Should Americans Be Happier Than They Are?

» Ronald W. Pies, MD

Should Americans feel happier than they do? Despite the heroic efforts of Harvard psychology professor Steven Pinker, I remain unconvinced. As a fellow humanist, I sympathize with Prof. Pinker’s predicament. Having amassed a bushel basket of data for his magisterial new book, Enlightenment Now, the good professor is perplexed: why aren’t we Americans as happy as we should be, given all the wonderful things we have in our lives? (Spoiler alert: beware of those who tell you how really, really happy you should be).

The author described feeling emotionally overwhelmed and moved to tears, in a state of intense positive emotion, on watching the moment when, as Pope Francis was ministering to a group of strangers, a young boy rose from his chair and gave the Pope a hug. Questioning the origins of this response led the author to ask others about their response to the same, and similar, events. He found others had the same feelings, often accompanied by a burst of goodwill and what he called “benevolence.” But he wasn’t satisfied and decided to do more research.

Burke discovered that Thomas Jefferson had described this emotional state in his writings: “When any… act of charity or of gratitude is presented to our sight or imagination, we are deeply impressed with its beauty or feel a strong desire in ourselves of doing charitable or grateful acts also.” Burke goes on to say that Jefferson asserted that observing sadness and angst will only delay our emotional recovery.

Pinker gives numerous examples to support his thesis that the US suffers from an “Optimism Gap.” Since 1992, Pinker notes, homicide rates in the US have declined sharply. Maternal mortality in the US has fallen dramatically since the 1950s. And Americans, on average, have been getting richer (despite the fact, as Pinker concedes, that “the rich got richer faster than the poor and middle class got richer”). Leisure time for Amer-

Looking for Kama Muta in All the Right Places

» Allan Tasman, MD

A recent article on the CNN website caught my eye. No, it wasn’t about the crazy state of the world or of American politics. It was an article by Daniel Berke, the CNN religion editor, “Seeing the Pope help strangers made me tear up. Later I learned why.”

The man who is a pessimist before 48 knows too much; if he is an optimist after it, he knows too little.
– MARK TWAIN

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Happiness in America

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ican men and women, on average, has increased markedly since the 1960s. And, Pinker argues, for all the hand-wringing about “right-wing backlashes” the values of Western countries, including the US, have been getting “steadily more liberal” since the 1980s.

So what’s to complain about? And yet, as Pinker vividly puts it, Americans “... seem to bitch, moan, whine, carp, and kvetch as much as ever...” and the proportion of Americans who report being happy has held fairly steady for decades. Pinker notes that there has been a “slight decline” since 1972 in the proportion of Americans saying they are “very happy.” Actually, data from the 156-country 2018 World Happiness Report show that the US ranks 18th in the world—a significant drop from 14th place in 2017.

To give Prof. Pinker his due: he bolsters his arguments with (count ’em) 75 graphs and more than 30 pages of references. If, at times, he sounds like someone from the Murky Gulch Chamber of Commerce, trumpeting the town’s many virtues, Pinker is, nevertheless, an eloquent apostle of the Enlightenment—roughly the last two-thirds of the 18th century, known for its championing of “reason, science, humanism, and progress.” Indeed, Pinker is in the direct line of progressive optimists from Nicolas de Condorcet (1743–1794) to Barack Obama. He reminds me, wistfully, of Ludovico Settembrini, the humanist pedagogue in Thomas Mann’s novel, The Magic Mountain. Like Pinker, Settembrini argues passionately for (in Mann’s words) “... the recent progress of humanitarian ideals” and “the triumph forcing back of epidemic disease,” contrasting the “horrors of pestilence with the feats of modern medical science.” And, like Settembrini’s noble sentiments, Prof. Pinker’s thesis is only partly convincing.

So why aren’t Americans happier? Pinker offers a number of hypotheses, which I will not detail here, for America’s Optimism Gap. (Two examples: “People have... lost their comforting faith in the goodness of their institutions...” and “...the media and commentariat... could reflect on their own role in keeping the country’s anxiety at a boil.”) For the most part, Pinker seems to argue that if only we, misinformed Americans, would look at the facts, we would realize how truly well off we are.

And, to be sure, Americans have many blessings for which to be grateful. But while Pinker is quick to point out how our biases can distort our perception of how good things are, he seems unaware of his own selective presentation and interpretation of the evidence. Pinker’s biases are evident in at least 3 areas that impinge on mental health issues.

Pinker rightly debunks the myth that “suicide has been steadily rising and has now reached historically high... or epidemic proportions.” Indeed, data from the Centers for Disease Control show that, for the US population as a whole, rates of completed suicide in the US (all ages) were about the same in 2010 as they were in 1960 and 1980 (12.1, 12.5, and 12.2 per 100,000, respectively).

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Kama Muta

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good deeds “can ‘elevate’ our bodies and minds, opening our chests and hearts.” This description parallels an aspect of what Jewish theologians described early in the first millennium of the states that emerge when fulfilling one of God’s most important precepts, tikkan olam, translated as “healing the world.”

Jefferson believed there were “four major components of the emotion: a triggering event (you witness moral beauty) a physical sensation (your chest dilates, a motivation (you want to help others) and an emotional feeling (you are uplifted and optimistic).” This 200-year-old definition is essentially the description in modern usage from social psychologists of the emotional state Jefferson called “elevation.”

Burke refers to the fact that UCLA anthropologist, Alan Page Fiske, uses a more ancient language, Sanskrit, when he describes this feeling as Kama Muta. No, I didn’t misspell this and mean Kama Sutra. To Fiske, “the closest we can come to the meaning of kama muta in English are words such as moved, touched, stirred, or smitten.”

At this point I was hooked, so I did what any modern day researcher would do. I searched for Kama Muta on Google. What a disappointment! Nothing appeared except a Wikipedia article put the term Kama in the context of its Hindu origins.

Unlike our common usage of Kama, which more often indicates a sexual kind of desire or longing (as in Kama Sutra, with sutra meaning a work of writing, such as a book or in some usage a scripture), the meaning of Kama more appropriately “refers to any kind of desire, wish, passion, longing, pleasure of the senses, the aesthetic enjoyment of life, affection, or love, with or without sexual connotation.”

With that context in mind, I followed the Google trail to the website of the Kama Mut Lab. This laboratory is based at the University of Oslo in Norway but includes collaborators from other institutions including Dr. Fiske at UCLA. This research group has been publishing their research on this topic for almost two decades. They define Kama Muta on their website as “a positive emotion evoked by observing or actively taking part in a sudden intensification of a communal sharing relationship... commonly accompanied by physiologic reactions including weeping, feelings of warmth and chills or goosebumps... and [which] motivates acting communally or altruistically.”

They go on to say this is a positive emotional feeling that might make someone feel more connected to another and to do something to help others share this feeling. Sound familiar?

The website offers a long list of examples wherein a person might feel Kama Muta. They include things such as the feeling state of a mother holding a newborn for the first time right after birth, a person coming upon an injured child and wanting to offer comfort and caring, or a college roommate disclosing physical abuse leading the other roommate to disclose his or her own terrible experiences.

The list of examples is much too long to describe in detail here, but it struck me that a commonality of most examples posted is the engaging of an empathic resonance between two people or of an individual within or responding to a group of people. I was surprised, though, especially given that the researchers are primarily a group of psychologists, that there was no mention of the experience of any health care clinician, especially a psychotherapist, within a therapeutic alliance.

I think Kama Muta is a ubiquitous experience, though not necessarily a frequent one, for any psychiatrist treating patients. Since I’m a psychoanalyst, I think not only of hospitalized patients I’ve treated, but more of patients I’ve treated psychotherapeutically. I’m particularly thinking of a patient with a very severe personality disorder and bulimia, whose binging and purging was the only way of soothing herself she had ever known since early adolescence. Pertinent for this discussion is the feeling I had on the day she told me, after many years of searching together for a solution, that the evening before we met she was able to calm herself without having to throw up. I know now the feeling I experienced at that moment was Kama Muta.

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However, over the past 15 years, the total US suicide rate has increased 24% from 10.5 to 13.0 per 100,000—
a statistic Pinker does not cite.

While Pinker acknowledges that “suicide rates rise sharply during ad-
lescence,” he doesn’t acknowledge that suicide among US teens and
young adults has nearly tripled since the 1940s.1 Furthermore, between
1999 and 2014, the suicide rate among adolescents (aged 10–14)
nearly doubled, with most of the in-
crease occurring after 2007, and with
the sharpest rise occurring in girls.1

It is probably not coincidental that there have been large generational
increases in psychopathology (based
on MMPI data) among American
college students between 1938 and
2007, according to the research of Dr.
Jean Twenge and colleagues.2 Taken
in toto, these findings do not paint a
picture of happy young people in this
country—and raise serious questions
as to what is fueling these trends.

Pinker emphasizes the fact that,
worldwide, life expectancy has
increased markedly between 1771
and 2015, including in the Americas. But he does not discuss the fact that
in the US, life expectancy has actu-
ally declined in recent years. Specifi-
cally, it declined 0.1 years between
2014 and 2015.3 As economist Jeffrey
Sachs has observed, “This reversal in
the upward trend of life expectancy is
shocking and almost unprecedented
for a rich country in recent decades.”2 The Center for Disease Control has
emphasized the role of rising sub-
stance abuse, and especially the mod-
ern opioid epidemic, in the reversal.

Rising income inequality in the
US does not seem to trouble Prof.
Pinker very much. He argues that
income inequality per se is not the same thing as poverty; that “the majority
of the human race has become much
better off” in recent decades; and
that, in any case, “. . . income in-
equality is not a fundamental compo-
nent of well-being.” On this last
point, I believe Pinker has overlooked
substantial evidence to the contrary,
though some of it probably emerged
after the completion of his book.

For example, in a recent compre-
hensive analysis of income inequali-
ty and mental health, Vikram Patel
and colleagues4 found a strong cor-
relation between income inequality
and elevated rates of depression. Spe-
cifically, in their review of 28 studies,
mostly from high-income countries,
the authors found that, “Nearly two-
thirds of all studies and 5 out of 6 lon-
gitudinal studies reported a statisti-
cally significant positive relationship
between income inequality and risk
of depression; only one study report-
ed a statistically significant negative
relationship.” Of course, these find-
ings do not prove that income in-
equality directly causes depression; how-
ever, the authors quite reason-
ably hypothesize that, “At the indi-
vidual level, the effects of income
inequality on general health are like-
ly to be primarily mediated through
psychological stress.”

Loneliness and social
disconnection in the US

In his discussion of loneliness, Pink-
er heaps scorn on the “hysterical mis-
conception” that “modern life [has]
. . . set us drifting apart without human
contact or emotion.” In support of his
position, he provides a graph show-
ing that, among US students (8th
grade to college), loneliness has de-
clined in the years from 1978 to 2011
(based on the UCLA Loneliness
Scale). To be sure, there is little evi-
dence of an “epidemic” of loneliness
in the US, as sometimes claimed in
the popular media, and reported rates
of loneliness differ considerably, de-
pending on the study methodology.

Research from the late Dr John Ca-
cioppo,5 based on the decades-long,
federally run Health and Retirement
Study, suggests that rates of loneliness
in the U.S. have probably increased
on the order of 3% to 7% percent over
the past 20 years. Moreover, Prof.
Julianne Holt-Lunstad and colleagues6
report that between 20% and 43% of
US adults older than 60 experience
loneliness, which is frequent or intense loneliness. Since loneliness has been associated with
impaired daytime functioning, re-
duced physical activity, lower subjec-
tive well-being, and poorer physical
health.7

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Unlike Prof. Pinker, I think the declining state of American happiness is largely a rational response to the mess in which “we the people” find ourselves. And yet, like Pinker, I believe things can get better. Witness the idealism of the students who survived the Parkland High School shootings, and who now protest the unconscionable gun-related carnage in this country.

