURSE 13

TREATMENT OF SCHIZOPHRENIA

Director: Phillip Janicak, M.D. **Faculty:** Rajiv Tandon, M.D.; Morris Goldman, M.D.; Stephen R. Marder, M.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) describe the psychopathological

APA 166TH ANNUAL MEETING COURSE GUIDE

dimensions, recent *DSM-5* diagnostic criteria, and neurobiological underpinnings of schizophrenia; (2) describe the clinically relevant pharmacological aspects of first- and second-generation antipsychotics, as well as novel therapies; (3) better, understand the efficacy, safety, and tolerability of antipsychotics when used for acute and chronic schizophrenia; and (4) describe recent approaches to integrating medication strategies with psychosocial and rehabilitation programs. **Sunday, May 19, 9-4; 6 hours; Moscone Convention Center; advance: $300; on site: $340; spaces available: 90**

COURSE 14

OFFICE-BASED BUPRENORPHINE TREATMENT OF OPIOID DEPENDENCE

Director: Petros Levounis, M.D. **Co-Director:** John A. Renner Jr., M.D. **Faculty:** Andrew John Saxon, M.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) identify the clinically relevant pharmacological characteristics of buprenorphine; (2) list at least five factors to consider in determining if the patient is an appropriate candidate for office-based treatment with buprenorphine; and (3) describe the resources needed to set up office-based treatment with buprenorphine for patients with opioid dependence. **Sunday, May 19, 7:30-4:30; 8 hours; Moscone Convention Center; advance: $300; on site: $340; spaces available: 80**

COURSE 15

ESSENTIALS OF ASSESSING AND TREATING ADHD IN ADULTS AND CHILDREN

Director: Thomas E. Brown, Ph.D. **Faculty:** Jefferson Prince, M.D.; Anthony Rostain, M.D., M.A. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) recognize the wide range of executive function impairments characteristic of ADHD in adults, adolescents, and children; (2) explain current research-based understandings of pathophysiology of ADHD; (3) assess and diagnose ADHD in adults, adolescents, and children using updated instruments and methods; (4) select appropriate medications and psychosocial interventions for treatment of ADHD and various comorbidities; and (5) implement and monitor effectiveness of multi-modal treatment plans for patients with ADHD and various comorbidities. **Sunday, May 19, 9-4; 6 hours; Moscone Convention Center; advance: $300; on site: $340; spaces available: 80**

COURSE 16

THE INTEGRATION OF PRIMARY CARE AND BEHAVIORAL HEALTH: PRACTICAL SKILLS FOR THE CONSULTING PSYCHIATRIST

Director: Lori Raney, M.D. **Co-Director:** Jurgen Unutzer, M.D., M.P.H., M.A. **Faculty:** Anna Ratzliff, M.D., Ph.D.; John Kern, M.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) make the case for integrated behavioral health services in primary care, including the evidence for collaborative care; (2) describe the roles for a primary care consulting psychiatrist in an integrated care team; (3) list models of care used to provide primary care services in mental health settings; (4) apply a systematic approach to target health behavior change and medical illness in a mental health setting; and (5) discuss principles of integrated behavioral health care. **Sunday, May 19, 9-4; 6 hours; Moscone Convention Center; advance: $300; on site: $340; spaces available: 150**

MONDAY, MAY 20

COURSE 17

PRACTICAL ASSESSMENT AND TREATMENT OF BEHAVIOR DISTURBANCE FOR THOSE WITH MODERATE TO SEVERE DEMENTIA

Director: Maureen Nash, M.D. **Faculty:** Sarah Foidel, O.T.; Maria Shindler, M.S.N., R.N. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) describe different types of behavior disturbance and how they may present in differing types of dementia; (2) describe when and how to use various types of behavioral interventions to prevent and treat behavior disturbance in those with dementia; (3) have a framework for understanding and treating those with behavior disturbance due to advanced dementia; (4) discuss the risks, benefits, and alternatives to pharmacological treatment of behavior disturbance in those with advancead dementia; and (5) discuss the challenges of interpreting evidence to treat behavior disturbance in those with dementia. **Monday, May 20, 8-noon; 4 hours; Moscone Convention Center; advance: $165; on site: $190; spaces available: 80**

COURSE 18

EXPLORING TECHNOLOGIES IN PSYCHIATRY

Director: Robert Kennedy, M.D. **Co-Director:** John Luo, M.D. **Faculty:** Carlyle Chan, M.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) review the various current technologies and connections that are possible in psychiatry and medicine; (2) evaluate the emerging technologies and how they will impact the practice of medicine in the near future; and (3) delineate the pros and cons of electronic physician-patient communication. **Monday, May 20, 8-noon; 4 hours; Moscone Convention Center; advance: $165; on site $190; spaces available: 80**

cdrin/Shutterstock

COURSE 19

ECT PRACTICE UPDATE FOR THE GENERAL PSYCHIATRIST

Director: Laurie McCormick, M.D. **Co-Director:** Charles H. Kellner, M.D. **Faculty:** Donald Eknoyan, M.D.; Peter B. Rosenquist, M.D.; Andrew Krystal, M.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) consider the indications and risk factors for ECT and estimate likely outcomes based upon patient characteristics; (2) define the physiologic and neurocognitive effects of ECT as they relate to specific and potentially high-risk patient populations; (3) review the evidence related to ECT stimulus characteristics and summarize the differences between brief and ultra-brief pulse width stimuli; and (4) define strategies for optimizing treatment outcomes during the ECT course and maintaining remission over time. **Monday, May 20, 8-noon; 4 hours; Moscone Convention Center; advance: $165; on site: $190; spaces available: 100**

COURSE 20

ADVANCES IN NEUROPSYCHIATRY: THE NEUROPSYCHIATRY OF EMOTION AND ITS DISORDERS

Director: C. Edward Coffey, M.D. **Faculty:** Robert Robinson, M.D.; Matthew Menza, M.D.; W. Curt LaFrance Jr., M.D., M.P.H.; M. Justin Coffey, M.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) demonstrate knowledge of the neurobiology of emotion; (2) demonstrate knowledge of the pathophysiology of mood disorders; and (3) demonstrate knowledge of the evidenced-based management of mood disorders in patients with stroke, Parkinson's disease, epilepsy, and Alzheimer's disease. **Monday, May 20, 8-noon; 4 hours; Moscone Convention Center; advance: $165; on site: $190; spaces available: 150**

COURSE 21

PATIENT SAFETY AND QUALITY IMPROVEMENT IN THE PRACTICE OF PSYCHIATRY

Director: Avram H. Mack, M.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) apply quality improvement methods to a psychiatric practice; (2) rec-

APA 166TH ANNUAL MEETING COURSE GUIDE

ognize important concepts of the patient safety culture; (3) describe the function of a root cause analysis and other methods of elucidating the basis of errors; (4) define the concept of "error;" and (5) describe the meaning of "patient safety" used in general medical settings as distinct from the term "safety" as used in psychiatric practice. **Monday, May 20, 8-noon; 4 hours; Moscone Convention Center; advance: $165; on site: $190; spaces available: 45**

COURSE 22

EMERGENCY PSYCHIATRY: PRACTICAL TIPS FROM THE EXPERTS

Director: Rachel Lipson Glick, M.D. **Co-Director:** Seth Powsner, M.D. **Faculty:** Scott Zeller, M.D.; Avrim Fishkind, M.D.; Jon S. Berlin, M.D.; Leslie Zun, M.D., M.B.A. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) assess, manage, and treat an agitated patient; (2) assess the patient for acute precipitants of psychiatric crisis, including causative or contributing medical conditions; and (3) perform a comprehensive suicide/homicide risk assessment. **Monday, May 20, 8-noon; 4 hours; Moscone Convention Center; advance: $165; on site: $190; spaces available: 80**

COURSE 23

ADVANCED ASSESSMENT AND TREATMENT OF ADHD

Director: Thomas E. Brown, Ph.D. **Faculty:** Anthony Rostain, M.D., M.A.; Jefferson Prince, M.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) understand current research on nature and pathophysiology of ADHD as developmentally impaired executive function; (2) explain emerging models of comorbidity of ADHD with other psychiatric disorders; (3) adequately assess more complicated cases of ADHD in children and adults; (4) plan modification of medication treatments to deal with psychiatric or medical complications of ADHD in adults and children; and (5) develop effective treatment plans to effectively address complicated ADHD across the life cycle. **Monday, May 20, 8-noon; 4 hours; Moscone Convention Center; advance: $165; on site: $190; spaces available: 100**

COURSE 24

ADHD IN ADULTS: FROM CLINICAL RESEARCH TO PRACTICE

Director: Craig Surman, M.D. **Co-Director:** Paul Hammerness, M.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) recognize ADHD as a disorder broadly impacting control of mental activity and behavior; (2) implement assessment strategies for adults with ADHD; (3) appreciate the evidence basis, and limits of that basis, for ADHD interventions; and (4) learn principles for choosing among treatment strategies for ADHD in adults. **Monday, May 20, 8-noon; 4 hours; Moscone Convention Center; advance: $165; on site: $190; spaces available: 150**

COURSE 25

RISK ASSESSMENT FOR VIOLENCE

Director: Phillip Resnick, M.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) identify the relative risk of violence in schizophrenia, bipolar disorder, and substance abuse; (2) specify four components of dangerousness; and (3) indicate three factors that increase the likelihood that violent command hallucinations will be obeyed. **Monday, May 20, 8-noon; 4 hours; Moscone Convention Center; advance: $165; on site: $190; spaces available: 120**

COURSE 26

AUTISM SPECTRUM DISORDERS: DIAGNOSTIC CLASSIFICATION, NEUROBIOLOGY, BIOPSYCHOSOCIAL INTERVENTIONS, AND PHARMACOLOGIC MANAGEMENT

Director: Alice Raymay Mao, M.D. **Co-Director:** Kimberly Stigler, M.D. **Faculty:** Julie Chilton, M.D.; James Sutcliffe, Ph.D.; Matthew N. Brams, M.D.; Karen Pierce, M.D.; Jennifer Yen, M.D.; Stephanie Hamarman, M.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) have up-to-date information on neuroimaging, genetics, and psychopharmacology research; diagnostic procedures; and educational/psychotherapeutic and behavioral interventions; (2) review clinical translational research; and (3) integrate psychopharmacologic, behavioral, and educational interventions for individuals with ASD through the lifespan. **Monday, May 20, 9-4; 6 hours; Moscone Convention Center; advance: $300; on site: $340; spaces available: 150**

COURSE 27

SLEEP MEDICINE: A REVIEW AND UPDATE FOR PSYCHIATRISTS

Director: Thomas D. Hurwitz, M.D. **Faculty:** Max Hirshkowitz, Ph.D.; Imran S. Khawaja, M.B.B.S.; R. Robert Auger, M.D.; Elliott Lee, M.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) recognize the major categories of sleep disorders that can affect patients in their practices; (2) determine which patients should be referred to a board-certified sleep physician; (3) help patients with obstructive sleep apnea pursue treatment; (4) determine if patients experience excessive daytime sleepiness; and (5) facilitate use of CBT principles to treat insomnia. **Monday, May 20, 9-4; 6 hours; Moscone Convention Center; advance: $300; on site: $340; spaces available: 85**

COURSE 28

PSYCHODYNAMIC PSYCHOPHARMACOLOGY: PRACTICAL PSYCHODYNAMICS TO IMPROVE PHARMACOLOGIC OUTCOMES WITH TREATMENT-RESISTANT PATIENTS

Director: David Mintz, M.D. **Faculty:** David F. Flynn, M.D.; Samar Habl, M.D.; Barri Belnap, M.D.; Peter Collori. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) cite and understand the evidence base that connects meaning and medication; (2) diagnose common dynamics that interfere with healthy use of medications; and (3) use practical psychodynamic interventions to ameliorate pharmacologic treatment resistance. **Monday, May 20, 9-4; 6 hours; Moscone Convention Center; advance: $300; on site: $340; spaces available: 45**

COURSE 29

NEURODEGENERATIVE DISORDERS PRESENTING AS PSYCHIATRIC DISORDERS IN THE MENTAL HEALTH SETTING

Director: Ted Huey, M.D. **Co-Director:** Chiadi Onyike, M.D., M.H.S. **Faculty:** Adam Boxer, M.D., Ph.D.; Stephanie Cosentino, Ph.D.; Mary De May, M.D.; Jill S. Goldman, M.S., M.Phil.; Bruce L. Miller, M.D.; Katherine Rankin, Ph.D.; Howard J. Rosen, M.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) identify behavioral, emotional, and cognitive syndromes that suggest an underlying neurodegenerative disorder in patients presenting for psychiatric evaluation; (2) appropriately evaluate and refer these patients including interpretation of neuropsychological and genetic testing and imaging; and (3) treat neuropsychiatric symptoms in patients with neurodegenerative disorders, especially patients with frontotemporal lobar degeneration (FTLD). **Monday, May 20, 9-4; 6 hours; Moscone Convention Center; advance: $300; on site: $340; spaces available: 45**

Z.H.Chen/Shutterstock

APA 166TH ANNUAL MEETING COURSE GUIDE

COURSE 30

MOTIVATIONAL INTERVIEWING FOR ROUTINE PSYCHIATRIC PRACTICE

Director: Steven Cole, M.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) describe the three questions and five skills of Brief Action Planning (BAP); (2) explain how BAP aligns with the "Spirit of Motivational Interviewing (MI)"; (3) discuss 13 advanced communication and MI skills for persistent unhealthy behavior (PUB); (4) use BAP and 21 skills of Comprehensive Motivational Interventions (CMI) in routine clinical practice; and (5) teach BAP to trainees, team members, or colleagues. **Monday, May 20, 1-5; 4 hours; Moscone Convention Center; advance: $165; on site: $190; spaces available: 80**