In the end, perhaps the most “reasonable” stance is neither optimism nor pessimism, but that of the philosopher, Jacques Barzun: “I have always been—I think any student of history almost inevitably is—a cheerful pessimist.”

Dr. Pies is Editor in Chief Emeritus of Psychiatric Times, and a Professor in the psychiatry departments of SUNY Upstate Medical University, Syracuse, NY and Tufts University School of Medicine, Boston.

References

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FROM THE EDITOR
You Say Hello—and I Say Goodbye

SUSAN KESWICH | GROUP EDITORIAL DIRECTOR

Allow me to paraphrase Bob Dylan. The Times . . . it is a changin.
What's changing exactly at Psychiatric Times ?
First, there are hellos. Four psychiatrists have joined the distinguished members of our Editorial Board. It's an honor to introduce:

Raymond Young-Jin Cho, MD, who is Associate Professor in the Department of Psychiatry and Behavioral Science at Baylor College of Medicine. Dr. Cho is double boarded in psychiatry and neurology. Dr. Cho did his undergraduate and postgraduate work at the University of Toronto, where he studied biology, physics, physiology, and neuroscience. He did his psychiatry residency at the University of Pittsburgh, where he served in a variety of positions, including as Director of the University's Clinical Cognitive Neuroscience Laboratory. In 2014, he became Associate Professor of Psychiatry and Director of the integrated Clinical Neuroscience and Treatment Program at the University of Texas Health Science Center in Houston. In 2017, he moved to Baylor.

What drew him to psychiatry? “It represents the perfect mix of science and humanities,” he writes. “I was drawn to patients with psychosis who are debilitated by their illnesses’ effect on core aspects of their cognition, emotions, and behavior. I was also drawn by the promise of clinical and research efforts in helping this population.”

When he isn’t working, Dr. Cho spends time with his family, while armchair philosophizing, and indulging his love of music. He plays piano and guitar, he sings, he listens to classical music, jazz, and progressive rock, and he writes rock and pop.

John J. Miller, MD, is Medical Director of Brain Health at Exeter, New Hampshire, staff psychiatrist at Seacoast Mental Health Center, consulting psychiatrist at Exeter Hospital, and psychopharmacology consultant to psychiatric clinical nurse practitioners, psychologists, and physicians. He has delivered over 2500 lectures, including CME symposia and national teleconferences and frequently speaks on pharmacogenomics, atypical antipsychotics, antidepressants, and mood and psychotic disorders. He earned his MD at UMass Medical School in Worcester, where he completed his residency in adult psychiatry.

Why psychiatry? “I studied biochemistry in college, which I continue to study today. A course in molecular evolution lit a fire of passion to understand the nature of the universe at multiple levels, which still burns in my soul. I initially planned to obtain a PhD in genetics, but ultimately decided to attend medical school.”

“As a psychiatrist, I continue to learn about consciousness through both my love of biochemistry and Mindfulness. I have worked part time for the past 10 years at our local community mental health center, where I enjoy treating patients. I feel fortunate to spend most of my time learning, lecturing, writing, and consulting. This is my 26th year as the volunteer psychiatric consultant at the Insight Meditation Society in Barre, Mass, which provides me with a constant reminder of the importance of my own practice of meditation.”

Katharine A. Phillips, MD, is on the faculty at Weill Cornell Medical College and the staff of New York Presbyterian Hospital in New York City. She is also Professor of Psychiatry and Human Behavior at the Warren Alpert Medical School of Brown University. Dr. Phillips is internationally recognized for her research and clinical expertise in body dysmorphic disorder (BDD) and other obsessive-compulsive and related disorders.

Dr. Phillips first became interested in BDD when, as a resident, she saw patients who were intensely preoccupied with minimal or nonexistent defects in their appearance (for example, “gretsesque” skin or a “huge” nose) to the point that it caused suffering and interfered with psychosocial functioning—often to a se-

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Phoebe M. Tucker, MD, is Professor of Psychiatry, Arnold and Bess Ungerman Endowed Chair in Psychiatry, and Vice Chair of Education in the Department of Psychiatry at the University of Oklahoma Health Sciences Center in Oklahoma City. In 2017, she was one of "Americas Most Honored Professionals—Top 1%" and has repeatedly been named one of Castle Connolly’s Top Doctors.

A diplomate of the American Board of Psychiatry and Neurology, Dr. Tucker earned her MD from the University of Oklahoma, where she completed her residency. She currently serves as Medical Director of the Physician Wellness Program at the Oklahoma County Medical Association and is a Distinguished Life Fellow of the APA.

Dr. Tucker writes: "I met my husband Les in Cote d’Ivoire many years ago when we were both in the Peace Corps. We’ve been married 45 years, with 2 grown offspring. My original degree was in English literature from UC Berkeley. After volunteering in a hospital in Africa, I went to medical school, completed general adult residency, and have been in the department of psychiatry at OUHSC ever since except for 3 years as Dean of Student Affairs for the medical school. My research has focused on PTSD and trauma (including the Oklahoma City bombing), anxiety disorders, and biological markers of psychiatric disorders (heart rate variability, interleukins, etc.) Teaching is a passion.

Les and I still love to travel—some favorite trips were living and teaching in Australia, floating down the Amazon, going to Machu Picchu and Lake Titicaca, visiting China, seeing our former exchange student in Japan."

And for that goodbye... Let me seize this opportunity to say farewell to my friends and colleagues and mentors at Psychiatric Times. As this issue goes to print, I’m heading out the door for my first day of “retirement”—a summer of being outdoors and a fall and winter of travel.

I’ve been so proud to be a part of this publication for almost a decade, and to have had the honor—and pure pleasure—of working with 4 amazing editors-in-chief, Drs. Ron Pies, James Knoll, Allan Tasman, and Michelle Riba. I also want to shine a light on my manager, Sara Michael, and on the editorial team, Natalie Timoshin, HeidiAnne Duerr, and Laurie Martin, for the passion and skill they bring to their work, and for helping make Psychiatric Times one of the best read psychiatric publications in the US. They will continue to provide you with the latest in psychiatry—from residency to retirement—in print or online. Their editorial mission is to deliver the information you need to fulfill your mission—to provide optimal care of your patients.

Shine on!

Dr. Phillips is the author of more than 320 publications and has written or edited 11 books. She has given more than 550 presentations in the US and abroad. She has received numerous honors and awards, including a Special Presidential Commendation from the American Psychiatric Association for her research accomplishments.

Dr. Phillips serves on a number of editorial and scientific advisory boards. From 2007–2013, she chaired the DSM-5 Work Group on Anxiety, Obsessive-Compulsive Spectrum, Post-Traumatic, and Dissociative Disorders and was a member of the DSM-5 Task Force; she is currently a member of the DSM Review Committee for Internalizing Disorders. She is a Fellow of the American College of Neuropsychopharmacology, a member of the American College of Psychiatrists, and a Distinguished Fellow of the APA. She has repeatedly been included in Best Doctors in America, Castle Connolly’s Who’s Who in America, and Who’s Who in the World.
Can We Prescribe Resilience?

J. Eric Vance, MD
Dr. Vance is Associate Professor, Psychiatry and Behavioral Medicine, Virginia Tech Carilion School of Medicine, Roanoke, VA.

It is time for the psychiatric and wider medical world to embrace lessons from the growing science of resilience to treat the wide range of stress-related medical and psychiatric disorders more effectively. Quite often, physicians admonish patients to lower their stress levels, while patients quietly wonder how a lifetime of adversity can be undone, or how to extricate themselves from stressful jobs, relationships, or living environments. In these clinical situations, clinicians need to be prepared to offer concrete suggestions to build protective factors for resilience, rather than presuming that patients can magically get rid of their stressors.

The healing professions can be forgiven for coming late to the science of resilience, since vastly greater research and educational efforts have traditionally focused more on the pathogenic impact of stress and risk factors to generate disease, rather than how to harness the healing potential of biopsychosocial protective factors. It is beyond dispute that a subset of high-risk individuals is exceptional inborn qualities of temperament, likeability, getting along well with peers and adults, sense of humor, empathy and care-taking, emotional control.

Protective factors include characteristics of the individual and environmental experiences, and may occur at various developmental stages, but all seem to derive from a small handful of fundamental requirements for resilient functioning: a sense of safety, positive social connections, feelings of competence and control, and positive outlooks. Understanding the neurophysiological systems that underlie resilient functioning is crucial to effectively prescribing to the needs of high-risk patients, and to developing innovative ways to more efficiently induce these systems to build resilience.

Evolution of a sense of safety

The human nervous system evolved to serve the fundamental function of modulating behaviors of approach and avoidance so as to optimize the organism’s chances of survival and reproduction. Polyvagal theory observes that humans engage in a continual sensory process of “neuroception,” involving constant surveillance of afferent inputs to ascertain levels of risk, threat, safety, and opportunity to produce behavioral responses that will best serve the needs of survival and reproduction. Depending on the valence of afferent signals of neuroception, neurophysiological states are produced that bias our anticipation of novel or unexpected stimuli and result in behavioral and autonomic responses that respond to situations of risk or opportunity.1

Understanding how neuroception produces neurophysiological states in the autonomic nervous system is crucial to understanding how resilient individuals cope with stress. With the explication of polyvagal mechanisms in the parasympathetic nervous system, we have been able to move beyond simplistic models of stress response. Based on the interpretation of these sensory inputs through the brain, we not only respond to risk and threat with well-known fight, flight, or freeze mechanisms, but also respond to conditions of safety and opportunity by activating key components of the parasympathetic nervous system to promote rest, relaxation, restoration, and social engagement. The most resilient individuals seem to have an ability to adeptly use these complex neurophysiological systems, to defend or recover from threats and trauma, and to seek or generate opportunities that create a sense of safety, control, and social connection.

Social skills for resiliency

Resilient individuals often have exceptional inborn qualities of temperament, personality, and social skills, starting with “easy” infant temperament, developing through childhood into likeability, getting along with others, sense of humor, altruistic tendencies, interpersonal problem-solving, and good emotional regulation—characterized as “emotional intelligence.” These social skills typically arise under conditions of safety, from the orchestrated action of the social engagement system (SES), which, when activated, facilitates positive social affiliation, recovery and restoration, and possibly reproductive behaviors. Resilient individuals use their emotional intelligence to calm themselves quickly and effectively in the wake of risk or danger, as well as to attract and maintain loving and supportive social relationships, which in turn assist them in calming their neurophysiological state.

The SES includes the neuromotor pathways responsible for the production of the most important and intimate gestures of facial and vocal expression. Under the optimal conditions of a secure mother-infant attachment relationship, there is extensive inter-change of empathic facial and vocal interaction between mother and infant to entrain the SES of the developing infant. The components of the SES, along with the insular cortex, and various other sensorimotor cortical regions interact to generate a “mirror neural system” in humans. Capacities such as empathy, emotional self-awareness, and mentalization, are thought to arise from the mirroring social-emotional interplay of mother-infant attachment. Conversely, if the attachment is insecure, disorganized, or absent, there can be profound deficits in emotional regulation, stress-coping, and social engagement, such as in borderline personality functioning.3

In the interest of prescribing resilience, it is crucial to understand that in-born social skills and secure mother-infant attachment are strong protective factors, but their absence does not determine destiny. The adaptive importance of effective social engagement has resulted in significant lifelong plasticity in the SES. For example, meditation favorably alters tonic EEG rhythms and thereby enhances emotional regulation. Yoga and meditation are often recommended to augment the treatment of a variety of psychiatric and medical illnesses, and involve resting or stretching in a place of comfort, quiet, and safety, breathing in a relaxed manner—using a bit of “physiological trickery” to send safe neuroception to the brain that triggers the relaxation response. Frequent or daily “dosing” of such practices seem to effect plastic neurophysiological changes.