COURSE 31

CAN'T WORK OR WON'T WORK? PSYCHIATRIC DISABILITY EVALUATIONS

Director: Liza Gold, M.D. **Faculty:** Marilyn Price, M.D., C.M.; Donna Vanderpool, J.D., M.B.A. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) evaluate the relationship between psychiatric disorders, impairment, and disability; (2) identify psychiatric and nonpsychiatric factors relevant in disability evaluations; (3) become familiar with a "work capacity" model to develop a disability case formulation and answer most frequently asked questions in a disability evaluation; (4) improve competence in writing disability reports; and (5) understand potential liability associated with performing disability evaluations and develop related risk-management skills. **Monday, May 20, 2013; 1-5; 4 hours; Moscone Convention Center; advance: $165; on site: $190; spaces available: 100**

COURSE 32

EVALUATION AND TREATMENT OF SEXUAL DISORDERS

Director: Waguih Ishak, M.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) acquire practical knowledge and skills in evaluation of sexual disorders; (2) acquire practical knowledge and skills in treatment of sexual disorders and (3) learn to apply gained knowledge/skills to real examples of sexual disorders. **Monday, May 20, 1-5; 4 hours; Moscone Convention Center; advance: $165; on site: $190; spaces available: 45**

COURSE 33

BRIEF BEHAVIORAL INTERVENTIONS FOR INTEGRATED CARE CONSULTING PSYCHIATRISTS

Director: Anna Ratzliff, M.D., Ph.D. **Co-Director:** Kari Stephens, Ph.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) list fundamental principles of two evidence-based brief behavioral interventions in primary care integrated behavioral health programs: Modular anxiety treatment and behavioral Activation for depression; (2) integrate brief behavioral interventions into treatment plans for primary care settings; and (3) support the use of brief behavioral skills during consultation with behavioral health care managers. **Monday, May 20, 1-5; 4 hours; Moscone Convention Center; advance: $165; on site: $190; spaces available: 80**

COURSE 34

RATIONAL OPIOID PRESCRIBING AND PRESCRIPTION DRUG ABUSE

Director: Scott Fishman, M.D. **Faculty:** Robert M. McCarron, D.O. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) identify the recent statistics indicating a public health problem of prescription drug abuse; (2) recognize how the goals of pain treatment contrast with outcomes of addiction; (3) differentiate substance dependence, misuse, tolerance, addiction, and nonadherence; and (4) identify the main components of a risk-management approach to pain care. **Monday, May 20, 1-5; 4 hours; Moscone Convention Center; advance: $165; on site: $190; spaces available: 150**

COURSE 35

THE DETECTION OF MALINGERED MENTAL ILLNESS

Director: Phillip Resnick, M.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) demonstrate skill in detecting deception; (2) identify factors that distinguish genuine from faked hallucinations; and (3) detect malingered psychosis. **Monday, May 20, 1-5; 4 hours; Moscone Convention Center; advance: $165; on site: $190; spaces available: 100**

TUESDAY, MAY 21

COURSE 36

BRAIN STIMULATION IN PSYCHIATRY

Director: Ziad Nahas, M.D., M.S. **Co-Director:** Linda Carpenter, M.D. **Faculty:** John P. O'Reardon, M.D.; Mustafa Husain, M.D.; Darin D. Dougherty, M.D., M.Sc. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) recognize the different brain stimulation modalities currently applied for psychiatric treatments; (2) recognize the principals behind their applications; and (3) recognize where each stand with respect to clinical investigations or clinical practice. **Tuesday, May 21, 8-noon; 4 hours; Moscone Convention Center; advance: $165; on site: $190; spaces available: 90**

COURSE 37

THE EXPERT WITNESS IN PSYCHIATRIC MALPRACTICE CASES

Director: Phillip Resnick, M.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) identify practical pitfalls of being an expert witness; (2) write better malpractice opinion reports; and (3) be a more effective expert witness in depositions. **Tuesday, May 21, 8-noon; 4 hours; Moscone Convention Center; advance: $165; on site: $190; spaces available: 80**

COURSE 38

A PSYCHODYNAMIC APPROACH TO TREATMENT RESISTANT MOOD DISORDERS: BREAKING THROUGH TREATMENT RESISTANCE BY FOCUSING ON COMORBIDITY AND AXIS II

Director: Eric Plakun, M.D. **Faculty:** Edward Shapiro, M.D.; David Mintz, M.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) describe recent research evidence suggesting that psychosocial factors play a major role in the cause and more effective treatment of treatment-resistant mood disorders; (2) explain the contribution to treatment resistance of personality pathology, including primitive defenses like projective identification; (3) define the psychopharmacologic treatment approach called "psychodynamic psychopharmacology" and explain its role in treatment resistance; and (4) utilize specific psychodynamic principles to improve outcomes in patients with treatment-resistant mood disorders. **Tuesday, May 21, 9-4; 6 hours; Moscone Convention Center; advance: $300; on site: $340; spaces available: 45**

COURSE 39

NEUROPSYCHIATRIC MASQUERADES: MEDICAL AND NEUROLOGICAL DISORDERS THAT PRESENT WITH PSYCHIATRIC SYMPTOMS

Director: Jose Maldonado, M.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) understand the incidence, epidemiology, and clinical features of the most common endocrine disorders masquerading as psychiatric illness; (2) understand the incidence, epidemiology, and clinical features of the most common metabolic disorders masquerading as psychiatric illness; (3) understand the incidence, epidemiology, and clinical features of the most common infectious disorders masquerading as psychiatric illness; (4) understand the incidence, epidemiology, and clinical features of the most common autoimmune disorders masquerading as psychiatric illness; and (5) understand the incidence, epidemiology, and clinical features of the most common CNS disorders masquerading as psychiatric illness. **Tuesday, May 21, 9-4; 6 hours; Moscone Convention Center; advance: $300; on site: $340; spaces available: 80**

COURSE 40

MINDFULNESS-BASED COGNITIVE THERAPY FOR THE TREATMENT OF MAJOR DEPRESSIVE DISORDER

Director: Stuart James Eisendrath, M.D. **Faculty:** Maura McLane, M.S., L.M.F.T.; Erin Prior Gillung, M.A. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) understand the basic aspects of mindfulness meditation and its application to psychotherapeutic interventions for major depression; (2) understand the theoretical and therapeutic differences between mindfulness-based cognitive therapy (MBCT) and traditional cognitive-behavior therapy; (3) understand existent research and literature supporting MBCT broadening therapeutic implications; (4) understand MBCT contribution to the field of neuroscience and the understanding of depression through a biophysical model; and (4) engage in experiential meditation exercises and learn how these techniques can be applied in psychotherapeutic settings. **Tuesday, May 21, 1-5; 4 hours; Moscone Convention Center; advance: $165; on site: $190; spaces available: 80**

WEDNESDAY, MAY 22

COURSE 41

EVIDENCE-BASED GROUP AND INDIVIDUAL PSYCHOSOCIAL TREATMENTS FOR ADULT ADHD: THEORY AND PRACTICE

Director: Anthony Rostain, M.D., M.A. **Faculty:** J. Russell Ramsay, Ph.D.; Mary Solanto, Ph.D.; Susan Sprich, Ph.D.; Alexandra Philipsen, M.D. **Educational Objectives:** At the conclusion of this session, the participant should be able to (1) cite major findings from the published literature on psychosocial interventions for adult patients with attention-deficit/hyperactivity disorder (ADHD); (2) describe similarities and differences among two group interventions and two individual-focused interventions, all of which are reasonably effective for treating adults with ADHD; and (3) apply individual and group treatment approaches to the clinical-practice setting. **Wednesday, May 22, 9-4; 6 hours; Moscone Convention Center; advance: $300; on site: $340; spaces available: 80**

MEMBERS IN THE NEWS

Joan Arehart-Treichel

Thresholds, which is headquartered in northern Chicago, serves poor, seriously and persistently mentally ill individuals throughout the city.

Psychiatrist Helps the Overlooked Travel Path to Recovery

Steven Weinstein, M.D., makes house calls as he practices recovery-focused psychiatry with some of Chicago's poorest and most severely mentally ill individuals.

BY JOAN AREHART-TREICHEL

For Steven Weinstein, M.D., "recovery" means giving impoverished individuals with serious and persistent mental illness a leg up.

Twice a week, as medical director of Thresholds, one of the oldest and largest psychosocial rehabilitation agencies in the United States, he gets his own legs moving to make that happen. He grabs his satchel with the paperwork and other items he needs, along with—as he puts it—"the principles and practice of recovery-oriented psychiatry," and out the door he goes.

"I try to embody the principles of offering hope, showing acceptance, approaching people in a way that allows them to feel dignity and that shows them respect. I try to partner with my patients while also holding them accountable and emphasizing that it is their responsibility to make changes."

Weinstein then exits Thresholds' headquarters, which is located in the Ravenswood neighborhood in northern Chicago; hops into his black Volvo; and heads off to pay house calls on patients. He makes these home visits as part of an Assertive Community Treatment (ACT) team that meets daily to discuss patients' issues and successes. All members of this ACT team make such home visits.

Once Weinstein begins his round of house calls, he cruises throughout different neighborhoods looking for a parking spot, enters decrepit apartment buildings or flophouses, and knocks on doors to see whether patients are home. If they are home, it means finding out how they are doing, providing psychotropic medications or psychotropic-medication injections, or trying to convince them to take such medications.

On a recent crisp fall day, Weinstein visited "Don"—a patient with bipolar disorder. Don's room was a disaster: spoiled food and soiled clothes were strewn everywhere, and cockroaches and bedbugs were evident. "Don't sit down!" Weinstein whispered to this reporter, who had been invited to accompany him on his rounds.

Weinstein listened attentively as Don talked about his life. He talked to Don about taking psychotropic medications, but without success. "I think he enjoys these manic phases," Weinstein lamented after the visit. (The good news, however, is that several weeks later, Weinstein reported that his efforts and those of his ACT team colleagues did pay off as Don agreed to take the medications.)

Weinstein then visited "Craig," a bright young man who was taking a computer class in spite of his schizophrenia. Although Weinstein had placed Craig on high doses of an antipsychotic medication, Craig admitted that the demons in his mind were still tormenting him from time to time. "His is a heartbreaking situation, especially since he lives with family members who have little appreciation of his illness or of what he has to endure," Weinstein later commented.

see **Recovery** on page 23

Joan Arehart-Treichel

Steven Weinstein, M.D., chats with a patient on his rounds of some of Chicago's poorest neighborhoods. "Meds alone do not help such people build self-esteem or meaningful lives," he says.

What Is Thresholds?

"Recovery from serious and persistent mental illness—notably schizophrenia, schizoaffective disorder, bipolar disorder, or major depression—is not the same as recovery from a [physical] illness," Steven Weinstein, M.D., medical director of Thresholds, explained during a recent interview. "It is more of a process, of having people look at their lives and think about what they'd like to do differently and then making changes in that direction—say, taking steps to reduce drug use, going to school, or getting more involved in the community as a regular citizen. Our message is, 'You can have a meaningful life in spite of your illness.' "

To help patients toward this end, Thresholds offers them myriad psychosocial services—for instance, Assertive Community Treatment (ACT) team visits to their homes, dual-diagnosis treatment, integrated mental and general medical care clinics, smoking-cessation programs, and programs directed at mothers, adolescents, and veterans.

Thresholds also offers outreach to the homeless who are seriously and persistently mentally ill. "We have teams—mobile units—who go out and ride the train lines to places where the homeless folks hang out," Emily Moen, director of public relations at Thresholds, told *Psychiatric News*. "They do that over and over again, recognizing that the incidence of severe mental illness among people who are homeless is very high. It takes a lot of engagement and a lot of visits before we can get them into our services." And sometimes psychiatry residents accompany them on their rounds.

Of all Thresholds' services, the supported-employment program is his favorite, Weinstein admitted. "Even though many of our clients/patients have cognitive deficits and experience auditory hallucinations, and even though most do not even have a high-school education, some have made amazing changes in their lives once they started thinking about how it would feel to work in their community and earn a paycheck. Of the 645 clients/patients served by the supported-employment program in 2011, more than a third obtained jobs.

"On any given day," Weinstein pointed out, "we at Thresholds serve about 3,000 people. Some receive intensive daily services, others receive monthly or weekly services. We served over 6,000 people last year. We have over 900 staff members, and that includes some 600 staff members who are doing clinical work. We have three child psychiatrists and eight adult psychiatrists who work for us on a contract basis. There are two of us psychiatrists full time, and we are trying to hire another. We are growing."

FROM THE EXPERTS

Case Study: When Worrying Is Complicated By Substance Use in Sports

BY DAVID MCDUFF, M.D.

Jim D. is a 50-year-old married Caucasian male Division I college lacrosse coach. He lives alone in a two-bedroom apartment near campus. He has three daughters (ages 15, 13, and 11). His family lives in Georgia. He took the job as head coach of a high-profile program in another state last year after spending seven years building a successful smaller college program. He works 12 hours a day.

History and Presenting Illness

Jim approached the college's sports psychiatrist after an energy/sleep seminar for coaches. He jokingly said, "I thought you were talking about me even though I don't know you." He described consistent difficulty falling asleep and frequent early morning awakening dating back to his college lacrosse-playing days. He noted a recent pattern of an overactive mind (constantly reviewing the day, upcoming games, daily schedules, and his family). He tried to reduce this overthinking with glasses of wine, TV channel flipping, dipping oral tobacco, eating microwave dinners, or talking to his family. Despite these strategies and the use of 150 mg of trazodone, it often took Jim 90 minutes to fall asleep. Even if he fell asleep from exhaustion, he would frequently awaken at 3 a.m. thinking about the next day's challenges. He tried a controlled-release sleeping pill, but it gave him morning grogginess. Jim rarely worked out, and his weight had increased by 30 pounds. He rarely ate breakfast but drank strong coffee to "get going." He was healthy except for acid reflux, which was controlled by antacids.

Diagnosis and Treatment

Axis I: 300.00 anxiety disorder NOS; 305.1 nicotine dependence; 291.1 alcohol misuse NOS, 292.9; caffeine misuse NOS; 327.02 insomnia related to above; V62.89 phase of life problem (job change, family separation).

Jim's awakening and unwinding routines were changed. Upon awakening, he ate fruit and yogurt and drank cold water. He followed this with three 60-second, high-intensity cardiovascular exercises (that is, pushups, jumping rope) with rest in between. He also made sure to go outside and find the sun and breathe rapidly through his nose for at least 60 seconds. Once at work, he ate a heartier breakfast of oatmeal or an egg-white omelet. He limited his coffee to two cups.

For unwinding, he ate dinner before coming home and eliminated wine and late-night TV. He added 30 minutes of music or nonsports reading under low light and established an 11 p.m. bedtime. In addition, he learned relax-

see **From the Experts** on page 22

David McDuff, M.D., is a clinical professor of psychiatry at the University of Maryland School of Medicine and author of *Sports Psychiatry: Strategies for Life Balance and Peak Performance* from American Psychiatric Publishing. APA members can purchase the book at a discount at http://www.appi.org/SearchCenter/Pages/SearchDetail.aspx?ItemId=62415.

It doesn't matter what antidepressant you're prescribing if the conditions aren't right.

WHEN AUGMENTING ANTIDEPRESSANTS, SSRI + DEPLIN® RESULTED IN 2X SUPERIOR RESPONSE RATES OVER SSRI + PLACEBO IN 30 DAYS*

Nutritional management with Deplin® works to create a natural condition in the brain by regulating sufficient quantities of monoamines required to achieve and maintain the benefits of antidepressant therapy, so your treatment can have the effect you intended.*

MAKE DEPLIN® YOUR FIRST-LINE AUGMENTATION AGENT.
To learn more, see the study at www.LMTHF-AmJPsychiatry.com
or email L-methylfolate@pamlab.com.

*Papakostas G, Shelton R, Zajecka J, et al. L-Methylfolate as Adjunctive Therapy for SSRI-Resistant Major Depression: Results of Two Randomized, Double-Blind, Parallel-Sequential Trials. AM J Psychiatry. Volume 169, Number 12, December 2012: 1267-1274.
DEPLIN® is a medical food dispensed by prescription for the clinical dietary management of the metabolic imbalance associated with depression. Use under medical supervision.
© 2012 Pamlab, LLC. All Rights Reserved.

Old Drug May Find New Use as Autism Treatment

A drug's effectiveness in treating autism suggests that targeting the GABA system in the brain may be a viable therapeutic approach.

BY JUN YAN

A repurposed old drug known as bumetanide reduced key symptoms in children with an autism spectrum disorder, a group of French researchers reported in a study published online December 11, 2012, in *Translational Psychiatry*.

Bumetanide is a loop diuretic commonly prescribed for fluid retention caused by heart failure or liver or kidney disease. In the brain, however, it also acts on a transporter protein embedded in cell membrane to allow the outflow of intracellular chloride ion, thus lowering the concentration of chloride inside the cell.

Based on research into pediatric seizures, scientists believe that reducing intracellular chloride is important for GABA neurons' inhibitory function in the brain. Therefore, bumetanide is being tested for the treatment of neonatal epilepsy as well as autism.

In the French study, Professor Eric Lemonnier, a clinician at CHRU Brest Hospital in Bohars, France, and colleagues carried out a randomized, double-blind, placebo-controlled study in 60 patients aged 3 to 11 who had been diagnosed with autism or Asperger's syndrome. Half of these children took placebo and half took 1 mg of bumetanide every day for three months. They were evaluated for autism symptoms by clinicians who did not know which treatment each patient had received.

At the end of the three-month treatment period, children who took bumetanide showed an average reduction of 5.6 points on the Childhood Autism Rating Scale (CARS), which was a statistically significant change when compared with an average reduction of 1.8 points among the children who took placebo.

The CARS is a scale used to measure behavioral symptoms in autism spectrum disorders, and the assessments are usually made from a videotaped session of children playing and interacting with their caregiver and from directly questioning the children's parents.

The participating clinicians also rated their overall impression of the patients' change in autistic symptoms. Fourteen of the 30 bumetanide-treated patients were rated as having had either significant or small improvement, compared with six of the placebo-treated patients.

After digging more deeply into the data, the researchers concluded that among the five CARS subscales (designated A-E), the mean score in stereotyped behavior and restricted interest (subscale D) showed the largest difference between subjects who took bumetanide and those who took placebo. In addition, study patients with milder autism at baseline had a larger response to bumetanide than did those with more severe symptoms.

The safety of bumetanide is well known, since the drug has been widely used for decades. Because of its risk for causing hypokalemia, the researchers closely monitored the patients' serum potassium levels and provided potassium supplements to six bumetanide-treated children whose potassium level dropped to or below 3.5 mMol/L. One child was withdrawn from the study early because of hypokalemia.

The researchers emphasized that bumetanide does not cure autism, as the patients' severity of symptoms, measured by the CARS, went back up within one month after the end of study treatment. They also pointed out that larger clinical trials are needed to determine the right dosage of bumetanide and the types of patients most likely to benefit from this treatment. PN

"A Randomized Controlled Trial of Bumetanide in the Treatment of Autism in Children" is posted at http://www.nature.com/tp/journal/v2/n12/full/tp2012124a.html.

Genetic Discovery Could Change The Way Pain Is Treated

The discovery of a snip of genetic material that influences pain sensitivity may open the way to highly personalized pain treatment.

BY JOAN AREHART-TREICHEL

In a genomewide association study of some 500 subjects, Japanese scientists have identified a snip of genetic material that appears to influence both pain sensitivity and susceptibility to substance dependence.

It appears to be the most potent snip of genetic material associated with human opioid sensitivity that has been identified to date, the scientists said in their research report published online November 27, 2012, in *Molecular Psychiatry*. The lead scientist was Kazutaka Ikeda, Ph.D., project leader of the Addictive Substance Project at the Tokyo Metropolitan Institute of Medical Science.

The snip of genetic material is a single nucleotide polymorphism (SNP) called rs2952768. It is located on chromosome 2 and includes a gene called CREB1 and one called METTL21A. The CREB1 gene makes CREB-1, a protein that induces transcription of genes in response to hormonal stimulation of the cAMP pathway. The METTL21A gene makes METTL21A, an unknown protein probably related to methylation.

Those subjects who had the C variant of rs2952768, especially two copies of it, needed more analgesia after cosmetic surgery than did subjects who had the T variant. The same applied to subjects who needed analgesia after abdominal surgery. Thus subjects who had the C variant seemed to be less sensitive to opioid medications than were those who possessed the T variant.

Moreover, a cohort of some 900 individuals with alcohol dependence, other substance dependence, or eating disorders were genotyped to see whether they possessed the C variant or the T variant of rs2952768. Those carrying the T variant (and who were presumably more sensitive to opioids) were found to be more at risk of serious substance dependence than were those with the C variant.

Finally, in another arm of this study, approximately 500 healthy subjects who had been genotyped for rs2952768 were given a personality questionnaire. Those who possessed the T variant of rs2952768 (and thus expected to be more at risk of serious substance dependence) scored higher on "reward dependence" than did those who possessed the C variant.

Altogether the results suggest that rs2952768 influences both pain sensitivity and the risk of substance dependence, the researchers said.

They are also attempting to harness these discoveries to create personalized treatment for pain. As Ikeda explained to *Psychiatric News*, they are recruiting 200 subjects who are about to undergo surgery to take part in a randomized, double-blind, placebo-controlled study. Half will receive conventional pain medications (opioid analgesics) after surgery. So will the other half, but in the latter group, the amount of opioid analgesics given will be partially determined by the variant of rs2952768 that the subjects possess. That is, subjects with the C variant, who are presumably less sensitive to opioids, will get more medication than those with the T variant. The researchers will then compare the outcomes of the two groups to evaluate whether the personalized treatment is more effective than the conventional one in countering postsurgical pain.

Ikeda said that, to his knowledge, he and his colleagues are among the first to attempt to use variations in psychiatric-related genes or SNPs for treatment purposes. "A polymorphism in the gene encoding aldehyde dehydrogenase 2 (ALDH2) is useful for predicting vulnerability to alcoholism," he said. "But I do not know whether clinicians are using such knowledge in their practices."

The study was funded by the Japanese Ministry of Education, Culture, Sports, Science, and Technology; the Japanese Ministry of Health, Labor, and Welfare; and the Smoking Research Foundation. PN

"Genome-wide Association Study Identifies a Potent Locus Associated With Human Opioid Sensitivity" is posted at http://www.nature.com/mp/journal/vaop/ncurrent/full/mp2012164a.html.

Renew Membership Now

If you have not yet paid your 2013 membership dues, you can do so on the APA Web site at http://www.psychiatry.org. Select "Pay Member Dues" from the left-hand menu bar and log on using your APA member ID and password. You can also call APA's Customer Service Department toll free at (888) 357-7924. If you are planning to attend APA's 2013 annual meeting, which is being held May 18 to 22 in San Francisco, your 2013 membership dues must be paid for you to qualify for the member registration rates. Remember, advance registration rates for the annual meeting are now in effect (see box on page 3 for registration information). So pay your dues now to take advantage of the discount!

Tyler Olson/Shutterstock

Traffic-related air pollution has been shown to induce inflammation. Inflammation may be involved in some forms of autism, according to emerging evidence.

Autism Linked to Air Pollution In Preschool Children

A pollution-based case-control study suggests that being exposed to high levels of traffic-induced air pollution, such as that emitted on freeways, might be a risk factor for autism.

BY JOAN AREHART-TREICHEL

Could exposure to traffic-related air pollution contribute to autism? A study published online November 26, 2012, in *Archives of General Psychiatry* and funded by the National Institute of Environmental Health Sciences suggests so.

Two years ago, Heather Volk, Ph.D., an assistant professor of research at the University of Southern California, and her colleagues found a provocative association between living near a freeway and autism. This association implied that traffic air pollution might be a culprit in autism.

They decided to conduct another study to test the hypothesis. The cohort included 279 preschool children with autism and 145 preschool children with typical development (controls). In addition to vehicle-emission rates, the researchers used local meteorological data, traffic volume, and road geometry to construct mathematical models of traffic-related air pollution in the areas where the subjects lived. The researchers then used the models as well as the addresses of the subjects to see whether they could find any links between traffic air pollution and autism.

They could. The children residing in areas with the highest levels of traffic air pollution were three times more likely to have autism than were the children residing in areas with the lowest levels. Moreover, the children with autism were twice as likely as controls to have been exposed to high levels of traffic air pollution during their mothers' pregnancy and three times as likely as controls to have been exposed to high levels of traffic air pollution during the first year of life. Some specific traffic air pollutants—nitrogen dioxide and particulate matter—were likewise associated with autism during pregnancy and the first year of life. Finally, the findings remained solid even when demographic and socioeconomic factors as well as maternal smoking during pregnancy were considered.

"This study is a major contribution to the literature regarding factors potentially involved in the cause of autism," Christopher McDougle, M.D., a professor of autism at Harvard Medical School, said during an interview. "While we know that genetic contributions exist, it is also clear that environmental factors are also important. To date, few environmental factors related to the cause of autism have been identified by rigorous scientific investigation."

There are also some possible routes whereby traffic air pollution could lead to autism, McDougle pointed out. "Previous research has shown that concentrations of particulate air pollutants, such as polycyclic aromatic hydrocarbons, can reduce the expression of genes, including the MET receptor tyrosine kinase gene, which is important in early life neurodevelopment and is markedly reduced in the brains of people with autism. Traffic-related air pollution has also been shown to induce inflammation after both short- and long-term exposure. Emerging evidence demonstrates that inflammation may also be involved in some forms of autism."

"We are currently studying whether genes involved in brain development and genes that help the body metabolize toxins interact with air pollution exposure to alter autism risk," Volk told *Psychiatric News*. "We are also working to study whether there are particular time points when exposure may be important." PN

An abstract of "Traffic-Related Air Pollution, Particulate Matter, and Autism" is posted at http://archpsyc.jamanetwork.com/article.aspx=1393589

Research Leaders, Advocates Discuss Autism With Congress

A House of Representatives panel hears testimony from federal officials and patient advocates about recent advances in research on autism and its treatment, as well as about future challenges.

BY MARK MORAN

Despite enormous advances in autism research and the development of treatment and services, challenges persist especially around understanding recent dramatic increases in prevalence.

So said government officials and patient advocates at a hearing last month before the House of Representatives Committee on Oversight and Government Reform.

Alan Guttmacher, M.D., director of the National Institute on Child Health and Human Development, outlined the goals, objectives, and achievements of the federal government's Interagency Autism Coordinating Committee. This committee was created by the Children's Health Act of 2000, reestablished by the Combating Autism Act of 2006 and reauthorized by the Combating Autism Reauthorization Act of 2011.