Wolmer and colleagues’ report that teaching emotional intelligence skills to Israeli school children in a war zone decreased the rate of PTSD. Musical tones delivered in the frequency range of intimate social communication may activate the SES in some autistic children.4 Interventions aimed at producing laughter and positive affect have increasingly been shown to improve health.5 This set of observations suggests that we are able to induce positive change by “imposing” protective experiences into a person’s life that result in protective plastic changes in neurophysiological systems underlying resilience. Thus, in the face of stress, our patients should be urged into practices of meditation, yoga, learning emotional intelligence, music, and laughter to enhance a sense of safety and activate the SES.

Positive social connection

The big payoff for an effective SES and exceptional emotional intelligence is the ability to form positive social connections easily. Humans are social animals, and there is safety in numbers, so social connection and affiliation serve to enhance a sense of safety and build resilience. The first

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### TABLE

Common psychosocial protective factors

| Personality traits: easy infant temperament, likeability, gets along with peers and adults, sense of humor, empathy and care-taking, emotional control |
| Cognitive skills: above average IQ, good reader, good student, good problem-solving abilities |
| Family: parents high school educated, parents employed, family rules, routines, rituals, positive discipline with discussion, attendance to church or place of worship, alternate caretakers available to family |
| Involvement: sports, clubs, jobs, volunteer work, church youth groups, organizations |
| Relationships: secure mother-infant attachment, warm/positive relationship with a parent, peer support, positive partners, adult mentors outside the family |
| Outlooks: perception of caring parent, perception of competency, perception of control (internal locus of control), realistic hopes and expectations for the future, spiritual faith, perception of resilience |
Resilience (continued from page 20)

example of a social connection in the human life cycle is the mother-infant attachment following birth. We know that the neuroreceptive interchange between mothers and infants includes vocal and facial interactions, skin to skin contact, and breastfeeding, and result in the release of the neuropeptide oxytocin, which activates the SES, enhances pair-bonding, lowers cortisol, and has anxiolytic effects.

Oxytocin has wide-ranging functions and affects care receiving and care giving, positive social interactions, interpersonal trust, monogamous pair-bonding, and sexuality. Moreover, it produces stress effects, while enhancing immune function and wound healing. These pro-social, anti-stress actions arise from oxytocin’s function as a key regulator of parasympathetic cardiovascular control and social engagement.

While a secure mother-infant bond is a beneficial protective factor, some resilient individuals are able to thrive without it, finding other supportive relationships in the extended family, or outside the immediate family (adult mentors, peers, or loving partners), to gain the benefits of social connection. Tierney and colleagues report that high-risk youths matched with mentors from the Big Brothers/Big Sisters program have less entry into substance abuse, better school attendance, and better relationships with parents and peers.

The stories of resilient youths also often include experiences of assuming caretaking skills at a young age, having to care for their younger siblings or disabled parents. In psychiatry, we sometimes condemn this “parentification” of children, and mourn the loss of a carefree childhood, but this early caretaking experience likely results in an oxytocin effect, building empathy, an early sense of responsibility, and problem-solving skills, all of which, promote resilience.

The neurophysiological benefits that arise in loving social support relationships may also explain how social involvement and belonging to organized social structures enhances medical and mental health. Affiliation with social, athletic, or religious organizations promotes health benefits and has been shown to moderate the progression to depression among traumatized, high-risk youths and decrease anxiety and depression in adults.

The recommendations to maximize the protective benefits of socialization include tending to, and deepening close relationships, expanding and developing new relationships, and joining structured social activities.

Feelings of competence and control

Another pathway to resilience involves finding ways to experience a sense of competence and control with the activities of daily living. Resilient individuals exhibit a wide range of competencies such as athletic, musical, artistic, or writing talents as well as problem-solving skills. Remarkably, the true level of competency, or specific activity, matters less than the mere perception of competency on the part of the individual. It is the perceived competence and confidence in one’s ability, that seems to propel resilient people into higher education, entrepreneurship, or passionate hobbies and avocations.

The underlying neurophysiological mechanism by which perceived competency works its magic may partially involve testosterone, which has beneficial effects on mood in both men and women. Findings from tests of social competence indicate that winners of many types of games gain a transient increase in testosterone. Moreover, testosterone levels correlate with social dominance in many animal societies, and in humans, achieving a sense of competency or ascendency in one’s chosen skill may raise testosterone, and confer a protective effect.

Resilient individuals often exhibit a perception of control (ie, internal locus of control). The underlying neurophysiological mechanism involves modulation of the hypothalamic pituitary adrenal axis (HPA) and cortisol release. Animals and humans attenuate stress response and cortisol release if they have a perception of control, even in the context of aversive experiences. Having a perception of control is the resilient antidote to the damaging neurophysiological effects of “learned helplessness” among trauma

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There are roughly 1 million lesbian, gay, bisexual, transgender, and queer (LGBTQ) adults who are 65 years or older, and this number is expected to double by 2030. They are a vastly diverse group with unique health care needs. However, research on aging LGBTQ populations has been historically neglected. Large-scale surveys have traditionally excluded sexual orientation and gender identity. Before 2000, research was limited to a few small studies.  

This began to change after the Institute of Medicine recognized these critical gaps and set federal milestones to change this. Several studies emerged. One of them is Caring and Aging with Pride, a 2010 national survey of 2560 LGBTQ adults aged 50 and older. More than 500 of whom are older than 65.4

### Essential terminology

There are many terms that capture the diversity of the LGBTQ community. Sexual orientation is a broad term used to describe a person to whom someone is physically, emotionally, or romantically attracted. Some may identify as straight, lesbian, gay, bisexual, pansexual, queer, or a number of other sexual orientations. Clinically, it is important to not immediately assume that because one identifies as heterosexual, he or she has not had sexual contact with someone of the same sex—particularly when assessing risk of sexually transmitted infections. 

A 2003 New York City survey found that 9.4% of men who identified as heterosexual reported having sexual intercourse with at least one man in the past 12 months. The term queer was a slur that has been recently reclaimed by many in the LGBTQ community and can describe those who don’t neatly fit into any sexual or gender categories. It is a controversial term, and it is often avoided by those for whom this still evokes negative connotations. In lieu of the LGBTQ acronym, the US federal government and the National Institutes of Health often use the term sexual and gender minority to be more inclusive.5

Gender or gender identity can be defined as one’s inner sense of being male, female, both, or neither. Sex, however, is generally based on anatomical or biological characteristics, such as genitals, chromosomes, and/or hormones. Gender expression or gender role describes one’s outward manifestation of gender identity, which includes clothing choices, mannerisms, and social interactions. One may identify as transgender if one’s gender identity doesn’t fit with the sex assigned at birth. Cisgender refers to persons whose gender identity matches their sex. Many view gender as a socially constructed binary between male and female; however, this is not the case. There are a growing number of gender-nonconforming, gender-fluid, and non-binary individuals who do not fully identify as male or female and who live outside the gender binary.6

In the clinical encounter, knowing and respecting a patient’s preferred pronouns are essential to creating a safe space. They may be masculine (he/him), feminine (she/her), or gender neutral (ze/zeir/singular they). This may or may not match what is indicated in their medical record, so it is important for clinicians to politely inquire if they are unsure.

### Historical context

To understand the experiences and needs of the aging LGBTQ population, it is important to consider the culture, politics, and social norms that existed when these elders came of age, because each affects identity development and self-perception. It also teaches us to note important distinctions among different cohorts within the aging LGBTQ population. For example, a significant proportion of the aging LGBTQ population—particularly those born before 1945—came of age in an environment where same-sex behavior was highly stigmatized and illegal in many places. Hiding one’s sexual orientation was essential for survival. This started to change with the Civil Rights Movement and sexual revolution of the 1960s. The Stonewall Inn riots of 1969 led to the growth and expansion of the Gay Liberation Movement in the early 1970s. In 1973, the American Psychiatric Association removed homosexuality from DSM. Prior to this, it was considered a sociopathic personality disorder that warranted the need for numerous conversion therapies to “cure” individuals with same-sex attractions and/or behaviors. The historic stigmatization of same-sex attraction as a mental illness has led to a lasting distrust and fear of psychiatrists and other health care providers. In the 1970s, more LGBTQ people came out and became more visible and vocal. Burgeoning gay and lesbian communities grew in major urban hubs. However, in the early 1980s, the rapid spread of HIV and AIDS led to millions of deaths—devastating many communities. Inaction and indifference by government agencies, such as the National Institutes of Health and the FDA, led to the formation of several activist organizations, such as ACT UP, to counter this. It also fueled the assumption that the medical establishment is not to be trusted.

The transgender and gender-nonconforming community has also experienced a long history of stigma, prejudice, and fear. After homosexuality was removed from the DSM, there was a continued pathologization of transgender identities by maintaining the diagnosis of gender identity disorder, which was changed to gender dysphoria in DSM 5.7 Although the existence of a diagnosis is controversial, many argue that it is necessary to compel insurance companies to cover hormone therapy, gender-affirming surgeries, and other treatments. Moreover, there is ongoing conflict between trans patients and clinicians regarding the clinicians’ role as gatekeepers who have traditionally restricted access to medical and surgical interventions. This role can make establishing a therapeutic relationship with trans patients more challenging.

### Disparities and minority stress

The existing literature on LGBTQ elders shows higher rates of legal and economic discrimination, rendering them less likely to have sufficient financial resources to care for themselves or to obtain proper health care. LGBTQ older adults are more likely to have poorer mental health: 31% of LGBT elders have symptoms of depression—2 to 3 times higher than the general geriatric population; 39% report having suicidal ideation at some point in their lives. Among the transgender elderly, 48% report symptoms of depression and 71% report a history of suicidal ideation. And, LGB individuals are 2 to 3 times more likely to have a substance use disorder. They are more likely to smoke and engage in excessive drinking and risky sexual behavior. The risk increases among those who report higher levels of internalized homophobia.

LGBTQ older adults also report higher levels of disability and poor physical health. Lesbians and bisexual women are at increased risk for cardiovascular disease, are more likely to be obese, and have a lower likelihood of getting a mammogram.

### TABLE. Resources and organizations dedicated to aging LGBTQ populations

<table>
<thead>
<tr>
<th>Organization</th>
<th>Description</th>
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<tbody>
<tr>
<td>National Resource Center on LGBT Aging (<a href="https://www.lgbtageningcenter.org">https://www.lgbtageningcenter.org</a>)</td>
<td>A compendium of resources dedicated to improving the quality of services and supports offered to LGBT older adults</td>
</tr>
<tr>
<td>Advocacy and Services for LGBT Elders (SAGE) (<a href="https://www.sageusa.org">https://www.sageusa.org</a>)</td>
<td>Founded in 1978, SAGE is the largest and oldest organization dedicated to improving the lives of LGBT older adults</td>
</tr>
<tr>
<td>The LGBT Aging Project (<a href="http://fenwayhealth.org/the-fenway-institute/lgbt-aging-project/">http://fenwayhealth.org/the-fenway-institute/lgbt-aging-project/</a>)</td>
<td>Sponsored by Fenway Health in Boston</td>
</tr>
<tr>
<td>LGBT Aging Issues Network (LAIN) (<a href="http://www.asaging.org/lain">http://www.asaging.org/lain</a>)</td>
<td>Sponsored by the American Society on Aging, LAIN seeks to foster professional development, research, and dialogue on LGBTQ issues</td>
</tr>
<tr>
<td>The Transgender Aging Network (TAN) (<a href="http://forge-forward.org/aging/">http://forge-forward.org/aging/</a>)</td>
<td>Provides numerous publications and a few listservs that focus on the needs of aging transgender individuals</td>
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than heterosexual women. Gay and bisexual men have higher rates of asthma, hypertension, and HIV infection. The prevalence of HIV infection increases among transgender women, African Americans, and Latinas compared with white LGBTQ older adults.

Minority stress theory conceptualizes this by suggesting that higher levels of social stigma, prejudice, and victimization lead to a greater risk of adverse health effects. This applies to LGBTQ older adults, of whom 82% have experienced at least one lifetime episode of victimization because of actual or perceived sexual and/or gender identity; 64% report at least 3 episodes. Fear of discrimination or going back into the closet also serves as a major barrier to seeking healthcare. Many are reluctant to come out to their clinicians—21% report not revealing their LGBTQ identity to their healthcare provider. Among bisexuals, this percentage increases. Many cite fear of being treated differently or receiving subpar care because of their sexual orientation or gender identity.

While the literature does not show an increased likelihood of neurocognitive disorders, LGBTQ elders are more likely to lack available caregivers or face risk of discrimination in nursing homes and other care facilities. Compared with their heterosexual counterparts, they are more likely to live alone and less likely to be married and have children, which affects their ability to find dedicated caretakers as they age. Older lesbians and gay men tend to delay entering residential care out of fear of discrimination; 75% believe these facilities do not include anti-discrimination policies, and 34% believe they would have to conceal their sexual orientation to live within the facility.

Resilience
In spite of the existence of numerous sources of adversity, most aging LGBTQ individuals are in good health, are aging well, have high satisfaction with their lives, and have strong personal and social ties with others. Some argue they may actually be more equipped to accept aging than their heterosexual counterparts. This may be explained through crisis competence theory, which states that the experience of coping with stigmatization earlier in adulthood (i.e., being LGBTQ) may better equip a person to cope with the stigma associated with aging.

Community also plays a big role in this. In the Caring and Aging with Pride study, 90% of participants reported feeling good about belonging to their communities. Although LGBT elders are less likely to have biological children, on whom they can rely as caretakers, 75% report having “second families” or “families of choice” that are based on long-term friendship, mutual support, and love; 89% report having at least 3 people they can count on if they encounter a “serious problem.”

Factors that encourage successful aging in LGBTQ adults include having a positive self-identity, socioeconomic resources, access to healthcare, a life partner, and both informal and community-based supports. Most of the research on resilience focuses on lesbian and gay older adults, and little is known about resilience among bisexual and trans elders; however, one focus group study reveals trans elders build and maintain their resiliency through volunteering, teaching, and engaging in advocacy and LGBTQ events.

Creating a safe and welcoming environment
Before the clinical encounter:
1. Educate yourself on the health needs of the aging LGBTQ population. LGBTQ older adults have often needed to educate their clinicians on basic terminology or identities. (See Table for several resources.)

2. Familiarize yourself with the concept of gender diversity and with the evaluative process for gender dysphoria. The Standards of Care, published by the World Professional Association for Transgender Health, is a helpful resource.

3. Educate your nursing and ancillary staff, such as administrative assistants, medical assistants, and security staff. The National LGBT Health Education Center offers online training.

4. Add questions about sexual orientation and gender identity on patient registration forms (Sidebar).

5. Place objects in your office or the waiting room that indicate your office is a safe space—this may include rainbow stickers, pride posters, and related reading materials. LGTBQ patients often look for clues to assure them that coming out is accepted and encouraged.

6. Check whether your institution’s nondiscrimination policies include sexual orientation, gender identity, and gender expression. You can also check to see if your facility is listed in the Healthcare Equality Index, which is a national benchmarking tool sponsored by the Human Rights Campaign.

7. Offer gender-neutral bathrooms for transgender and gender-nonconforming older adults. Some therapists offer a “gender closet,” a safe space where patients can explore different forms of gender expression.

During the clinical encounter, keep in mind the historical context. Older LGBTQ adults consistently report feeling skeptical of healthcare professionals and reluctant to rely on a system that has traditionally discriminated against them. It may take some additional effort to gain their trust. When asking about sexual orientation or gender identity, ask relevant questions with explanations about why the information is needed to avoid the perception of intrusion or excessive curiosity. Remember that not every LGBT patient—even when asked—will disclose true sexual orientation or gender identity at first.

Don’t assume patients are heterosexual or cisgender. Clinical questions should be inclusive and avoid making assumptions about the patient’s sexual behavior or relationships. For example, when asking about relationship status, avoid gendered words such as “husband” or “wife.” Ask patients what pronouns they use (masculine/feminine/gender neutral) and apologize if you accidentally use the wrong one.

Explore risk factors for poorer physical and/or mental health, including history of victimization and trauma, internalized stigma, long-term concealment of sexual identity or gender identity, isolation, and lack of connection to the LGBTQ community. Explore existing or potential protective factors such as active involvement with community and/or religious organizations (not necessarily LGBTQ oriented), existence of positive coping mechanisms, having a positive sense of sexual or gender identity, and having adequate financial and health care resources.

If relevant, explore if, when, and how they came out, and discuss any concerns or fears about being out and aging. If they are out, explore their relationship with the LGBTQ community. Ask about past experiences of victimization and loss related to their LGBTQ identity—including whether they have ever been coerced or forced into psychiatric treatment, subjected to some form of conversion therapy, lost family or friends to HIV infection or other illnesses, or lost relationships and friendships because of being LGBTQ.

Encourage patients to prepare an advance directive or living will that can inform others of their wishes should they be unable to make decisions for themselves. This is particularly important for LGBTQ elders because same-sex partners are sometimes not given automatic next-of-kin status in hospitals. These documents can also request that medical (CONTINUED ON PAGE 27)
Where There’s Smoke, There’s Fire

SPECIAL REPORT

INFLAMMATION AND PSYCHIATRY
PART 2

Roger S. McIntyre, MD and Carola Rong, MD

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Abnormalities in the inflammatory system are linked to many brain-based disorders, including but not limited to, MDD and bipolar disorder (BD). The impetus to consider inflammation as potentially relevant to the pathoetiology of domain-based psychopathology (eg, anhedonia) and/or mental disorders, is provided by a confluence of factors.

Many individuals who receive conventional treatments for mood disorders do not achieve/sustain symptom remission. Patient reports also indicate that among those who experience “clinically relevant improvement,” significant deficiencies and dissatisfaction with treatment remain, particularly as it relates to experiences in positive mental health, vitality, resiliency, and premorbid levels of function.

Support for research on inflammation in psychiatry comes from advances in the characterization of neurobiological alterations in individuals with brain-based disorders. The ability to identify and characterize genomic variants in large data sets using Genome-Wide Association Studies, as well as a fuller understanding of the role of microRNA. Finally, the Research Domain Criteria initiative of the NIH, has brought the field to the attention of common dimensions/domains of psychopathology regardless of DSM category.

Evidence implicates inflammation as a fundamental neurobiological alteration, thus targeting this system may provide beneficial effect on illness trajectory. Preliminary evidence indicates that some anti-inflammatory treatments are not only generally effective in mitigating dimensional psychopathology measures, but may have additional benefits on comorbidity that differentially affects individuals with mood disorders (eg, obesity).

Neurobiology of inflammation

The inflammatory system can be classified into either the innate or the adaptive immune system. The innate system is primordial with low memory capacity present throughout much of the animal species and comprising multiple cellular populations including but not limited to monocytes. The adaptive and/or humoral immune system is responsible for humoral immunity (eg, antibodies) and is comprised of cellular populations (B and T cells) that are capable of recognizing billions of different antigens.

The primary role of the inflammatory system dating back to early humanity was to fight off pathogens, which often came from wounding at the hands of predators and other humans. Inflammation was also key for wound healing. The agricultural revolution occurred approximately 10,000 to 12,000 years ago and brought humanity into close proximity with animal-borne pathogens. While this had the negative effect of increased mortality in the short term, in the longer term, it may have also fortuitously augmented immune-inflammatory capability. Advances in food production, agriculture, hygiene, sanitation, urbanization, as well as vaccination, all have contributed to the shift away from infectious disease, and to chronic non-communicable diseases as the principle source of morbidity and mortality.

Notwithstanding the fact that predators and pathogens are no longer the principle instigators of the inflammatory system, the system is still wired to react to “threat” without regard to cause. For much of the past century, causes such as urbanization, dissolution of family structure, social alienation, air pollution, and exposure to refined high-glycemic high-calorie foods, along with financial stressors, have become principles triggers of the inflammatory system.

Consequently, “low-grade” inflammation is now implicated as cause, consequence, and comorbidity of many noncommunicable diseases, including mood disorders.

Findings indicates that many individuals with mood disorders exhibit alterations in both innate and adaptive immune systems in both the peripheral and central compartments. For example, comprehensive reviews and meta-analyses indicate that pro-inflammatory cytokines and acute phase proteins (eg, C-reactive protein (CRP), interleukin-1, interleukin-6, tumor necrosis factor-α), are abnormal in individuals with mood disorders. Rather than conceptualize mood disorders as associated with elevated proinflammatory markers, it is more accurate to state that mood disorders are associated with a pro-inflammatory balance (ie, relative increase in proinflammatory markers associated with relative decrease in select anti-inflammatory markers). The consequence is an abnormal “inflammatory biosignature.”

But what is the extent to which the disturbances in the inflammatory system proceed, cause, are associated with, and/or are consequences of mood disorders? Each of these possibilities could be of relevance in any patient. Results from longitudinal studies show that a proinflammatory balance is associated with an increased risk for incident mood disorders. For some individuals with mood disorders, perturbations in the inflammatory-homeostatic network are more pronounced during a state of depression compared with periods of remission. Mechanistically, this may be related to proinflammatory effects of sleep disruption, chaotic eating patterns, as well as dysphoric cognitive emotional processing. For other individuals, the magnitude of disturbance in the inflammatory system may be greater later in the illness.
INFLAMMATION AND PSYCHIATRY

SIGNIFICANCE FOR PRACTICING PSYCHIATRISTS

Clinicians who provide care to persons with mood disorders should consider the possibility of inflammatory alterations as contributory to the primary illness process as well as comorbidity and possibly a point of intervention.

- Disturbances in neuroinflammation are implicated in the etiology and progression of individuals with mood disorders.
- Alterations in inflammation may also provide a partial explanation for comorbidity and mood disorders.
- Behavioral strategies (eg, diet, exercise, improved sleep hygiene) should be understood as anti-inflammatory approaches; psychosocial therapies (eg, mindfulness-based therapy), and a variety of pharmacological treatments for depression (eg, lithium) have immune-modulating effects.