"On the research front, we have seen some remarkable progress in understanding the prevalence of ASD [autism spectrum disorders], developing screening methods and interventions with potential to be used to identify and treat ASD in very young children, and understanding the risk factors that may contribute to the development of ASD," Guttmacher told the committee. "This research is rapidly moving toward translation into practical tools that can be used in the clinic and community settings to change outcomes for people with ASD. Federal agencies have also coordinated efforts to enhance critical services programs; identify best practices to support the education, health, and employment needs of people on the spectrum; and develop new mechanisms and strategies to enable broad access to health care, services, and supports."

He was joined in the hearing by Coleen Boyle, Ph.D., director of the National Center for Birth Defects and Developmental Disabilities at the Centers for Disease Control and Prevention (CDC).

"In March 2012, the CDC released updated estimates of prevalence . . . indicating that 1 in 88 children had been identified with an ASD," she said. "This number compares with an identified prevalence of 1 in 110 in 2009, estimated using data from surveillance year 2006. In 2007, we reported a rate of 1 in 150 children, based on data from 2002.

"While there is no simple explanation for the increase, we know that it is due in part to improved methods for identification and diagnosis and to increased public awareness partly resulting from the expansion of behavioral health services in local communities. However, we do not know exactly how much of the increase is due to these factors. To better understand the causes of the increase, we need to continue tracking ASD and continue working with our colleagues at NIH and in the broader scientific community to improve identification of risks and protective factors associated with autism."

Boyle said ASD remains nearly five times more common among boys than girls. "We also know that the largest increases in identified prevalence over time were among Hispanic and African-American children, and children without intellectual disability," she said. "Some of the most recent increases can be attributed to greater awareness of ASD and improved identification of children with ASD within communities. However, this explanation can account for only part of the increase over time, since more children were identified with ASD among all racial and ethnic groups and at all levels of intellectual ability."

Also speaking at the hearing were representatives from the Autism Society, Autism Speaks, the Autistic Self-Advocacy Network, SafeMinds, the Global and Regional Asperger Syndrome Partnership, and the Asperger Initiative at Mercyhurst University. PN

A video of the hearing and the text of the testimony are posted at http://oversight.house.gov/hearing/1-in-88-children-a-look-into-the-federal-response-to-rising-rates-of-autism.

MED CHECK

BY LESLIE SINCLAIR

MDD Drug Begins FDA Review Process

The Takeda and Lundbeck pharmaceutical companies announced October 1, 2012, that they had submitted a New Drug Application (NDA) to the U.S. Food and Drug Administration (FDA) for the investigational agent ***Brintellix (vortioxetine, also identified as Lu AA21004)*** for treatment of major depressive disorder (MDD) in adults. Brintellix is thought to work through a combination of two complementary mechanisms of action: receptor activity modulation and reuptake inhibition.

The NDA includes data from six short-term placebo-controlled studies, including one dedicated study in elderly patients. The studies were conducted in regions throughout the world and showed statistically significant efficacy of vortioxetine in a daily dosage range of 5 mg to 20 mg. The efficacy of vortioxetine was also demonstrated in a long-term relapse-prevention study in MDD, and the vortioxetine global clinical development program included more than 7,500 individuals who took the drug.

The most commonly observed adverse reactions in the studies were nausea, constipation, and vomiting. Overall, 6.5 percent of the patients who received vortioxetine discontinued treatment due to an adverse reaction, compared with 3.8 percent of placebo-treated patients.

The review of the NDA is expected to be completed by October.

Merck Investigates Amyloid Enzyme Inhibitor

Merck announced December 3, 2012, that it has started a phase 2/3 clinical trial to evaluate safety and efficacy of ***MK-8931*** versus placebo in patients with mild to moderate Alzheimer's disease. MK-8931 is Merck's novel investigational oral β-amyloid precursor protein site-cleaving enzyme (BACE) inhibitor, and it is the first with this mechanism to advance to this stage of clinical research. The amyloid hypothesis asserts that the formation of amyloid peptides that lead to amyloid plaque deposits in the brain is the underlying cause of Alzheimer's disease, and BACE is believed to be a key enzyme in the production of amyloid β peptide. Evidence suggests that inhibiting BACE decreases the production of amyloid β peptide and may therefore reduce amyloid plaque formation and modify disease progression.

A global, multicenter randomized placebo-controlled study, called EPOCH, will be used to initially evaluate the safety of MK-8931 in a cohort of 200 patients prior to advancing into a larger phase 3 study. The study is expected to enroll up to 1,700 patients in the main phase 3 cohort. The primary efficacy outcomes of the study are the change from baseline in Alzheimer's Disease Assessment Scale–Cognitive Subscale (ADAS-Cog) score and the change from baseline in the Alzheimer's Disease Cooperative Study–Activities of Daily Living (ADCS-ADL) score.

Lilly to Conduct Additional Solanezumab Study

Eli Lilly announced December 12, 2012, that it plans to conduct an additional phase 3 study of ***solanezumab***, the monoclonal antibody being studied as a potential therapy for patients with mild Alzheimer's disease. Additional details, including study design and length, are still being determined.

Solanezumab is a monoclonal antibody that binds to soluble monomeric forms of β-amyloid after it is produced, allowing it to be cleared before it clumps together to form β-amyloid plaques. Last August, Lilly announced that its clinical trials in more than 2,000 people showed that the drug was unable to halt the disease's progress on measures of cognition and functionality (*Psychiatric News*, December 7, 2012). But Lilly did note evidence of "statistically significant slowing of cognitive decline in subjects with mild to moderate Alzheimer's who were taking the drug."

Eric Siemers, M.D., senior medical director of Lilly's Alzheimer's disease team, said in a press release, "We believe the results demonstrating a slowing of cognitive decline in patients with mild Alzheimer's disease treated with solanezumab are the first data from phase 3 clinical trials that support the amyloid hypothesis."

Lilly expects to initiate this new study no later than the third quarter of 2013.

Chantix Meta-Analysis Completed

When the FDA first expressed concerns about the possible increased risk of cardiovascular adverse events associated with the smoking-cessation drug ***Chantix (varenicline)*** in a Drug Safety Communication (DSC) dated June 16, 2011, the agency said it would require Pfizer, the drug's manufacturer, to conduct a meta-analysis of randomized, placebo-controlled trials of the drug. In a DSC issued December 12, 2012, the FDA presented that meta-analysis. Results indicated a higher occurrence of major adverse cardiovascular events (a combined outcome of cardiovascular-related death, nonfatal heart attack, and nonfatal stroke) observed in patients using Chantix compared with those on placebo. However, these events were uncommon in both the Chantix and placebo groups, and the increased risk was not statistically significant, which means it is uncertain whether the excess risk for the Chantix group was due to the drug or due to chance.

The FDA advised health care professionals to weigh the risks of Chantix against its benefits, while noting that smoking is a major risk factor for cardiovascular disease and that Chantix is effective in helping patients quit smoking and abstain from it for as long as one year. "The health benefits of quitting smoking are immediate and substantial," the agency emphasized in the communication. The Warnings and Precautions section of the Chantix label has been updated to include the results of the meta-analysis.

The DSC is posted at http://www.fda.gov/Drugs/DrugSafety/ucm330367.htm.

FDA Committee Votes Against Zohydro

The FDA's Anesthetic and Analgesic Drug Products Advisory Committee (AADPAC) met December 7, 2012, to discuss the NDA submitted by Zogenix for ***Zohydro (hydrocodone bitartrate extended-release capsules),*** an opioid analgesic medication for management of moderate to severe chronic pain when a continuous, around-the-clock opioid analgesic is needed for an extended period. Zohydro, which does not include other active pharmaceutical ingredients such as acetaminophen or ibuprofen, would represent the first single-entity hydrocodone-containing drug product on the market, if approved.

The committee voted 2-11 (with 1 abstention) against the approval of Zohydro, with committee members expressing concern about abuse potential and dependency.

"Zogenix recognizes and appreciates that prescription opioid misuse and abuse is a critical issue," said Stephen Farr, Ph.D., president and CEO of Zogenix. "We remain confident in the measures we have proposed to support safe use of Zohydro ER and are committed to continuing to work with the FDA through the review process."

The date for completion of FDA review of the application is March 1. The AADPAC provides the FDA with independent expert advice and recommendations, but the final decision about approval of a medication is made by the FDA. If approved, Zohydro will be classified by the Drug Enforcement Administration as a Schedule II drug, and the Risk Evaluation and Mitigation Strategy (REMS) for Zohydro ER will be consistent with the recently introduced FDA-approved REMS for extended-release and long-acting opioids. PN

From the Experts

continued from page 19

ation breathing and did this before bed. He continued his trazodone 50 mg or 100 mg, but took it earlier (90 minutes before lights out). To prevent accommodation to trazodone's sedating effects, he skipped it a few nights a week and occasionally used zolpidem 10 mg if he didn't fall asleep in 30 minutes. Finally, he purchased a white-noise machine for his nightstand.

For lifestyle change, he increased his exercise, improved his nutrition, and halved his oral tobacco use in preparation for a summer quit attempt. He established a goal of losing 30 pounds and began by eating three smaller meals a day with snacks in between. For stress control, he added a midday exercise routine of cardio, stretching, and lifting and a 30-minute postpractice walk or campus library visit to read news.

Discussion

Jim is a typical case of a hard-working college or professional coach, but this case could just as easily been about a corporate executive or physician. To produce and maintain energy and unwind, such professionals often resort to using stimulants and sedatives. Once the dosage gets higher, then toxic effects on sleep, stress control, and mood can occur. Jim's very high dose of moist snuff (one can/day) was likely producing nocturnal nicotine withdrawal and early awakening. His overthinking and worrying are typical of busy coaches under pressure and need to be countered with lifestyle change.

Simple modifications of awakening and unwinding routines along with improved nutrition, exercise, and mini-stretch/breathing breaks are very powerful. If reduction of substances and lifestyle changes are not fully effective, then an anxiolytic medication trial is warranted. The key for any hard-working professional is to manage energy using sound stress-control strategies. PN

Prevention

continued from page 5

Another prominent advance in mental illness prevention, Koplan pointed out, is the Interactive Screening Program (ISP) of the American Foundation for Suicide Prevention (AFSP). The ISP is an anonymous, interactive Web-based method of reaching out to students at risk of suicide. It has been shown to be effective in getting these students into treatment. The ISP is now being used in more than 40 colleges and universities in the United States, according to the AFSP Web site.

"There has also been very good research on drug- and alcohol-abuse prevention," said Christopher Oleskey, M.D., M.P.H., an assistant professor of psychiatry at Yale University.

Evidence Makes Conclusions Difficult

The scientific evidence for the prevention of certain disorders, however, is stronger than it is for others. For instance, the evidence for preventing schizophrenia is considerably skimpier than that for preventing depression, Frederick Langheim, M.D., Ph.D., a staff psychiatrist at Dean Health Systems in Madison, Wis., observed. The same holds true for bipolar disorder prevention, Oleskey indicated.

And the evidence may be stronger for secondary prevention—that is, for preventing recurrent episodes of an illness—than for primary prevention. For example, there is more robust scientific evidence on how to prevent additional episodes of unipolar depression and bipolar depression than for preventing them in the first place, Alexopoulos said.

But much more will undoubtedly be learned about mental illness prevention during the next few years because, as Koplan said, "it's a tremendously growing field. Within psychiatry it is becoming clearer that prevention is important, and in public health, people are starting to realize how common mental illnesses are." The field, she added, will also benefit from increased dissemination of mental illness prevention interventions that are found to be effective. Indeed, the Substance Abuse and Mental Health Services Administration is already attempting to disperse evidence-based interventions for preventing mental illness through the National Registry of Evidence-Based Practices and Programs, she pointed out.

Prevention Studies in the Works

So what findings in mental health prevention might be emerging during the next few years?

Reynolds and his colleagues are studying whether problem-solving therapy, behavioral treatment for insomnia, and walking can prevent full-fledged depression in people who are mildly depressed. They are also looking to see whether cytokine levels in the bloodstream might be used as a biomarker for depression risk and to determine if a depression prevention intervention is working.

"Some of my research pertains to factors driving treatment delay . . . in young people with first-episode psychosis," Compton said. "We are finding that a number of factors contribute to this variable period of treatment delay. . . . Understanding the factors that contribute to delayed help-seeking may benefit programs focusing on early intervention for psychotic disorders."

"I think we are going to learn that we can prevent mental illnesses in ways that we haven't thought of at this time," Oleskey predicted. PN

Information about mental illness prevention can be found in *The Clinical Manual of Prevention in Mental Health*, published by American Psychiatric Publishing. APA members can purchase the book at a discount at http://www.appi.org/SearchCenter/Pages/SearchDetail.aspx?ItemID=62347.

Neurodevelopmental

continued from page 7

functioning. *DSM-IV* criteria had required an IQ score of 70 as the cutoff for diagnosis; the new criteria recommend IQ testing and describe "deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility."

The new criteria also include severity measures for mild, moderate, severe, and profound intellectual disability.

Swedo explained that forensic psychiatrists consulting with the work group had testified to the problematic nature of using IQ scores alone for diagnosis. They have sometimes had to assess someone with an IQ of, say 71, as not having intellectual disability in the presence of severe deficits in adaptive functioning—because the IQ score alone gave a false impression of their judgment capacity—therefore making that person eligible for the death penalty.

"Moving away from a specific number and incorporating functional testing is going to be very helpful to clinicians in matching diagnosis to individual patients," she said. PN

Additional information, including video interviews with Susan Swedo, M.D., on ASD and specific learning disorder, and with David Kupfer, M.D., and Dilip Jeste, M.D., on the development of *DSM-5*, is posted at http://www.psychiatry.org/dsm5.