Other anti-inflammatory approaches that appear promising include the use of minocycline 60 to 200 mg daily, which has demonstrated beneficial effects on negative and cognitive symptoms of schizophrenia, as well as depressive symptoms of bipolar disorder.10,11 The antidiabetic agent liraglutide, which also targets the inflammatory system, is FDA-approved for not only type 2 diabetes but also weight loss.12 Preliminary proof-of-concept data indicate that liraglutide may improve depressive and cognitive symptoms in adults with bipolar disorder. A randomized placebo-controlled double blind proof-of-concept study is evaluating infliximab for adults with bipolar disorder, who have pretreatment elevated CRP levels; results are expected in July of 2018. Finally, renewed interest in the gut microbiome/microbiota provides convergent evidence indicating that for some individuals with mood disorders, disturbances in the inflammatory system may be partially mediated by gut dysbiosis. It is not known, however, whether dietary manipulation, as a single modality intervention, is sufficient to correct gut dysbiosis and normalize a proinflammatory balance associated with improvement in psychopathology.

Summary

For some individuals with mood disorders, disturbances in the inflammatory system are directly causative of select symptom/domain of psychopathology (eg, fatigue, anhedonia, cognitive impairment). The pivotal role played by inflammatory systems suggests that engaging with this target could modify illness trajectory in mood disorders.

In the short term, what type of “anti-inflammatory” approaches should clinicians consider for their patients? Sleep hygiene, normalization of sleep behavior, and resetting of sleep systems relevant to psychopathology in select individuals. Psychosocial interventions (eg, mindfulness-based therapies) exert anti-inflammatory effects and beneficial effects for individuals who have been affected by trauma, which in itself may be an antecedent to mood disorders s well as a proinflammatory trigger. In addition, the significant contribution of comorbidity (eg, obesity) to inflammation invites the need to specifically target these conditions when present, reiterating the emphasis on the need for treating the entire patient.

Currently no anti-inflammatory agent can be considered as being ready for “prime time” or highly recommended for use in persons with mood disorders either along with, or adjunctive to other agents. Instead, select anti-inflammatory agents should be considered promising, with a need for more evidence to establish efficacy, short- and long-term safety, as well as to identify which populations are more-or-less likely to respond.

It is not without interest, however, that preliminary data suggest that short-term exposure to minocycline, liraglutide, omega-3 fatty acids, as well as ketamine and L-methylfolate, may be preferentially effective in patients with a proinflammatory balance. Rigorous studies are needed to evaluate dietary interventions that specifically target the gut enterotype as potentially anti-inflammatory and anti-depressant/pro-cognitive.

From a population health perspective, it would be propitious to evaluate the effect of “anti-inflammatory approaches” such as the removal of soft drink machines from public schools on brain health, as well as a fuller characterization of the proinflammatory effects of urbanization, social isolation, and climate change on incident depression. Climate change is particularly relevant in some parts of the world, with emerging evidence that links air pollution and suicide.

Dr. McIntyre reports that he is on the Speakers Bureau for AstraZeneca, Bristol-Myers Squibb, Janssen-Ortho, Eli Lilly, Lundbeck, Pfizer, Shire, Otsuka, Purdue, Takeda, and Allergan; he has received research support/grants from Stanley Medical Research Institute, National Alliance for Research on Schizophrenia and Depression (NARSAD), and National Institutes of Mental Health. Dr. Rong reports no conflicts of interest concerning the subject matter of this article.

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trajectory after multiple episodes, suggesting a communicative and/or consequential effect.

Additional confounding factors relevant to mood disorders are the effect of comorbidity on the inflammatory system and iatrogenic effects. For example, overweight/obesity, as well as diabetes mellitus, are associated with abnormalities in the inflammatory system, while some medications (and other treatment modalities) may exert either salutary and/or amplifying effects on the proinflammatory balance (eg, lithium and weight-promoting drugs respectively).

Advances in neuroscience have enabled the identification of disturbances in the inflammatory system across multimodal and multilevel units of analysis. Disturbances in the inflammatory system have been identified in genetic variance, peripheral and central cytokine alterations, brain nodal structure, and circuit alteration in response to inflammatory challenge. Moreover, findings indicate associations between inflammation and motivation, reward, cognitive emotional processing, and cognition.

Can anti-inflammatory treatments ameliorate depressive symptoms?

Conventional treatments for mood disorders can exert clinically mediated effects on the human inflammatory system. It is largely a consequence of the “streetlight” effect that relatively little attention has been given to it, with most of the emphasis over the past several decades on the monoamine system. It is not without historical interest that the first Nobel prize in medicine and physiology awarded to a psychiatrist was for the therapeutic effects of malaria fever for individuals institutionalized in insane asylums.4

Conventional pharmacotherapy (eg, SSRIs), as well as other classes of psychiatric medication (eg, lithium) exert effects across disparate levels of the inflammatory system. Perhaps the most compelling proof-of-concept that SSRI therapy indirectly engages inflammatory systems is replicated evidence that the prophylactic use of SSRI reduces the hazard for incident depressive episodes in persons receiving interferon-α therapy for hepatitis C or cancer. Conventional pharmacotherapies, small to moderate-sized study trials, as well as systematic reviews and meta-analyses, give reason to believe that clinically significant benefits within dimensional measures of depression, anxiety, anhedonia, and cognitive functions may be realized with these treatments. Rather than conceptualize anti-inflammatory agents as mechanistically identical, it would be more accurate to evaluate these agents separately according to their postulated mechanism of action, as not all agents can be expected to be helpful, and some may even engender psychopathology. For example, corticosteroid therapy prescribed to individuals with established or latent mood disorders unequivocally exacerbate risk and severity of mood disturbance in select cases. Moreover, available evidence indicates that NSAIDs may interfere with optimal antidepressant efficacy. It is conjectured that deleterious effects of corticosteroids on cognitive emotional processing are in part due to “off-target” effects of these agents (ie, suppressing endogenous anti-inflammatory effects and amplifying proinflammatory balance), while for NSAIDs they may alter critical molecular targets relevant to SSRI efficacy.

It may be that the beneficial effects of anti-inflammatory interventions are elevated in discrete subpopulations with mood disorders with perhaps less meaningful effects in other subpopulations. For example, infliximab, FDA-approved for several inflammatory related conditions, significantly mitigates depressive symptom severity in individuals with elevated pre-treatment CRP levels, but not in depressed individuals with lower CRP levels. Furthermore, a proinflammatory balance observed in pretreatment may also identify a subgroup of individuals more likely to benefit from other approaches that engage inflammatory systems (eg, omega-3 fatty acids, ketamine, L-methylfolate, aerobic exercise).1-3 Nonpharmacological approaches (eg, electroconvulsive therapy, mindfulness-based therapy, aerobic therapy), are all “anti-inflammatory,” indicating that the inflammatory system is a convergent target across multiple treatment modalities.1,9

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Smoke and Fire

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Why Are Depressed Patients Inflamed? A New Path to Personalized Treatment in Psychi atr y

» Carmine M. Pariante, MD, PhD

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With 7 meta-analyses published on this topic between 2009 and 2017, there is little doubt that patients with major depres- sion have, on average, have increased activity of the inflammatory system. This is indicated by raised circulating levels of proinflammato- ry cytokines, such as interleukin (IL)-6 and tumor necrosis factor (TNF)-α, and of acute phase proteins such as c-reactive protein (CRP). However, not all depressed patients have increased inflammation.

Using the American Heart Asso- ciation definition of high cardiovas- cular risk (CRP >3 mg/L) to identify “inflamed” depressed patients, only approximately one-fourth to one-half of all depressed patients reach this threshold. Raison and colleagues1 report that 45% of treatment-resistant depressed patients in a clinical trial with infliximab had a CRP concen- tration greater than 3 mg/L. Similar findings were seen by Rethorst and collea- gues.2 A slightly lower rate was found by Wysokinski.3 Remarkably, we still do not know the factors that lead to increased inflammation in these depressed patients.

The role of early life stress

Results from our research show in- creased inflammation not only in de- pressed patients who have a history of childhood maltreatment but also in persons who have experienced mal- treatment but who are not depressed.4 These findings suggest that exposure to childhood maltreatment is a poten- tial risk factor for depression.

In a subsequent study, we found that inflammation is increased also in depressed patients with lower so- cioeconomic status in childhood or adulthood, and in patients with more cardiovascular risk factors, such as being overweight or having high blood pressure, high total cholester- ol, and high glycated hemoglobin.5 However, early life stress increases CRP levels over and above these other confounders.

These findings were replicated in other studies. In a meta-analysis of the literature on the effects of early life stress on inflammation, early (mostly prepubertal) exposure to physical and sexual violence, or se- vere social deprivation increased in- flammation in young adults—espe- cially (but not only) if depressed.6

More recently, we have been able to replicate the association between early life stress and increased in- flammation in young adults who have been exposed to stress not in childhood but in utero because of a history of depression.7–9 In a subsequent study, we found that offspring exposed to ma-ternal depression, now young adults, have increased inflammation as shown by raised CRP levels, in the absence of any depressive symp- toms. Thus, exposure to stress in utero is associated with increased in- flammation in adulthood as a risk factor for depression, rather than be- ing a consequence of depression.

The role of immune genes

We recently reviewed the effects of immune gene variants on depres- sion’s severity and response to anti- depressant treatment.10 Based largely on candidate-gene studies, findings indicate that common genetic vari- ants are involved in both immune activation and depression. The most replicated and relevant genetic vari- ants include single nucleotide poly- morphisms (SNPs) in the genes for interleukin (IL)-1β, IL-6, IL-10, TNF-α, phospholipase A2, and CRP.

Moreover, a number of studies have shown that the effects of some SNPs may only become evident in the presence of life stressors, through a “gene—environment” interaction. For example, Kovács and collea- gues11 report that the high—IL-1β T allele of the rs16944 SNP leads to increased depressive symptoms in adults, but only in individuals exposed to early life stress. Similarly, we have recently found that a poly- morphism in the alpha-2-macroglo- bulin, an acute phase protein that is activated during inflammation, leads to depressive symptoms but only in the presence of a history of early life stress.12

The role of omega-3 fatty acids

The BanII polymorphism of the cyto- toxic phospholipase A2 (cPLA2) gene13 and the rs4648308 polymor- phism in the cyclooxygenase 2 (COX-2) gene regulate the risk for depression in patients exposed to in- feron (INF-α).14 Interestingly, car- riers of the 2 genotypes were found to have lower levels of the omega-3 fatty acids, docosahexaenoic acid (DHA) and eicosapentaenoic acid (EPA), before and during IFN-α treatment.

Considering the putative antidepres- sants and anti-inflammatory ac- tion of these omega-3 fatty acids, we speculated that genetically driven low levels of these endogenous anti- inflammatory compounds increase the risk of inflammation-induced de- pression. We followed-up this initial observation with a clinical trial, which showed that prophylactic treatment with EPA and DHA (fill- ing the putative endogenous anti-in- flammatory reserve) prevents or de- lays the onset of INF-α induced depression.15

Our findings are consistent with a recent clinical trial by Rapaport and colleagues14 who used immune bio- markers to predict treatment re- sponse to EPA (vs placebo) as nutri- tional treatment for depression. Participants with increased inflam- mation improved more on EPA than placebo. These findings confirmed the notion that increased inflammation can characterize a group of de- pressed patients who are more likely to benefit from treatment with omega-3 fatty acids. It is interesting to note that subjects with no inflamma- tion did better on placebo than on EPA.

Response to conventional antidepressants

Depressed patients who are resistant to conventional antidepressants tend to have higher concentrations of im- mune biomarkers, both as plasma/ serum proteins and as blood mRNA levels. Blood mRNA levels of 2 pro- inflammatory cytokines—macro- phage inhibiting factor (MIF) and IL-1β—are accurate and reliable prospective predictors of antidepres- sant response.15 We independently replicated these findings in 2 clinical samples. Both samples demonstrated identical positive predictive values and specificity of 100% for future non-responders.

...
A larger, GENDEP sample, provides evidence that increased inflammation can predict better response to some antidepressants. High levels of serum CRP predicted lack of treatment response to the SSRI, escitalopram, but not to the tricyclic (and noradrenergic uptake inhibitor) nor-triptryptane. The researchers explain this by speculating that antidepressants with a noradrenergic action may have anti-inflammatory properties and are thus more likely to be effective in patients with high inflammation.

Interestingly, molecular analyses can explain why 2 immune biomarkers (MIF and IL-1β) may be better predictors than one biomarker alone (CRP). Functionally, CRP is only loosely connected with IL-1β (it is not connected with MIF), which indicates that patients with high levels of CRP may differ from those with high levels of MIF or IL-1β. CRP levels in the study undertaken by Uher and colleagues predicted a response by only about 11% compared with 40% to 50% of the variance explained by cytokines mRNA levels in our study.

Because MIF and IL-1β are functional neighbor targets, it is possible that having high levels of either of these cytokines is enough to activate downstream targets of both, thus affecting the neuroplasticity targets of MIF and the neurodegeneration targets of IL-1β. These widespread molecular abnormalities would likely inhibit the response to a wide range of antidepressants.

These findings and those for omega-3 fatty acids confirm the notion that high levels of inflammation identify a group of depressed patients who are less likely to respond to conventional antidepressants. Indeed, these patients can benefit from nutritional interventions or from specific antidepressants that may have anti-inflammatory properties.

**Personalized treatment**

Perhaps the strongest evidence that supports the role of immune biomarkers in personalizing the treatment of depression comes from the clinical trial in which infliximab was used as an adjuvant strategy to treat severe, treatment-resistant depressed patients. The study found that only depressed patients with high levels of inflammation (in this case, CRP > 5 mg/L) respond to infliximab, while the anti-inflammatory is detrimental to mental health in patients with no inflammation, who respond better to placebo. These findings are similar to those of Rapaport and colleagues, who found that patients with increased inflammation improve more on EPA than placebo, and patients with no inflammation improve more on placebo than on EPA. Ongoing clinical trials are attempting to replicate these findings using adjuvant treatment with other anti-inflammatory therapies such as sirukumab (ClinicalTrials.gov Identifier: NCT02473289) or minocycline (EudraCT Number: 2015-003413-26).

**A new scenario in clinical practice**

Together, the studies reviewed in this article provide a new model for clinical practice—one where the treatment of depressed patients is not governed by trial and error, but rather where patients with treatment-resistant depression can access new interventions sooner. This model would allow patients with inflammation above certain thresholds access to more assertive antidepressant strategies, including augmentation with antidepressants and nutritional strategies, or directly with anti-inflammatory therapy. Patients with inflammation below the suggested cutoffs could be directed toward usual care.

Randomized controlled trials that test the efficacy of using blood-based biomarkers compared with treatment as usual need to be undertaken that can provide clear guidelines for a personalized approach. We still do not know if there is a difference in the potential antidepressant action of different anti-inflammatory drugs; we do know that there is an increased risk of adverse effects, such as gastric bleeding, when combining most conventional antidepressants with anti-inflammatory drugs. Therefore, we are still a long way from prescribing or advising patients to take aspirin for their depression. In the meantime, high-dose EPA (at least 1 g/d) is a safer, and thus more routinely advisable, adjuvant strategy for depressed patients with high inflammation until we have such clear guidelines.

Professor Pariente has received consultation fees from Eleusis Ltd, research funding from Johnson & Johnson as part of a program of research on depression and inflammation, and research funding from the Medical Research Council (UK) and the Wellcome Trust for research on depression and inflammation as part of two large consortia that also include Johnson & Johnson, GSK, and Lundbeck.

## References


Geriatric Psychiatry

(Continued from page 29)

Staff respect the person’s gender identity and gender expression while incapacitated. Sample templates can be found on The Transgender Law Center website.

**Conclusion**

The aging LGBTQ population consists of numerous diverse, rich, and complex communities. While there are increased rates of depression and substance use disorders and increased reports of victimization and discrimination, there is also strong evidence of resilience and high rates of successful aging. Regardless, clinicians can play a vital role by creating a safe and open environment that allows people to be themselves.

[Dr. Johnson is an unpaid board member of Trans Bodies Trans Selves, a 501(c)3 nonprofit that is dedicated to empowering trans communities and publishes Trans Bodies, Trans Selves: A Resource for the Transgender Community.]

**References**

The Therapeutic Cannabis User: 5 Key Issues

Josef Witt-Doerring, MBBS and Thomas Kosten, MD

Dr. Witt-Doerring is a PGY 3 Psychiatry Resident; and Dr. Kosten is Professor of Psychiatry, Neuroscience, Pharmacology, Immunology and Rheumatology, and Vice-Chair, Psychiatry for Research, Baylor College of Medicine.

The first two decades of the 21st century have seen a shift in the public’s perception of therapeutic cannabis use. A drug once seen as a widespread danger to society is now experiencing renewed interest as a treatment for medical conditions, including a number of mental health conditions.¹

Unlike other federally approved drugs, which are vetted through carefully monitored clinical trials assessing both safety and efficacy, the legalization of whole plant cannabis products (WPCP) for medical use across states has been mostly decided through popular referendum. Presently, the efficacy and safety of therapeutic cannabis use in all mental health conditions remains equivocal and few medical indications are supported by clinical trial data.

The new wave of cannabis legalization has been accompanied by an increase in the dissemination of industry-driven marijuana advocacy content across all media platforms.² Consequently, recreational and therapeutic cannabis use is growing nationally without a strong foundation of clinical research to guide its use. Under these new conditions, psychiatrists are increasingly likely to encounter patients who report that they use cannabis to treat their mental health conditions, regardless of its legality in their state.³

The current use of cannabis for mental health conditions departs from the traditional paradigm of prescribed medications for clinical practice in 2 specific areas. First, doctors cannot base their treatment plans on high quality clinical trials. Second, doctors cannot reliably restrict access to cannabis as it is easily accessed through either legal or illegal avenues. As a result, many practitioners can find encounters with patients identifying as therapeutic cannabis users to be awkward and anxiety producing.

This brief review explores 5 key issues clinicians can consider when encountering the therapeutic cannabis user.

Limitations in the evidence base

There are anecdotal reports of WPCP improving symptoms across a range of mental health conditions, such as PTSD, depression, anxiety, sleep disorders, opiate dependence, traumatic brain injury, and even schizophrenia.¹ The classification of cannabis as a Schedule 1 drug has hindered research into its potential therapeutic applications. Conducting research into WPCP has required considerable resources and bureaucratic skill in negotiating with the National Institute on Drug Abuse and the Drug Enforcement Administration to execute these studies, and the results from these studies have been limited. (Moderate evidence was found that cannabinoids, primarily nabiximols, were an effective treatment in improving short-term sleep outcomes in individuals with sleep disturbance associated with obstructive sleep apnea syndrome.) A recent comprehensive review by The National Academy of Sciences, Engineering, and Medicine reported that there was limited evidence to support the use of WPCP for the treatment of mental health conditions.³ This conclusion followed from the absence of high quality data on effectiveness rather than the presence of disconfirming evidence or clear safety considerations, although safety concerns are raised about cannabis hastening the onset of schizophrenia in vulnerable individuals.

Clinical trials conducted by pharmaceutical companies have been the driving force of drug research since the latter 20th century. However, without the possibility of proprietary control over the botanical product, pharma has focused primarily on studying isolated and synthetic cannabinoids, which can be patented.

These products differ significantly in their specific effects and from tetrahydrocannabinol (THC), because most synthetics are full agonists, while THC is a partial agonist. Partial agonists are generally safer because as the dose is increased, these drugs act as antagonists blocking many toxic properties including overdose from the substance, in this case THC. Furthermore, THC compounds do not mimic the effects of WPCP as the synergistic effect of cannabinoids and terpenoids can create distinct pharmacological effects.⁴

Some states, notably Colorado and California, have increased support and funding for cannabis research to overcome these hurdles.⁴⁵ Subsequently, a number of ongoing studies are investigating the use of cannabis in treating PTSD. Unfortunately, it remains likely that high-quality trials investigating the therapeutic effect of cannabis in other mental health conditions will be slow as long as the current disincentives to bring our world back to life...
Cannabis use will no longer be supplanting use. Second, it allows clinicians and patients to preemptively assess when therapeutic cannabis use, but should counsel patients about the legal ramifications of using cannabis products within their own state. In all states, driving under the influence of cannabis is illegal, even if it has been prescribed for a medical condition. Similar to the driving-under-the-influence laws involving alcohol, if an offender has multiple past charges or is at fault in a serious accident, he or she can be charged with a felony. Marijuana paraphernalia should also be removed from vehicles because in some states this can be used as proof of cannabis intoxication even there hasn’t been any cannabis use. Cannabis concentrates such as waxes, tinctures, and oils are prosecuted differently among states. For instance, in Texas, marijuana concentrates are not considered marijuana by Texas courts and are instead grouped with more serious drugs such as ecstasy, MDMA or Molly, PCP, and mescaline. While possession of less than 4 ounces of pure leaf marijuana is typically classified as a misdemeanor, possession of cannabis concentrates is classified as a felony. Patients should be informed that a felony charge can seriously affect housing and employment prospects.

Adapting your practice

The psychiatric cannabis user can be a challenging patient to manage, because it can seem unethical to collaborate in a treatment plan involving a drug without a strong evidence base. However, clinicians who maintain this conservative position of viewing all cannabis use as a disorder needing treatment run the risk of appearing anachronistic and alienating patients.

The growing number of patients who use therapeutic cannabis do not have the same scruples as physicians do about using a drug without a traditional evidence base. Deferring to the lowest tier of evidence, these patients are satisfied using cannabis from their own anecdotal experience. Given the ubiquity of access to cannabis, with or without a prescription through legal or illegal channels, clinicians who want to remain relevant in treating therapeutic cannabis users must engage in earnest discussions about cannabis.

The effective clinician will create a non-judgmental environment that engenders the trust required to disclose therapeutic cannabis use. Once the alliance has been established the clinician can objectively discuss the pros and cons with the therapeutic cannabis user and the condition he or she is seeking to treat. Following the discussion, whether or not the patient decides to use cannabis, the clinician should provide assurance that he or she is available to work with the patient.

**Table DSM 5 criteria for cannabis use disorder severity**

<table>
<thead>
<tr>
<th>Criterion</th>
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<tbody>
<tr>
<td>• Used for longer periods in larger amounts</td>
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<tr>
<td>• Unable to cut down use</td>
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<tr>
<td>• Excessive time spent acquiring, using and recovering from cannabis use</td>
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<tr>
<td>• Strong urge to use cannabis</td>
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<tr>
<td>• Problems fulfilling work, school, and family obligations due to cannabis use</td>
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<tr>
<td>• Continued use despite persistent interpersonal problems caused by cannabis use</td>
</tr>
<tr>
<td>• Decrease in important social and recreational activities because of cannabis use</td>
</tr>
<tr>
<td>• Repeated use in physically dangerous situations</td>
</tr>
<tr>
<td>• Ongoing use despite worsening physical and psychological problems that are likely to have been caused by cannabis</td>
</tr>
<tr>
<td>• Have to use increased amount for the same desired effect</td>
</tr>
<tr>
<td>• Withdrawal reaction upon cessation</td>
</tr>
</tbody>
</table>

Mild: 2–3 symptoms; moderate: 4-5 symptoms; severe: ≥6 symptoms.