Recovery

continued from page 18

Then came a visit with "Ellie." In spite of her bipolar disorder, she was managing to work part time in a fast-food restaurant, thanks to Thresholds' supported-employment program. Weinstein relayed a message to Ellie from her boss: "If you stop hurrying so much in your work, your boss will let you work more hours." Ellie said that she would try to slow down.

As the day moved on, Weinstein visited "Yolanda"—a 57-year-old woman with schizophrenia. In addition to giving her psychotropic medications, he inquired about her breathing and examined her legs for edema since she refuses to see any physician but him. He then accompanied her across the street to a Subway restaurant. There he bought her a sandwich, and the two of them sat at a table and chatted about her life, health, and financial situation.

She talked about growing up in southern Illinois, and Weinstein used his iPhone to show her the geography of that region, not just because he is keen on demonstrating his interest in his patients beyond symptom control, but because he wanted her to think about the path that had led her to Chicago. Finally, as he accompanied her back to her apartment building, he observed, "It looks as if you need some new pants without holes in them. I think our ACT team can get some for you."

"That would be nice," she said.

Joan Arehart-Treichel

Ronald Grais, a board member of Thresholds, helped it buy a flophouse from the city of Chicago for $1. It is now being converted into affordable apartments for poor, seriously mentally ill individuals.

As Weinstein headed back to Thresholds after a day of making house calls, he admitted that he felt somewhat fatigued mentally and emotionally. His wife had once asked him, "How can you stand doing such grim work?"

"Grim? I don't find it grim," he replied. "I find it enormously rewarding." PN

What are several of the most important things that psychiatrists can do to promote recovery in their seriously mentally ill patients? Weinstein addresses this question in a video interview posted at http://www.youtube.com/my_videos_edit?ns=1&video_id=iYWbBLsTE0A.

The Future of Thresholds

Ronald Grais is a Chicago lawyer who works in a skyscraper in downtown Chicago. For 30 years, he has been a board member of Thresholds. He and Thresholds CEO Mark Ishaug discussed Thresholds' financial operation and future in an interview with *Psychiatric News*.

"Our annual budget is over $50 million," Ishaug said. "We get some fees through our housing programs and raise maybe [between] $3 million and $5 million a year through private sources—foundations, corporations, and individuals. But much of our resources comes from Medicaid. We used to serve a broader population when the state provided money for non-Medicaid-eligible people. But they cut those grants. So we are now more dependent on Medicaid than we ever have been for our survival."

In preparation for the Affordable Care Act, Ishaug continued, Illinois is planning to enroll some 500,000 newly eligible Medicaid recipients over the next couple of years. And Thresholds is positioning itself to become one of the principal providers for the new Medicaid recipients who have serious and persistent mental illness. Moreover, Thresholds is planning on becoming a "health home" for the thousands of people it serves. "This means that we need to think in a much more holistic, care-coordination kind of way," he said.

Still unresolved, though, he said, "is how we will get paid under the new Affordable Care Act." Under the act, Thresholds will have to demonstrate that the services it provides reduce hospitalizations and improve outcomes. "That will be a huge challenge," he said, "because even though we already increase health outcomes and reduce hospitalizations, we'll need to adapt our service model to a new payment system and a new model."

But during the next year, Grais said, Thresholds will be creating more partnerships with other mental health and general medical providers, which should help mold Thresholds into a health home for its thousands of patients.

Thresholds has already built some 1,000 units of supportive housing and is trying to increase that number, Grais said. For instance, he recently helped Thresholds purchase an old hotel—"a terrible place"—from the city of Chicago for $1. "We are now converting it into affordable apartments with money from different sources," he said.

"So all in all, it is a scary, but exciting time for Thresholds," Ishaug concluded. "What you are seeing today is only a glimpse of what we are going to be."

Montefiore
Inspired Medicine

GERIATRIC PSYCHIATRY FELLOWSHIP

Montefiore Medical Center. Established in 1983, the Medical Center's Division of Geriatric Psychiatry was among the first in the nation to develop a Fellowship Training Program. The faculty includes a past President of the American Association for Geriatric Psychiatry. This program differs from others in New York as a result of its close ties to the Fellowship Training Program in Geriatric Medicine.

The clinical experience is based in the psychiatric outpatient department and includes consultation to a teaching nursing home and house calls. There is ample supervision and the volume of service is limited to provide for professional growth. The curriculum includes multi-disciplinary seminars, case conferences, journal clubs and grand rounds. Fellows have responsibilities for teaching students and residents in medicine and psychiatry and the opportunity to participate in NIH studies of depression and dementia.

The salary exceeds $90,000 and benefits include paid membership in the American Association for Geriatric Psychiatry, travel allowance, and stipends for electives. Send your resume to Gary J. Kennedy MD, Division of Geriatric Psychiatry, Montefiore Medical Center, 111 East 210th Street, Bronx NY 10467. Phone 718-920-4236, fax 718-920-6538. **To receive an application via email, contact Dr. Kennedy at gkennedy@montefiore.org.**

We are an equal opportunity employer.

APA JobCentral

The Career Hub for Psychiatry

Connects Talent with Opportunity

Filling an open position? Searching for that ideal job? Get started at jobs.psychiatry.org

Manage Your Career

- Search APA JobCentral for psychiatry jobs by position, title, specialty, work setting, location, and key words to access relevant jobs.
- Create an account to save jobs, store multiple resumes and cover letters, keep notes, communicate with employers through our internal messaging system, and more through an engaging interface.
- Set up multiple Job Alerts specifying your skills, interests and location to receive an e-mail when an employer posts a job that matches your criteria.

Recruit for Open Positions

- Post your job in front of highly qualified psychiatrists.
- Cross promote your job listing in APA print publications, e-newsletters and social networking platforms such as Facebook and Twitter.
- Search the anonymous resume database to find your ideal candidate.

Go to **jobs.psychiatry.org** to get started!

APA JobCentral
The Career Hub for Psychiatry

AH1258

HORIZON
BEHAVIORAL HEALTH

Our Featured Position for Child and Family

We are seeking a Child Psychiatrist currently licensed in VA to work at our Child and Family Services Center. The physician will serve children with variety of mental health problems. Some hours may be working within community settings.

Child Psychiatrist should be able to perform psychiatric evaluation with assessment and create plan of care and treatment, working in close cooperation with case managers, and attend occasional meetings with the clinicians and case managers assigned to certain patients. On-call is not required.

Lynchburg, VA is a historic and attractive area with many amenities available throughout the city and surrounding counties. Located in the beautiful foothills of the Blue Ridge Mountains, Lynchburg has something to offer everyone, and is close enough to D.C., Richmond, and Charlottesville to make outings away from the area easy and interesting! Lynchburg has both an airport, and is served by Amtrak.

To forward your CV or for more information please contact:
Michael Johnson: (434) 847-3050 or Michael.Johnson@cvcsb.org

To see a full list of our employment opportunities and to apply please visit our website: **https://horizonBH.org/**
EOE/D/V

UMKC
School of Medicine

ACADEMIC DEPARTMENT CHAIR OF PSYCHIATRY AND MEDICAL DIRECTOR OF CENTER FOR BEHAVIORAL MEDICINE

The Missouri Department of Mental Health (DMH) and the School of Medicine at the University of Missouri-Kansas City (SOM) has initiated a national search for the next Chair of the Department of Psychiatry. The Chair position includes responsibilities as Medical Director for the Center for Behavioral Medicine, a 65 bed DMH inpatient facility and a 68 bed residential program in Kansas City. The successful applicant will oversee and provide leadership for all academic, clinical and research activities of the department, reporting directly to the Dean. There are currently over 40 full-time faculty members and 24 trainees in a general psychiatry residency program. Minimum qualifications are board certification in psychiatry and a distinguished record of clinical excellence, teaching and scholarly activity. We are seeking a Chair who has strong leadership skills in an academic setting and experience in research administration and program development.

Faculty members are employed by a number of health care organizations in the metro area, but report directly to the Chair regarding their academic appointment and service to the Department and the School of Medicine. The ability to work collaboratively with community partners in fulfilling the clinical, teaching and research missions of the department and expanding opportunities for these activities will be a crucial skill. The Center for Behavioral Medicine serves a diverse population and maintains partnerships with a wide array of provider systems in the community. The Medical Director provides leadership in fostering these important clinical and academic linkages. UMKC is an equal access, equal opportunity, affirmative action employer that is fully committed to achieving a diverse faculty and staff. Applications will be accepted until the position is filled.

Contact Information: Interested parties should combine all application materials (personal letter of interest with accompanying curriculum vitae and a list of references) into one PDF or Microsoft Word document; upload as an attachment in the UMKC career opportunities application at:

http://www.umkc.edu/hr/career-opportunities/job-posting-search-academic.aspx

Psychiatry

Career Opportunities

Army Medicine Civilian Corps is hiring psychiatrists and behavioral health professionals to staff hospitals and clinics worldwide. Work as a civilian federal employee providing health care to military personnel and their families.

Civilian employees are not subject to military requirements and receive exceptional benefits, including competitive salaries, health and life insurance, state-of-the-art training, tuition reimbursement, and more.

Your Career Search Starts Here

CivilianMedicalJobs.com

civilian CORPS ★ USA
worldwide medical & dental careers

The Department of Defense is an equal opportunity employer. Individuals with a disability are encouraged to apply.

Psychiatry

Inpatient & Outpatient Practices Minnesota & Wisconsin

HealthPartners Medical Group is a successful multispecialty physician practice in metropolitan Minneapolis/St. Paul, Minnesota and neighboring western Wisconsin communities. We are looking for talented, caring BC/BE psychiatrists to join our dynamic Behavioral Health team. Consider these practice opportunities:

Inpatient/Adult

Opening this December, the new inpatient psychiatric building at Regions Hospital in St. Paul will be the setting for our experienced team of psychiatrists, residents, therapists, social workers, NPs/PAs and nursing staff to provide exceptional care to adult psychiatric inpatients. Our new patient-centered care model schedule for this practice is 7 days on/7 days off, with no call responsibilities.

Outpatient/Adult

This team provides comprehensive psychiatric services at a variety of urban, suburban and semi-rural outpatient clinic sites. We are flexible to accommodate full- or part-time practices. Let us tell you more!

Please forward your CV and cover letter to: **lori.m.fake@healthpartners.com** or apply online at **www.healthpartners.jobs**. For more details, call 800-472-4695 x1. EO Employer

HealthPartners®
Medical Group

healthpartners.com regionshospital.com

PSYCHIATRY
BOARD REVIEW SERIES
THE KAUFMAN COURSES

SPONSORED BY MONTEFIORE MEDICAL CENTER CREDIT DESIGNATED BY ALBERT EINSTEIN COLLEGE OF MEDICINE

Accreditation Statement: Albert Einstein College of Medicine is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

OFFERING CERTIFICATION COURSES ONLY

CLINICAL NEUROLOGY FOR PSYCHIATRISTS
David Myland Kaufman, MD

This intensive three-day weekend course, offered for the 41st year, is designed for psychiatrists in practice and in residency as an update and board preparation. Focusing on essential topics, the course uses lectures, an extensive syllabus, and the newest edition of the textbook entitled *Clinical Neurology for Psychiatrists*, David M. Kaufman (7th edition, Elsevier).

AMA Statement: Albert Einstein College of Medicine designates this live activity for a maximum of 25 *AMA PRA Category 1 Credit(s)™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

NEW YORK
SUNY College of Optometry
33 West 42nd Street (Between 5th and 6th Avenues)
New York, NY 10036
June 19 – 21, 2013

LOS ANGELES
The Westin Hotel at the Los Angeles Airport
5400 West Century Boulevard
Los Angeles, CA 90045
July 19 – 21, 2013

PSYCHIATRY FOR PSYCHIATRISTS
Andrea J. Weiss, MD and David Myland Kaufman, MD

The Pre-test prepares attendees for the newly formatted psychiatry Certification exam utilizing a question and answer format to actively engage the learner and comprehensively review topics in psychiatry most relevant to that revised exam, as well as provide a clinical review an update for psychiatrists currently in practice. The course has been strategically updated to include audio, visual and written vignettes designed to familiarize participants with the new Part C section of the Certification Exam. This vigorous course complements standard psychiatry review courses and completes the review in Clinical Neurology for Psychiatrists. A small group of faculty who are experienced and well-informed about modern psychiatry and test-taking strategies will present essential information through a series of test-type questions, using an anonymous audience response system.

AMA Statement: Albert Einstein College of Medicine designates this live activity for a maximum of 16 *AMA PRA Category 1 Credit(s)™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

NEW YORK
SUNY College of Optometry
33 West 42nd Street (Between 5th and 6th Avenues)
New York, NY 10036
June 22 – 23, 2013

LOS ANGELES
The Westin Hotel at the Los Angeles Airport
5400 West Century Boulevard
Los Angeles, CA 90045
July 22 – 23, 2013

MAINTENANCE OF CERTIFICATION COURSE

THE PSYCHIATRY RECERT COURSE
Andrea J. Weiss, MD, and David Myland Kaufman, MD

This intensive two-day course designed for psychiatrists reviews the psychiatric information likely to appear on the recertification examination. It will cover current evidence-based treatments for psychiatric disorders, emphasizing clinical matters and advances in diagnosis and treatment. Presentation of the material will be in a mixed format, with both lecture and question-and-answer utilizing audience response system keypads.

AMA Statement: Albert Einstein College of Medicine designates this live activity for a maximum of 16 *AMA PRA Category 1 Credit(s)™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

NEW YORK
SUNY College of Optometry
Joseph and Roberta Schwarz Theater
33 West 42nd Street (Between 5th and 6th Avenues)
New York, NY 10036
Friday, January 11 to Saturday, January 12, 2013
7:30 AM – 6:00 PM

FOR MORE INFORMATION

- **Web site** Course Information or To Register: **www.cnfp.org**
- **Write:** CCME, 3301 Bainbridge Avenue, Bronx, NY 10467
- **Log onto:** www.abpn.org to view application deadlines
- **E-mail:** cme@montefiore.org
- **Call:** 718-920-6674 • **Fax:** 718-798-2336

balance

achieve yours.

scan for more info:

The GEO Group, Inc.

HIRING
PSYCHIATRISTS

Florida · Oklahoma · California

Contact Michele Dobos, Senior Recruiter
1-866-301-4436 ext. 5863

apply online: **www.jobs.geogroup.com**

The GEO Group, Inc.

EOE/M/F/D/V

The University of Louisville School of Medicine
Department of Psychiatry and Behavioral Sciences

Clinician-Educator Positions Available

General Psychiatry • Geriatric Psychiatry
Depression Center • Women's Mental Health • Addiction Psychiatry
Ambulatory Behavioral Medicine • Med/Psych • Collaborative Clinical Neuroscience
Hospitalist: Inpatient, Consultation-liaison, or Emergency Psychiatry

The Department of Psychiatry and Behavioral Sciences, Allan Tasman, MD, Chair is seeking dynamic, academically oriented Assistant or Associate Professor psychiatrists to join our expanding faculty in a rapidly growing medical center complex. In addition, a new joint operating agreement between the University hospital and a 14 hospital statewide network is bringing substantial new opportunities and resources. The city of Louisville is a metropolitan area with nearly one million people. The cost of living is low, cultural amenities are extensive, schools are excellent, and outdoor and family oriented activities abound. Responsibilities for these faculty positions include clinical assignments and medical student/resident teaching outside the primary clinical assignment. In addition, there are opportunities to collaborate in ongoing clinical and basic science research. Candidates should be Board Certified or Board Eligible in Psychiatry. These positions are full-time faculty appointments in the Department of Psychiatry and Behavioral Sciences at the University of Louisville School of Medicine. Competitive compensation and a comprehensive benefits package is included.

Christy Castle-Greenwell, Faculty Affairs Coordinator
Department of Psychiatry and Behavioral Sciences
401 E. Chestnut Street, Suite 600, Louisville, KY 40202
P: (502) 588-4424; F: (502) 588-4427
christy.castle-greenwell@ulp.org

The University of Louisville is an Affirmative Action, Equal Opportunity, Americans with Disabilities Employer, committed to diversity and in that spirit, seeks applications from a broad variety of candidates.

UNIVERSITY OF LOUISVILLE
It's Happening Here.

Diversity

The word describes the populations we serve, our professional colleagues and our own workplace opportunities. It's an exciting and rewarding environment made more so by a stable organization already working towards successful healthcare integration. Join us for professional growth and career options that make a difference in the lives of those who need our help.

The range of opportunities include positions in telepsychiatry, Wellness Centers, crisis resolution, consultation to integrated health/mental health/substance abuse programs, and field capable services, as well as clinics, jail and juvenile justice settings.

We offer competitive salaries (ranging from **$142,944** to **$288,483** annually) and excellent benefits.

HOPE · WELLNESS · RECOVERY
LAC DMH
LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

For consideration, email your CV to: omd@dmh.lacounty.gov
Roderick Shaner, M.D., Medical Director
Los Angeles County Department of Mental Health
550 South Vermont Avenue
Los Angeles, California 90020
(213) 738-4603

© Copyright 2013, County of Los Angeles. All Rights Reserved.

A better life is your calling.

Physician – Adult Psychiatry

The Department of Psychiatry at Maine Medical Center is seeking a BC/BE adult psychiatrist for their Outpatient Adult Services.

As an integral part of a growing mental health system and an integrated healthcare system, the attending physician will provide direct clinical care for adults and will supervise an interdisciplinary treatment team. The Department of Psychiatry is comprised of adult and child psychiatric residency and fellowship training programs, comprehensive outpatient treatment programs in adult, child and geriatric psychiatry, as well as inpatient, intensive outpatient and partial hospital programs.

Maine Medical Center has 637 licensed beds and is the state's leading tertiary care hospital and an academic medical center with a full complement of residencies and fellowships. The position involves teaching psychiatric residents and medical students from the Maine Medical Center-Tufts University School of Medicine Medical School Program, and an academic appointment at Tufts University School of Medicine.

Situated on the Maine coast, Portland offers the best of urban sophistication combined with small-town friendliness. The area provides four season recreational opportunities, such as skiing, hiking, sailing, and miles of beautiful beaches. Just two hours north of Boston, this is an exceptionally diverse and vibrant community. Portland is consistently voted one of the top spots in America to raise a family and was named America's most livable city by Forbes Magazine in 2009.

For more information, please contact:
Alison C. Nathanson, Director, MaineHealth Physician Recruitment Center
nathaa@mainehealth.org • (207) 396-8683

www.mainehealthphysicians.org

MaineHealth
Physician
Recruitment Center

MaineHealth is a not-for-profit family of leading high quality providers and other healthcare organizations working together to make their communities the healthiest in America. We are an equal opportunity employer.

CLASSIFIEDS

Classified Advertising Information

2013 Rates:

- $26 per line for orders of 1 to 2 insertions
- $24 per line for orders of 3 or more consecutive insertions if your written order specifies a 3 or more consecutive issue run
- $23 per line for orders of 6 or more insertions if your written order specifies a 6 or more issue run
- 1 line = approximately 42 characters
- 6 line minimum
- $35 extra for confidential blind box number
- Classified rates are non-commissionable
- Overseas and "Practice for Sale" advertisers are required to prepay in full with a credit card

Free Online Advertising:
Psychiatric News classified ads are posted on pn.psychiatryonline.org on the date of publication.

EMAIL and web page links:
For an additional $50 your prospects can e-mail a response to your ad in seconds. A web link transports prospects directly to your web site in just one click.

Logos:
Insert a 4-color logo above your ad for $275 per issue or a black-and-white logo for $195 per issue. Submit logo as 300 dpi TIFF or EPS.

Blind Box Replies:
A blind box address is available to provide confidentiality to advertisers. Please address all blind box advertising replies to:
ATTN.: Box P-XXX
Psychiatric News Classifieds
American Psychiatric Publishing Inc.
1000 Wilson Blvd, Suite 1825
Arlington, Virginia 22209-3901

Submissions:
Email or Fax ad request including issue dates desired, contact name, phone number, and billing address, to:
Eamon Wood
Psychiatric News Classifieds
(212) 904-0363 • Fax (212) 685-6126
ewood@pminy.com

The publisher reserves the right to accept or reject advertisments for *Psychiatric News* and is not liable for the failure, for any reason, to publish an ad. Advertisements will be typeset as submitted. Lines of space separating headlines and paragraphs are counted as chargeable lines. We do not provide proofs of ads before publication.

Deadlines:
All new advertising copy, changes, and cancellations must be received in writing by Friday, 5 p.m. (E.T) two weeks prior to publication date. All advertising copy, changes and cancellations received after the deadline will be placed in the next available issue. Publication dates are the first and third Fridays of every month. Upcoming deadlines are:

Issue	Deadline
February 15	February 1
March 1	February 15

All advertisers in this section must employ without regard for race, sex, age, nationality, or religion in accordance with the law. APA policy also prohibits discrimination based on sexual orientation or country of origin.

Nationwide

UHS

Nationwide Locations - General, Child, Geriatric and Addiction Psychiatrists for practice positions. Career opportunities with work/life balance. Competitive comprehensive compensation packages offered including bonus opportunity and student loan assistance depending on location. Some locations H1/J1 eligible.

- **ALASKA-** Anchorage
- **ARKANSAS-** Fayetteville
- **COLORADO-** Colorado Springs & Boulder
- **DELAWARE-** Wilmington & Dover
- **FLORIDA-** Ocala
- **GEORGIA-** Atlanta-St. Simons-Moultrie
- **ILLINOIS-** Chicago & Springfield
- **INDIANA-** Bloomington
- **KENTUCKY-** Hopkinsville
- **MASSACHUSETTS-** BOSTON city & suburbs
- **MISSISSIPPI-** Olive Branch (Memphis area) & Meridian
- **MISSOURI-** Kansas City & St. Louis (O/P Only)
- **NEW JERSEY-**Summit
- **NEW MEXICO-** Las Cruces
- **NORTH DAKOTA-**Fargo
- **OHIO-** Cleveland-Mansfield-St. Clairsville
- **OKLAHOMA-** Tulsa
- **PENNSYLVANIA-**Philadelphia-State College-Clarion-Pittsburgh Area
- **SOUTH CAROLINA-** Myrtle Beach-Columbia-Greenville area
- **TENNESSEE-** Nashville & Memphis
- **TEXAS-** Austin-Sherman-McAllen-Dallas
- **UTAH-** Salt Lake City & Provo/Orem
- **WASHINGTON-** Seattle area
- **WEST VIRGINIA-** Huntington

Universal Health Services, Inc.(UHS) www.uhsinc.com is the largest facilities based behavioral health provider in the country. Our nearly 200 facilities operate independently and develop programs that satisfy the needs of each community. Our services touch more than 350,000 lives each year - from youth and adult programs to dedicated services for the military.

For more information about all 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.physicianpracticeopportunities.com.

FCS

THE 1ST CHOICE IN PSYCHIATRIC RECRUITMENT

Visit our website www.fcspsy.com
Over 400 permanent searches nationwide.
800-783-9152

Magellan Behavioral Health

Psychiatrists Wanted for Medical Director Roles

Magellan Behavior Health is seeking to hire board certified psychiatrists for Medical Director positions in our Care Management Centers (CMC). Magellan is a clinically-driven and physician-led company where our physician leaders develop the clinical/medical mission of the CMC and have a direct impact on the health outcomes and quality of care in the region. There are full and part-time opportunities available for psychiatrists with or without managed care experience. Relocation is available for full-time positions. Current openings include:

- Des Moines, IA – Medical Director CMC
- Worcester, MA– Medical Director CMC
- San Diego, CA – Medical Director CMC
- New Jersey – Part-time Associate Medical Director
- Georgia – Part-time Associate Medical Director

Psychiatrists interested in exploring these opportunities should contact Kevin Palisi at (860) 507-1955 or email kjpalisi@magellanhealth.com. Apply online at http://www.magellanhealth.com.

ALABAMA

Horizon Health seeks a **Medical Director** for a new Geriatric Inpatient Psychiatric Program in **Baldwin County.** Excellent practice opportunity and income for 3 day per week coverage, while living on beautiful Gulf Coast. For more information contact: Mark Blakeney, Voice: 972-420-7473, Fax: 972-420-8233; email: mark.blakeney@horizonhealth.com EOE.

ARIZONA

Recognized by USN&WR as one of the top neuroscience programs in the country, the **Barrow Neurological Institute(r) (BNI)** in Phoenix, AZ is now recruiting a neuropsychiatrist to join a multidisciplinary team as part of the Barrow Center for Neuromodulation (BCN). The BCN is one of the busiest in the West, with over a 1000 DBS procedures in the last 10 years, and has an active clinical research program. The BCN is exploring new indications for DBS including depression, bipolar, Tourette's, autism, anxiety, dementia, and obesity. Psychiatric support for this endeavor is essential.

The candidate will join three functional neurosurgeons, three neurologists, and a basic research staff, and will be involved in the application of neuromodulatory procedures such as DBS, rTMS, ECT, and VNS to neuropsychiatric disorders. The candidate will collaborate with existing programs at the BNI in clinical and experimental use of neuromodulation through animal studies or human neuroimaging. He/she will also establish an outpatient neuropsychiatry clinic and assist in preoperative screening of candidates for neuromodulation procedures as well as recruitment of candidates for clinical trials.

We offer a very competitive salary and benefits package including personalized relocation, comprehensive insurance coverage, and a pension. For immediate consideration, please send your CV to:

Francisco Ponce, M.D.
Fax: (602) 294-4495
Email: Victoria.acosta@bnaneuro.net

CALIFORNIA

UC DAVIS SCHOOL OF MEDICINE DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES

Health Sciences Assistant/Associate Clinical Professor – Jail Psychiatric Services. The University of California, Davis, Department of Psychiatry and Behavioral Sciences is recruiting for a Health Sciences Assistant/Associate Clinical Professor in the clinician/teaching series to serve as teaching attending at the Sacramento County Jail. The Jail Psychiatric Service provides inpatient and outpatient clinical services at the Sacramento County Jail. General psychiatry residents and medical students rotate at these sites. Interest and experience in teaching and supervision of medical students, residents, and other mental health professional is highly desirable. The successful candidate should be board eligible or certified in general psychiatry and be in possession of or eligible for a California Medical license. The successful candidate will provide group and individual supervision of clinical cases for general psychiatry residents, psychology fellows, medical students and other mental health professionals (including timely and appropriate evaluation of trainee performance) as well as have the opportunity to lead small group seminars and case conferences. The Department provides a stimulating teaching and research academic environment and serves a culturally diverse population. See www.ucdmc.ucdavis.edu/psychiatry.