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**References**

Resilience (continued from page 21)

Based on neuroceptive perceptions, bedded in a subjective neural system. Stress or safety arise from our process-alike reactions. The realization that our neurophysiological systems are the emergence of resilient youths. The HPA axis, and likely contributes to establishing strong circadian rhythms such structured living environments to give their children the sense of safety, circling back to the ironic sinus arrhythmia and auditory processing in autism: modifiable deficit of an integrated social engagement system? Int J Psychophysiol. 2013;88:261-270.

It is not surprising that the perception of control is a very close proxy to a sense of safety, circling back to the neuroscience of safety. Overwhelmed, impoverished, or single mothers who nonetheless establish homes with routines, rules, rituals, chores, and positive discipline are in fact creating safe and predictable environments to give their children the perception of control. Immersion in such structured living environments establishes strong circadian rhythms and tunes the diurnal secretion of the HPA axis, and likely contributes to the emergence of resilient youths.

Positive perceptions and outlooks

The realization that our neurophysiological and behavioral responses to stress or safety arise from our processing of neuroceptive cues, leads to the inevitable conclusion that we live immersed in a subjective neural system. Based on neuroceptive perceptions, we calm or activate our restive physiology, activate our social engagement system, or grow guarded and defensive under threat. We engage in necessary or frivolous activities that make us feel as though we have control and help to distract us from stress. In large part, it is these perceptions, and the behaviors we produce from them, that determine our relative resilience.

The perception of control or competence can lower cortisol or elevate testosterone. In the same way, the perception of being loved, as evidenced to the brain by positive social or tactile cues, can increase oxytocin. Our knowledge of the action of mirror neurons has revealed that we can read the emotional perceptions off the faces of others, and enact them in our own brains, providing a mechanism to understand the reciprocity of social emotions, and how our perception of love from another can impact our own physiology. Among resilient children, merely having the perception that your parent loves you, even if absent or abusive, nonetheless serves as a protective factor.

The power of the perception of love is the only secular explanation for how faith in a loving deity has served as a protective factor. If absent or abusive, nonetheless if the power of faith in a loving deity has served as a protective factor. If absent or abusive, nonetheless, as it does for many resilient individuals. Likewise, resilient people may gain a perception of control as they generate realistic hopes and expectations for the future, in stark contrast to the outlook of futurelessness among drug addicts and trauma victims. Lastly, resilient individuals have the perception that they are resilient. Connor and Davidson found that adult medical patients who perceive themselves as resilient are more likely to have better health outcomes in a variety of medical conditions.

Cognitive behavioral therapy (CBT) has taught us that what we repeatedly think can influence how we behave. Therefore, CBT can serve as one tool to help patients change their perceptions to those of competence and control, of being loved, of future hopes, of faith, and of their own resilience. But the idea of sending all of our stressed-out patients to psychotherapy for CBT is no more realistic than telling them to eliminate the stressors from their lives.

Instead, let us suggest to our patients that they build their resilience by utilizing the intrinsic pathways that the parasympathetic social engagement system offers to give them a sense of competence and control. If we can help our patients enact the behaviors of a resilient life, their perceptions and neurophysiology are likely to follow.

Dr. Vance reports no conflicts of interest concerning the subject matter of this article.

References

Responding to the Opioid Epidemic and Expanding Access to Quality Treatment

The US is facing the largest epidemic of opioid overdose deaths in its history: in 2016, annual unintentional overdose fatalities from opioids are estimated to have exceeded 42,000 (more than 115 deaths every day).1 Approximately 2.4 million individuals in the US have an opioid use disorder (OUD). However, this number is likely an underestimate of the true burden.2 For instance, the National Survey on Drug Use and Health surveys about 67,500 non-institutionalized individuals each year.3 As a result, many at highest risk of OUD (e.g., incarcerated and institutionalized persons, the chronically homeless) are likely not to have been included. Moreover, recent fieldwork has shown that heroin use has been increasing more rapidly than may be reflected in national surveys.4

**CASE VIGNETTE**

“Vincent,” aged 28 years, is facing a 2-year sentence for a criminal charge (his first). He has been sniffing 8 to 10 bags of heroin a day for the past 6 months after regularly using 120 mg of oxycodone daily for the past 5 years. Initially, he only used oxycodone on the weekends when drinking with friends. Over a few years, the drug became a daily habit he needed to get through the work day. He has never been in drug treatment, but last year when he didn’t have enough money for oxycodone, he tried “bup” from a friend and it made him “sick.”

Vincent has managed to keep a construction job and works 6 AM to 3 PM most days. He lives with his mother. He says that he hates using heroin, but every time he tries to stop he has withdrawal symptoms, such as nausea, diarrhea, and muscle aches, and he cannot go to work. Sometimes if he doesn’t use, he becomes irritable with coworkers and debilitated by anxiety. He has not made it more than 24 hours without using for the past year. Aside from his drug addiction and related symptoms, Vincent denies other mood, anxiety, or trauma disorder symptoms.

**Clinical management of OUD**

Because OUD poses greater risks than other use disorders, it requires a different approach when evaluating risks and benefits of treatment. OUD is a chronic, relapsing disorder; therefore a treatment approach that involves only detoxification without maintenance medication is likely to be harmful because of the high risk of relapse and overdose.

**LEARNING OBJECTIVES**

At the end of this CE activity, participants should be able to:

- Evaluate the pros and cons of each of the three medications available in MAT
- Rationale the need for long-term treatment for best outcomes
- Understand the clinical management of opioid use disorder
- Explain the barriers associated with the use of MAT

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Methadone, FDA approved in 1972, is taken once daily. Methadone fully stabilizes opioid receptors for approximately 24 hours. Methadone maintenance is the most well-established treatment for OUD and when given at adequate doses (typically > 60–120 mg/d), is associated with reducing illicit opioid use and overdose death, with decreasing criminality, and with increasing employment.1 Methadone treatment for addiction is only available through strictly regulated opioid treatment programs accredited by the Substance Abuse and Mental Health Services Administration (SAMHSA). Persons with OUDs initially attend the opioid treatment program daily before receiving take-home doses.

Buprenorphine
Buprenorphine was FDA-approved in 2002 and works similarly to methadone but only partially activates opioid receptors, limiting overdose risk. Due to a lower risk of overdose than methadone, buprenorphine can be prescribed by physicians in general outpatient settings or attached to specialty treatment programs, also known as Office Based Opioid Treatment. Buprenorphine represents an important alternative maintenance treatment for patients unable or unwilling to attend methadone programs. Prescribers must go through a brief training and obtain a DEA “waiver.” Nurse practitioners and physician assistants can now also prescribe buprenorphine after obtaining a “waiver,” although they must first go through lengthier training. A major limitation of buprenorphine-based MAT is that providers are hard to find, especially in rural areas.

In general, patients with OUD have a 50% reduction in all-cause mortality while actively in treatment with methadone or buprenorphine.1 Given the robust evidence for clinical effectiveness, methadone and buprenorphine are included on the World Health Organization list of essential medicines, intended to be available and utilized in health systems at all times. Because of the tremendous benefits of buprenorphine for stabilizing active opioid use and reducing overdose risk, increased attention has been paid to innovative models for expanding access to same-day inductions such as through emergency rooms as well as expanding caseloads via tele-medicine.10

Which MAT modality would be the best fit for Vincent? What is the recommendation if Vincent also has chronic pain?
Buprenorphine may be the best fit for Vincent depending on local availability. With pain, buprenorphine dosed every 6 to 8 hours (ie, 4 mg q6h) would be preferable to methadone, which can accumulate in the blood levels over a one to two day period.

Naltrexone
Naltrexone completely blocks opioid receptors and has been available as an extended-release monthly injection (XR-naltrexone) since 2010. Naltrexone is FDA-approved in 2002 and works similarly to methadone but only partially activates opioid receptors, limiting overdose risk. Due to a lower risk of overdose than methadone, buprenorphine can be prescribed by physicians in general outpatient settings or attached to specialty treatment programs, also known as Office Based Opioid Treatment. Buprenorphine represents an important alternative maintenance treatment for patients unable or unwilling to attend methadone programs. Prescribers must go through a brief training and obtain a DEA “waiver.” Nurse practitioners and physician assistants can now also prescribe buprenorphine after obtaining a “waiver,” although they must first go through lengthier training. A major limitation of buprenorphine-based MAT is that providers are hard to find, especially in rural areas.

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Naltrexone
Naltrexone completely blocks opioid receptors and has been available as an extended-release monthly injection (XR-naltrexone) since 2010. Naltrexone can be given to protect patients from opioid relapse following detoxification. It has become a favored treatment option in many criminal justice settings, as patients do not develop tolerance or withdrawal while taking it and it cannot be abused.11 However, full detoxification from opioids before starting XR-naltrexone can be a hurdle to induction for many patients, especially those

Table 1 – The pros and cons of medication assisted treatment (MAT)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Pros</th>
<th>Cons</th>
</tr>
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<tbody>
<tr>
<td>Methadone</td>
<td>Easy induction following active drug use</td>
<td>Requires daily dosing initially for an extended period, often early morning</td>
</tr>
<tr>
<td></td>
<td>Lower medication costs but program fees vary</td>
<td>Many states and rural areas have limited or no access to programs</td>
</tr>
<tr>
<td></td>
<td>High retention rates at 12 months (~80%)</td>
<td>Programs can be targeted by drug dealers</td>
</tr>
<tr>
<td></td>
<td>Lowers drug use and criminal activity</td>
<td>Patients may combine benzodiazepines or other medications to boost methadone levels (ie, “nodding out”)</td>
</tr>
<tr>
<td></td>
<td>Long history of successful use among pregnant women</td>
<td>Can lead to cardiac arrhythmias</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>Minimal risk for overdose</td>
<td>Must be prescribed by a DEA-waivered clinician</td>
</tr>
<tr>
<td></td>
<td>Can be prescribed like any other Schedule III controlled substance</td>
<td>Patients must be in mild-moderate withdrawal before taking first dose (usually requires 12-36 h)</td>
</tr>
<tr>
<td></td>
<td>Flexible dosing (eg, daily or nightly, BID, TID)</td>
<td>Can precipitate painful withdrawal symptoms if taken too closely following full agonist opioids</td>
</tr>
<tr>
<td></td>
<td>Very good pain control when dosed every 6–8 hours</td>
<td>Has street value and can be sold/diverted</td>
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<tr>
<td></td>
<td>Often included in Prescription Drug Monitoring Programs (PDMPs)</td>
<td>Patients can intentionally space out doses and use in between</td>
</tr>
<tr>
<td></td>
<td>Likely has better outcomes for newborns with neonatal abstinence syndrome (compared to methadone)</td>
<td>Can be more easily manipulated and injected/abused than methadone dispensed from programs</td>
</tr>
<tr>
<td></td>
<td>Somewhat less stigma</td>
<td>Stigma remains</td>
</tr>
<tr>
<td></td>
<td>New injectable forms are coming to market requiring less frequent dosing</td>
<td></td>
</tr>
<tr>
<td>XR-Naltrexone</td>
<td>Also relieves cravings, like methadone and buprenorphine</td>
<td>Most difficult induction, requires full detoxification, typically &gt;7 days</td>
</tr>
<tr>
<td></td>
<td>Patients no longer fear going into withdrawal</td>
<td>Hard to find providers who have been trained to use</td>
</tr>
<tr>
<td></td>
<td>Blocks opioid use of any kind (this may be less true for some high potency fentanyl analogs)</td>
<td>Many insurers still do not cover as a pharmacy benefit and have tedious prior authorization processes hindering use</td>
</tr>
<tr>
<td></td>
<td>Injection has twice the retention rates of oral naltrexone</td>
<td>No pain relief and must be stopped for surgery/opioid analgesia</td>
</tr>
<tr>
<td></td>
<td>Less stigma</td>
<td>Lowers tolerance making patients more vulnerable to overdose risks with return to opioid use (this has been shown with oral naltrexone but not with XR-naltrexone)</td>
</tr>
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</table>

death following periods of abstinence.14 Medication-assisted treatments (MAT), methadone, buprenorphine, and extended-release naltrexone, approved by the FDA, have strong empiric evidence for superior outcomes compared with medication-free behavioral approaches or short-term detoxification.15 (Table 1 presents the pros and cons of MAT modalities; see Table 2 regarding MAT clinical management.)
with more severe addiction and psychiatric comorbidity. Regardless, recent head-to-head studies have shown that once patients initiate XR-naltrexone, they have similar or superior outcomes than those on buprenorphine.8

Would naltrexone work for Vincent? What if he also has chronic pain?