For full consideration, applications must be received by January 2. 2013. However, the position will remain open until filled through March 01, 2013.**Interested candidates should email a curriculum vitae and letter of interest in response to Position #PY-02R-13 to Nicole Prine at Nicole.prine@ucdmc.ucdavis.edu.** For more information concerning these positions, please contact the search committee chair, Dr. Robert Hales at rehales@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

Adult In-Patient, Outpatient Adult and Child psychiatric positions available with Butte County Behavioral Health Department. Both contracted and full/half time positions. $150/hour for contracted positions. We are a HPSA/NHSC-designated County. Please contact Dr. Carolyn Kimura, Medical Director, at 530-891-2850.

CLASSIFIEDS

UC DAVIS SCHOOL OF MEDICINE DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES

Health Sciences Assistant/Associate Clinical Professor – Outpatient Clinic. The University of California, Davis, Department of Psychiatry and Behavioral Sciences is recruiting for two Health Sciences Assistant/Associate Clinical Professors in the clinician/teaching series to serve as teaching attendings at one of the Sacramento County clinics staffed by UC Davis Faculty. General psychiatry residents and medical students rotate at these sites. Interest and experience in teaching and supervision of medical students, residents, and other mental health professional is highly desirable. The successful candidate should be board eligible or certified in general psychiatry and be in possession of or eligible for a California Medical license. The successful candidate will provide group and individual supervision of clinical cases for general psychiatry residents, psychology fellows, medical students and other mental health professionals (including timely and appropriate evaluation of trainee performance) as well as have the opportunity to lead small group seminars and case conferences. The Department provides a stimulating teaching and research academic environment and serves a culturally diverse population. See www.ucdmc.ucdavis.edu/psychiatry.

For full consideration, applications must be received by January 2. 2013. However, the position will remain open until filled through March 01, 2013. **Interested candidates should email a curriculum vitae and letter of interest in response to Position #PY-03R-13 to Nicole Prine at Nicole.prine@ucdmc.ucdavis.edu.** For more information concerning these positions, please contact the search committee chair, Dr. Robert Hales at rehales@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

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.

For more information or to apply online, go to www.sdcounty.ca.gov/hr. Interested candidates can contact Gloria Brown at 858-505-6525 or email CV & cover letter to Gloria.Brown@sdcounty.ca.gov, and you may also email Marshall Lewis, MD, Beh. Health Clinical Director, @ marshall.lewis@sdcounty.ca.gov. Please state clinical area of interest.

COLORADO

COLORADO SPRINGS: Great community to live and work! General Psychiatrist – Inpatient Services. Top salary & benefits with bonus opportunity plus signing bonus and relocation. Contact Joy Lankswert, In-house recruiter @ 866-227-5415; OR email joy.lankswert@uhsinc.com.

Horizon Health seeks a **Medical Director** and **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

CONNECTICUT

Adult/ Child Psychiatrist
Fairfield, CT

Group Psychiatry practice is seeking a full-time Psychiatrist. Excellent salary and benefits. Email CV to:doctorbeach52@gmail.com or fax to Attn: Melissa B. 203-255-3126.

If you are an Adult Psychiatrist seeking to excel in an expanding outpatient setting with extraordinary clinical support, we can make that happen.

Saint Francis Hospital and Medical Center in Hartford, Connecticut, has an exceptional opportunity for a BC/BE Adult Psychiatrist to help expand our outpatient behavioral health services. The position is open to adult psychiatrists, but there is also opportunity to tailor this position for a child psychiatrist interested in seeing adults and adolescents. The outpatient setting of this practice allows for flexible work hours.

Saint Francis Care behavioral health outpatient services are part of a multidisciplinary approach to psychiatric care with clinical support from adult and child psychiatrists, nurse practitioners, and master's-level therapists. Outpatient offices are located in Hartford and Glastonbury, with offices to be added in Simsbury and Enfield this year. Saint Francis Hospital and Medical Center is a 617-bed tertiary care teaching hospital. The Behavioral Health Service at Saint Francis Hospital and Medical Center includes four inpatient psychiatric units, psychiatric consultation and liaison services, and behavioral health services in the Emergency Department.

This opportunity will enable you to enjoy Connecticut living at its best with a unique mix of urban and suburban life near Hartford—a city known for its arts and sophisticated culture. The region is full of options for outdoor enthusiasts and urban trekkers. Hartford's central location offers its residents easy access all of New England's most sought-after attractions including Boston, New York City, the beaches and the mountains.

Contact Christine Bourbeau, Director of Physician Recruitment, today at 855-894-5590 or email your CV and letter of interest to CBourbea@stfranciscare.org for immediate consideration.

www.JoinSaintFrancisCare.com
EEO/AA- A/F/D/V
pre-employment drug testing

DISTRICT OF COLUMBIA

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 a psychiatrist for a full time appointment to begin immediately. This new faculty position will encompass service as Director for a comprehensive Trauma Disorders Program that has both inpatient and outpatient treatment components, as well as a clinical and teaching role as attending faculty member on the GWU Hospital Psychiatric Consultation-Liaison Service. Academic rank will be that of Associate Professor in the Non-Tenure Accruing track, with salary commensurate with qualifications. **Basic Qualifications** Applicants must be licensed in the District of Columbia, ABPN Board Certified in General Psychiatry, and ABPN Subspecialty Board Certified in Psychosomatic Medicine. Applicants must have clinical competencies in evidence-based therapeutics for patients with posttraumatic and dissociative symptoms, as well as educational experience as a teacher and clinical supervisor for other members of an interdisciplinary trauma treatment team. Applicants must have educational experience in psychiatric graduate medical education.

Review of applications begins February 18, 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/12926, and upload a letter of interest and curriculum vitae. Please send three letters of recommendation to:

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

Only completed applications will be considered. Candidates being considered for campus interviews may be asked to allow the Search Committee to contact their recent mentors or colleagues for reference. 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.

OCALA: Staff Psychiatrist for Inpatient & Partial Services. Highly competitive salary, benefits & bonus opportunity. Great community to live & work! Contact Joy Lankswert, In-house recruitment @ 866-227-5415; OR email joy.lankswert@uhsinc.com.

www.psychiatry.org

GEORGIA

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)

Geriatric Psychiatrist

WellStar Medical Group is seeking Board Certified Psychiatrist with Geriatric Fellowship training for full-time position. Will provide services in Gero Psych Unit at WellStar Cobb Hospital, located in Austell, northwest of Atlanta, GA. Competitive salary with comprehensive benefit package.

To apply please do online application www.wellstarcareers.org or contact 770-792-7539 for additional information.

KENTUCKY

HOPKINSVILLE (Nashville area commute) - Inpatient & partial programs. Staff Psychiatrist. Top salary, benefits & bonus compensation plan. **Fulltime or Part-time.** Contact Will DeCuyper, In-house recruiter @ 866-227-5415 OR email will.decuyper@uhsinc.com.

MARYLAND

PSYCHIATRIST/MEDICAL DIRECTOR

BE/BC Child/Adolescent Psychiatrist/Medical Director needed 20-40 hours a week for outpatient community mental health facility on Maryland's scenic Eastern Shore, one hour, 15 minutes from Baltimore-Washington area. The clinic is located in a Professional Shortage Area, is a National Health Service Corps site and is eligible for loan repayment. Send resume/vitae with cover letter to Michael Campbell. LCSW-C, Director, Caroline Co. Mental Health Clinic, P.O. Box 10 Denton, Md. 21629, phone 410-479-3800, ext. 117, fax 410-479-0052 or e-mail mike.campbell@maryland.gov - EOE.

PSYCHIATRIST: ADULT/CHILD. Medication Eval/Mgt. MD Bd Cert & 5 yrs Exp. Req'd. PT/ FT Active Caseload Provided, Excellent Growth Potential. Join Established Multispecialty Grp. Columbia Counseling Center www.counselingmaryland.com. Vita to drsminsky@gmail.com.

CLASSIFIEDS

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 **Jonathan Book, M.D., Clinical Director, SHC, 6655 Sykesville Road, Sykesville, MD 21784. For questions, call (410)970-7006 or e-mail JBook@dhmh.state.md.us.** EOE

FORENSIC PSYCHIATRIST

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, risk assessment, 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

PSYCHIATRIC ATTENDING POSITION AVAILABLE AT MARLBOROUGH HOSPITAL, MEMBER HOSPITAL OF UMASS MEMORIAL HEALTH CARE

The Department of Psychiatry at UMass Memorial Health Care is actively seeking an Attending Physician for its affiliated program at Marlborough Hospital. The position primarily involves the provision of inpatient psychiatric care, leading an interdisciplinary treatment team and participating in medical student education on the service. The unit at Marlborough involves 0.8 FTE, although full time employment is available for interested candidates. The ideal candidate will possess strong clinical abilities and a commitment to providing patient centered care in a collaborative environment. The physician will receive a highly competitive benefits package as part of our UMass Memorial Group Practice and academic appointment at the medical school commensurate with experience.

For consideration and/or additional details, or to learn about other opportunities affiliated with UMass, please send your CV and letter of introduction to: psychiatryrecruitment@umassmemorial.org.

Applicants are also encouraged to visit the UMass Department of Psychiatry's web site: www.umassmed.edu/psychiatry.

The Department of Psychiatry at Mount Auburn Hospital, affiliated with Harvard Medical School, is recruiting for a full-time position as attending psychiatrist on our geriatric psychiatry inpatient unit. The 15 bed unit, fully accredited by DMH, provides acute treatment to geriatric patients with a variety of psychiatric disorders. The full medical resources of our general hospital are utilized in the care of our patients. Responsibilities include attending patients on the unit, consultation to the medical/surgical services of the hospital, and participation in the teaching activities of the Department. A clinical appointment in psychiatry at Harvard Medical School is anticipated.

Please send letter of interest and cv to: Joseph D'Afflitti, M.D., Chair, Department of Psychiatry, Mount Auburn Hospital, 330 Mount Auburn Street, Cambridge, MA 02138; tel: 617 499-5054; email:jdafflit@mah.harvard.edu.

CAMBRIDGE HEALTH ALLIANCE: Outpatient Child/Adolescent Psychiatry Position

Cambridge Health Alliance, Division of Child and Adolescent Psychiatry, Harvard Medical School. Community based outpatient position in collaboration with local and regional agency partners. Role involves direct psychiatric care and consultation with multidisciplinary clinical teams at agency sites. Part time, 20-30 hours/week. Position also includes opportunities for teaching child psychiatry fellows, general psychiatry residents, medical students, and other trainees as well as participation in academic department activities. Academic appointment, as determined by the criteria of Harvard Medical School, is anticipated.

Qualifications: BE/BC, demonstrated commitment to public sector populations, strong clinical skills, strong leadership and management skills, team oriented, problem solver. Bilingual and/or bicultural abilities are desirable. Interest and experience with dual diagnosis and/or substance use disorders preferred. Competitive compensation, excellent benefit package. Cambridge Health Alliance is an Equal Employment Opportunity employer, and women and minority candidates are strongly encouraged to apply. **CV & letter to Joel Goldstein, MD, Dept. of Psychiatry, 1493 Cambridge Street, Cambridge, MA 02139. Fax 617-665-1204. Email: JoGoldstein@challiance.org** (email preferred).

Did you know

APA's advocacy resources include: the Legislative Action Center, where you can get updates on key issues and legislation, plus listings of elected officials and other election news; the APA political action committee; the department of Government Relations; and the APA Congressional Action Network. www.psychiatry.org/advocacy-newsroom

Berkshire Health Systems

Massachusetts. Consult-Liaison Psychiatrist Needed. 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 a consultation-liaison 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 alentine@bhs1.org.

MISSISSIPPI

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.

MISSOURI

St. Joseph, MO – Close to Kansas City – Wonderful city to live and work, great schools, and so close to the metro area—one of the Midwest's best kept secrets! 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; Call 1:5. Offering attractive student loan repayment plan if needed. Come join our incredible behavioral health team on this growing psych service. This is a "must see" opportunity! Please **call Terry B. Good at 1-804-684-5661,** Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

NEWS CAN'T WAIT, SO WHY SHOULD YOU?

Psychiatric News has launched a new communications service for members—a weekly e-newsletter called *Psychiatric News Update*.

Sign up at **alert.psychiatricnews.org**

NEW JERSEY

CHILD & ADOLESCENT PSYCHIATRIST Montclair, NJ

Child/Adolescent Psychiatrist for our Montclair, New Jersey location, to join our private fee-for-service comprehensive child, adolescent and adult therapy Center. Candidate will be part of a multi-disciplinary team and will provide psychiatric evaluation, medication management and, if desired, psychotherapy, in a supportive collegial atmosphere. He/She will also clinically oversee treatment at the Center. Salary and benefit package are generous, and include excellent medical and dental insurance benefits, generous vacation and CME time, retirement plan and more. Opportunities for growth also exist. Candidate must be board certified or board eligible in child/adolescent psychiatry. **E-mail cv to abbazn@aol.com.**

NEW MEXICO

LAS CRUCES: Staff Psychiatrist - Psychiatric Hospitalist – Adult Services Highly competitive salary, benefits & bonus opportunity. Great support teams & program services. Contact Joy Lankswert, In-house recruiter @ 866-227-5415; OR email joy.lankswert@uhsinc.com.

NEW YORK CITY & AREA

Rockland Psychiatric Center, Orangeburg, NY Psychiatrists

Rockland Psychiatric Center, the largest NY State psychiatric hospital, is affiliated with New York University and located 18 miles north of Manhattan in the scenic lower Hudson Valley. We are looking for Psychiatrists for our outpatient and inpatient units, serving seriously mentally ill adults. RPC offers regular hours, optional on-call for extra pay, excellent benefits, including NYS retirement system. Weekly Grand Rounds, large medical staff, collegial atmosphere. With 400 inpatient beds and an extensive regional outpatient network, there are many opportunities for movement and advancement once on staff.

Send CV to Mary Barber, MD, Clinical Director, mary.barber@omh.ny.gov.

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.

Adult and/or Child Psychiatrist

P/T – 15-20 hours per week (evenings and weekends) in an outpatient mental health facility in Brooklyn. Competitive compensation. Submit CV by fax or email only: 718-837-5676 or email to admin@nccny.com.

CLASSIFIEDS

Manhattan Psychiatric Center is seeking a Board Certified Psychiatrist to assume the duties of ward psychiatrist on the sex offender unit. This is a ward dedicated to the treatment of Article 10 sex offenders, with a manualized comprehensive program utilizing the latest in cognitive and relapse prevention strategies to engage this population.

The ward psychiatrist is the leader of a team of dedicated professionals and in this capacity will work in a multi disciplinary collaborative approach to attend to the complex needs of these patients.

Manhattan Psychiatric Center is an affiliate of NYU and there are opportunities for teaching of residents, medical students, as well as research. Forensic training is desirable, given the complexities of treatment and assessment of this population.

Please FAX CV to:
Samuel J. Langer, MD
Chief of Psychiatry
646-672-6386
or email to samuel.langer@omh.ny.gov.

Child Psychiatrist – New York City The Family Center for Bipolar Disorder in the Department of Psychiatry at Beth Israel Medical Center in Manhattan seeks a full-time child/adolescent psychiatrist with motivation, initiative, and interest to establish an Early Recognition and Prevention Program. The qualified individual should be Board-Certified in Child Psychiatry, have excellent clinical skills and a proven research track record. Prior publications are essential. Previous research funding is desirable. For consideration, please forward CV to Irina Kopeykina at ikopeykina@chpnet.org, or call 212-844-1868 for more information. EOE

NEW YORK STATE

ELMIRA PSYCHIATRIC CENTER
Adult and Adolescent Psychiatrists
Board Eligible/Board Certified - $148,421-$256,700
Limited Permit -Eligible applicants will also be considered

- All positions M-F 8-4:30
- Voluntary low stress on call at regular pay rate
- Student loan repayment available
- Excellent NYS benefits package
- Inpatient, Outpatient and Day Treatment services
- Our location offers: quality housing prices; little traffic; regional airport; Cornell University; 4hr drive to NYC, Toronto & Philadelphia; 5 ½ hr drive to Boston & DC; less than 1hr to Finger Lakes Wine Country; Watkins Glen International Racetrack.

For further info contact: Patricia Santulli, Director of Human Resources at: Elmira Psychiatric Center, 100 Washington Street, Elmira, NY 14901 or e-mail: P.Santulli@omh.ny.gov or call: (607) 737-4726 or fax: (607) 737-4722. An AA/EOE Employer

---

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 13669-229 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.**

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 the Bronx and Westchester County. 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

NORTH CAROLINA

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

Did you know
that APA provides support for managing a practice?
We provide members a wide variety of practical assistance on day-to-day issues that arise in managing a practice, such as reimbursement, relationships with managed care companies, coding, documentation, Medicare, Medicaid, establishing or closing a practice, and mental health/addiction parity. APA Members may access practice management assistance by calling the HelpLine at 800.343.4671, sending email to hsf@psych.org or through our website at www.psychiatry.org/practice

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 – OUTPATIENT POSITION with some on-call duties for the geropsych unit. Salaried position with production & performance bonuses; medical school loan repayment plan up to $200k. Portsmouth is close to Ashland, KY, an hour from Huntington, WV; it is 80 miles from Columbus and 110 miles from Cincinnati. The hospital was named 10th in the Top 100 Best Places to Work by Modern Healthcare and 36th on Fortune's top 100 Best Companies to Work For. Join our top notch team at this beautiful, impressive hospital and enjoy working every day with a great group of people. H1/J1s welcome. Please **call Terry B. Good, Horizon Health, at 1-804-684-5661,** Fax #:804-684-5663; Email: terry.good@horizonhealth.com.

Bundling your advertising products saves you money!

10% off discounts apply when bundling *Psychiatric News* and/or *Psychiatric Services* and APA JobCentral.
Contact Eamon Wood at **ewood@pminy.com.**

CLASSIFIEDS

PENNSYLVANIA

We have exciting full and part-time positions in a rapidly expanding department. Opportunities include responsibilities in and outside our five-hospital health system. There are immediate openings for **Child/Adolescent, Adult, Geriatric and Addictions psychiatrists**. We also seek psychiatric leadership to run our Pain Management and ECT services.

Psychiatric Hospitalist positions are also available. Excellent salaries and exceptional benefits 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.

One Hour to PHILADELPHIA - Two Hours from WASHINGTON, DC– Pretty Area – so close to several amazing metro areas. Inpatient position; adult and geriatric; attractive salary w/benefits plus bonus, or independent contractor arrangement if in practice already. Plans under way to open outpatient and other services. Grow with this program; join a great team! Please **call Terry B. Good at 1-804-684-5661,** Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

PHILADELPHIA: General Psychiatrist - Inpatient Services. Call only 5x per year! Child Psychiatrist—Day Treatment.**CLARION:** Child Psychiatrist—Inpatient/Partial Services. **STATE COLLEGE:** General or Child Psychiatrists–Inpatient, Partial or all O/P programs. All positions offer salary, benefits, bonus opportunity. Contact Tiffany Crawford, In-house recruiter @ 866-227-5415 OR Tiffany.Crawford@uhsinc.com.

SOUTH CAROLINA

Medical Director Position — 8-bed inpatient Geropsychiatric Unit; salaried with benefits or practice opportunity for those who prefer independent contract. Weekend call is one in four. Rounding on weekends is not necessary unless there is an admission on Friday or Saturday. Located in northeast SC, this small town is an easy drive to Florence, SC and Fayetteville, NC; 2 hours from Columbia, Myrtle Beach, Charlotte, Raleigh, and Wilmington. Please **call Terry B. Good at 1-804-684-5661,** Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

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

SCHOOL OF MEDICINE
VANDERBILT UNIVERSITY

INPATIENT PSYCHIATRIST
Vanderbilt University School of Medicine, Department of Psychiatry

The Department of Psychiatry is recruiting psychiatrists to provide inpatient services at the Vanderbilt Psychiatric Hospital located on the campus of Vanderbilt University Medical Center. The hospital offers specialized inpatient programs for children & adolescents and for adults with mood, psychotic, and substance abuse disorders. Successful BE/BC candidates will receive a faculty appointment with rank and salary commensurate to experience.

Applicants should email or send a letter of interest with an updated CV to Harsh K. Trivedi, MD, Executive Medical Director and Chief of Staff, Vanderbilt Psychiatric Hospital, 1601 23rd Avenue South, Nashville, TN 37212. Interested and eligible candidates may obtain further information by contacting Dr. Trivedi at 615-327-7024 or harsh.k.trivedi@vanderbilt.edu.

TEXAS

Established practice in North Dallas near Plano is looking for an outpatient adult or child psychiatrist. Excellent compensation. Great place to live and work. Call Mike Martin at 972-248-2299 or email your CV to info@dallaspsychiatry.com.

The Department of Psychiatry and Behavioral Sciences of the University of Texas Medical School at Houston has an extraordinary opportunity for psychiatrists seeking to develop and implement new outpatient clinical and research initiatives in community based outpatient clinics within the Houston area with our partner Harris Health. We are also adding faculty to our 250 bed inpatient hospital, the Harris County Psychiatric Center. Our inpatient and outpatient services include unique and robust clinical and research initiatives. The Department is looking to expand clinical and research areas and is seeking general psychiatrists, child and adolescent psychiatrists and geriatric psychiatrists to join a growing academic department dedicated to excellence in training and education, and primacy in research and investigation. The Medical School is part of the University of Texas Health Science Center Houston, located in the Texas Medical Center – the largest medical center in the world. Individuals applying for these positions must be Board Certified in general psychiatry, child & adolescent psychiatry and geriatric psychiatry or have completed an accredited training in these specialty and subspecialty areas in the United States. Additionally, they must be licensed or be eligible for licensing in the State of Texas. Depending upon the applicant's qualification and credentials, faculty appointments at the level of Assistant Professor, Associate Professor or Professor will be offered. Salary levels are very competitive and also carry excellent fringe benefit packages. To find out more information about these unique academically driven positions or to apply for them, please write to Jair C. Soares, M.D., Professor and Chair, and include a copy of your curriculum vitae and a letter of interest to 1941 East Road, Houston, Texas 77054, e-mail: Jair.C.Soares@uth.tmc.edu phone 713-486-2507; fax 713-486-2553. The University of Texas Health Science Center at Houston is an EO/AA employer. M/F/D/V

UTAH

SALT LAKE CITY and OREM/PROVO: Staff Psychiatrists - Psychiatric Hospitalist – Adult Services. Highly competitive salary, benefits & bonus opportunity. Great support teams & program services. Contact Joy Lankswert, In-house recruiter @ 866-227-5415; OR email joy.lankswert@uhsinc.com.

WEST VIRGINIA

HUNTINGTON: General Psychiatrist– Inpatient & Partial programs. Top salary, benefits, & bonus opportunity with little call. College town community – great quality of life. J1 & H1 eligible. Contact Will DeCuyper, In-house recruiter @ 866-227-5415 OR email will.decuyper@uhsinc.com.

Excellent private practice opportunity for a adult/ or child-trained psychiatrist in Southern West Virginia to join a well-established practice. In-patient, out-patient, and consultation services. Exceptional salary and benefits. Good place to raise children. Easy drive to several big cities, heaven for outdoor lovers. Can help with visa conversion and sponsorship. Fax cv to (304) 252-1703 or email nafa2 @aol.com.

50 Minutes from Pittsburgh – Forbes' Top Ten "Best Places to Live Cheaply" because of the low cost of living, highly rated schools, low unemployment and low crime rate. Seeking C/A Psychiatrist to work on a children's unit and adolescent unit in a very impressive general hospital that offers a full continuum of psychiatric care. This is an inpatient and outpatient position; salaried with benefits and attractive bonus plan. Top-notch staff; great quality of life—truly a "must see" position when considering a new job in a new place. Contact **Terry B. Good at 1-804-684-5661,** Fax #: 804-684-5663; terry.good@horizonhealth.com. EOE

Fellowships

UMass Addiction Psychiatry Fellowship

The UMass Addiction Fellowship in collaboration with the Bedford Veterans Center for Addiction Treatment (VCAT) has positions available for fellows to start on July 1, 2013. This fellowship program has affiliations with different private, public and federal sectors such as Adcare Hospital, Spectrum Health Systems, Community Healthlink and Bedford VA Hospital, that not only offers the fellow exposure to patients with a broad range of substance use disorders, but also prepares the fellow to be competent to succeed in highly demanding settings. Interested candidates should contact: Gerardo Gonzalez, MD, Director of Addiction Psychiatry Fellowship Program, Department of Psychiatry, University of Massachusetts Medical School, 365 Plantation Street, Worcester, MA 01605 or email gerardo.gonzalez@umassmed.edu. AA/EOE

APA JobCentral
The Career Hub for Psychiatry

Connects Talent with Opportunity

Filling an open position? Searching for that ideal job?
Get started at jobs.psychiatry.org

Manage Your Career
- Search **APA JobCentral** for psychiatry jobs by position, title, specialty, work setting, location, and key words to access relevant jobs.
- Create an account to save jobs, store multiple resumes and cover letters, keep notes, communicate with employers through our internal messaging system, and more through an engaging interface.
- Set up multiple Job Alerts specifying your skills, interests and location to receive an e-mail when an employer posts a job that matches your criteria.

Recruit for Open Positions
- Post your job in front of highly qualified psychiatrists.
- Cross promote your job listing in APA print publications, e-newsletters and social networking platforms such as Facebook and Twitter.
- Search the anonymous resume database to find your ideal candidate.

Go to **jobs.psychiatry.org** to get started!

APA JobCentral
The Career Hub for Psychiatry

AH1258

THERE ARE GOOD REASONS AMERICAN PROFESSIONAL AGENCY IS A LEADER IN PROVIDING MALPRACTICE INSURANCE FOR PSYCHIATRISTS

HERE ARE TWO OF THEM.

www.psychiatry.org

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

WWW.AACAP.ORG

JOIN YOUR COLLEAGUES WHO HAVE CHOSEN TO BE REPRESENTED BY OUR PROFESSIONAL TEAM AND OUR PROGRAM WHICH IS ENDORSED BY THE TWO MOST PROMINENT ASSOCIATIONS IN YOUR PROFESSION – THE AMERICAN PSYCHIATRIC ASSOCIATION AND THE AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY.

AS AN ALLIED WORLD POLICYHOLDER YOU WILL BENEFIT FROM THE EXPERIENCE OF AN INTERNATIONALLY RECOGNIZED RISK MANAGEMENT TEAM WHO WILL GUIDE YOU THROUGH THE EVER-CHANGING EXPOSURES THAT YOU MAY ENCOUNTER IN YOUR PSYCHIATRIC PRACTICE. OUR RISK MANAGEMENT TEAM IS AVAILABLE TO OUR INSUREDS 24 HOURS A DAY, SEVEN DAYS A WEEK OR THROUGH OUR HOTLINE.

WHEN IT COMES TO MALPRACTICE INSURANCE FOR PSYCHIATRISTS, GO WITH A WORLDWIDE LEADER

COVERAGE WILL BE UNDERWRITTEN BY AN INSURANCE SUBSIDIARY OF ALLIED WORLD ASSURANCE COMPANY HOLDINGS, AG

95 Broadway, Amityville, NY 11701

WWW.APAMALPRACTICE.COM

877-740-1777