XR-Naltrexone is a good choice for Vincent. However, he would need to stop using for a week before he could receive a naltrexone injection. Moreover, with comorbid pain, Vincent would need additional non-opioid analgesia since naltrexone does not treat pain.

Long-term treatment

OUD is a chronic disorder that requires ongoing treatment. Most patients relapse following cessation of MAT and relapse carries a risk of sudden overdose death. Long-term retention in treatment is associated with the most favorable outcomes.13 In addition to well-established clinical effectiveness, MAT produces cost-savings throughout the health care system by reducing inpatient and outpatient service utilization, pharmacy costs, and total expenditures.14 As a result, efforts to improve long-term retention (ie, beyond a minimum of 6 months), as recently endorsed by the National Quality Forum, without limits on treatment duration are often needed to maximize outcomes. Contingency management, motivational interviewing, and cognitive behavioral therapy have all shown promise in improving retention rates on MAT pharmacotherapies.

There are no studies that show benefit from discontinuing MAT. In general, the longer the treatment, the better the outcomes. A minimum of 12 months improves results, but indefinite treatment under a chronic medical illness model is often necessary. Patients should only be discontinued when clinically indicated—not for insurance or financial reasons.

Barriers to evidence-based care with MAT

Despite strong evidence for the effectiveness of MAT, the rates of initiation and retention beyond 6 months are low.14 Currently only about 20% of the estimated 2.4 million individuals with OUD are engaged in treatment.15 And only approximately 35% of those in treatment receive one of the MAT medications upon entering specialty care; consequently, the 6-month retention rate is less than 30% to 50% in most settings. Only a fraction of individuals with OUD achieve long-term remission in the US following a single episode of care, which contributes to our escalating opioid overdose mortality rate.16

At present, barriers to receiving care with MAT span many aspects of the drug treatment system (Table 3). Seventeen states have Medicaid programs that do not cover methadone maintenance and publicly funded programs often arbitrarily limit treatment duration.17 Although addiction treatment has been deemed one of ten “essential health benefits” under the Affordable Care Act, methadone and buprenorphine maintenance has not been included in the mandate. Recently, professional and consumer advocacy groups have been petitioning CMS to explicitly mandate MAT coverage under essential health benefits for substance abuse treatment.

Even with private or public insurance coverage, patients with OUD are often difficult to engage in treatment. Many patients in need of substance abuse treatment lack insight into the severity of their condition and do not willingly seek treatment. Many primary care settings are ill equipped to treat psychiatric comorbidity among patients with OUD or lack the resources for comprehensive services to engage patients. Given these challenges, specialized addiction services provided through publicly funded substance abuse treatment programs (both outpatient and residential) are likely to remain vital to the care of patients who are addicted to opioids. Yet institutionalized ideology favoring medication-free (“abstinence-only”) approaches modeled on treating alcoholism in the mid-20th century persists throughout these programs and some patients feel stigmatized for using MAT.

Resources for the clinician

There is no simple solution for resolving an epidemic as complex as the current opioid crisis. However, clinicians throughout the health care system can identify and effectively treat patients with OUD to reduce the risk of overdose...
Table 3 – Barriers to accessing evidence-based care with MAT

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Methadone</th>
<th>Buprenorphine</th>
<th>XR-Naltrexone</th>
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<tbody>
<tr>
<td>Medicaid coverage limitations</td>
<td>17 states do not cover (methadone maintenance is not included under “essential health benefit” designation)</td>
<td>Some states limit lifetime use (1-3 years)</td>
<td>At least 10 states cover as a medical benefit (rather than pharmacy benefit); requires physician to purchase the medication up front and bill after it is administered</td>
</tr>
<tr>
<td>Medicaid prior authorization restrictions</td>
<td>Some states have duration of treatment limits or require copayments beyond 3-6 months of treatment</td>
<td>48 states require prior authorizations, restricting access (ie, through burdens on providers, requiring documentation of counseling for approval)</td>
<td>“Step therapy” requires patients to have failed other treatments prior to approval</td>
</tr>
<tr>
<td>Commercial insurance coverage barriers</td>
<td>Rare coverage of methadone under “essential health benefit” designation</td>
<td>Many plans require “step therapy,” prior authorizations, and documentation of counseling. Some plans limit use to temporary detoxification only</td>
<td>May no longer pay for “medically necessary” treatment once patient is stable. Requires providers to “buy and bill” (purchase drug upfront and administer as a medical benefit)</td>
</tr>
<tr>
<td>Provider capacity</td>
<td>Physicians cannot prescribe in office-based settings or dispense via pharmacies due to federal regulations</td>
<td>&gt;40% of US counties don’t have a single buprenorphine-waivered physician, and half of waivered physicians have not started prescribing</td>
<td>Virtually no physicians administer as part of standard residency/training</td>
</tr>
<tr>
<td>Accessibility and finding a provider</td>
<td>Patients in rural areas spend upwards of $50 just on travel costs to attend daily; often long waiting lists</td>
<td>One-third of states have fewer than half of waivered physicians listed on the national buprenorphine treatment locator; in rural areas, waivered physicians often have full practices</td>
<td>Providers are exceptionally hard to find</td>
</tr>
<tr>
<td>Treatment programs</td>
<td>Most substance abuse treatment programs are not affiliated with methadone</td>
<td>Some treatment programs pressure patients to discontinue buprenorphine</td>
<td>Many programs lack medical professionals to administer</td>
</tr>
</tbody>
</table>

References


and death. There is extensive and freely available training as well as resource materials online to help clinicians learn more about MAT pharmacotherapy.

PCSS-MAT is a robust online mentorship initiative funded by SAMHSA and spearheaded by the American Academy of Addiction Psychiatry (AAAP). Many modules are posted at https://pcssmat.org/online-modules/. NIDA has a website dedicated to updates on evidence-based treatment for OUD: https://addiction.research.nida.nih.gov/evidence-based-treatments/

Many modules are posted at https://pcssmat.org/online-modules/. NIDA has a website dedicated to updates on evidence-based treatment for OUD: https://addiction.research.nida.nih.gov/evidence-based-treatments/

Providers are exceptionally hard to find.

Many programs lack medical professionals to administer.

Please note that the post-test is available online only on the 20th of the month of activity issue and for 18 months after.

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http://www.psychiatrytimes.com/cms

Lifeline for Pregnant and Postpartum Women Who Are Drowning in Plain Sight
Nancy Byatt, DO, MS, MBA
Expiration date: October 20, 2019

Genetics in the Clinical Setting: The Role of Psychiatric Genetic Counseling
Jehannine Austin, PhD, CGC
Expiration date: September 20, 2019
Jacobi Medical Center (JMC) is a modern, state-of-the-art, Level 1 Trauma Center located in an attractive and safe residential Bronx neighborhood just 20 minutes north of Manhattan. It is a North Bronx Healthcare Network hospital affiliated with North Central Bronx Hospital and a teaching site and academic affiliate of the Albert Einstein College of Medicine. It offers a full continuum of Acute Care Inpatient and Outpatient services in diverse Medical and Surgical specialties, including Psychiatry. The Department of Psychiatry has 89 Adult Acute Inpatient beds, a Comprehensive Psychiatric Emergency Program (CPEP), a Consultation-Liaison Service, an Adult Ambulatory Practice, and a Community-Based Assertive Community Treatment Program. The department employs evidenced-based best practices in providing the highest quality care to its patients, in a patient-centered approach that is respectful of their individuality, culture, and community.

North Central Bronx Hospital (NCBH) is a modern, state-of-the-art community hospital located in an attractive and safe residential Bronx neighborhood just 20 minutes north of Manhattan. It is a North Bronx Healthcare Network hospital affiliated with Jacobi Medical Center and a teaching site and academic affiliate of the Albert Einstein College of Medicine. It offers a full continuum of acute care inpatient and outpatient services in diverse Medical and Surgical specialties, including Psychiatry. The NCBH Department of Psychiatry has 70 Adult and Geriatric Acute Inpatient Beds, a Partial Hospital Program, Psychiatric Emergency Consultation-Liaison Service, an Adult Ambulatory Practice, and a community-based Assertive Community Treatment Program. The department employs evidenced-based best practices in providing the highest quality care to its patients, in a patient-centered approach that is respectful of their individuality, culture, and community.

Jacobi Medical Center & North Central Bronx Hospital are currently accepting applications and referrals for the following opportunities:

- Inpatient Attendings (JMC and NCBH)
- Attending Psychiatrist ER-CPEP (JMC)
- Inpatient Unit Chief (JMC)
- Attending Psychiatrist ER (NCBH)
- Moonlighting opportunities also available! (JMC and NCBH)

An academic appointment at Albert Einstein College of Medicine is offered. We offer a generous income package along with outstanding benefits, opportunities for advancement, retirement plan, malpractice, and much more!!

For immediate confidential consideration, please contact:
Carmen Velez – Office of Physician Recruitment. Velezcc@pagny.org
646-494-7559

www.pagny.org

Physician Affiliate Group of New York (PAGNY) is comprised of over 3,600 physicians and healthcare professionals who provide services to NYC Health + Hospital, the largest public healthcare system in the United States. Our practitioners are highly skilled professionals with outstanding credentials who deliver the highest level of quality healthcare to patients throughout New York City.

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Central New York Psychiatric Center (CNYPC) recognizes that our employees are our greatest resource. We are seeking motivated psychiatrists to help promote hope, resilience, and recovery within a culture of safety that employs a team approach. CNYPC is a dynamic organization that provides comprehensive forensic mental health services through a continuum of care at its inpatient setting, located in Central New York, and in the Correctional System throughout New York State. CNYPC is fully accredited by The Joint Commission.

Benefits:
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- Psychiatrist Loan Repayment Program offering up to $150,000 over 5 years.
- Flexible work schedules. Private practice permitted.
- Tele-psychiatry positions available.
- Optional paid on-call duty at the hospital.
- Opportunities for academic affiliation with SUNY Upstate, Division of Forensic Psychiatry.
- Generous benefits and retirement package.
- Relocation assistance.
- Robust continuing medical education opportunities.
- Positions in proximity to: Utica, Albany, NYC, Buffalo, Rochester, Elmira, Glens Falls, and Syracuse.

For more information, contact Melinda Carey, HR Specialist, at 315-765-3360 or Melinda.Carey@omh.ny.gov

NewYork-Presbyterian Psychiatry and Mental Health

NewYork-Presbyterian has one of the highest-ranked psychiatry programs in the country, according to U.S. News & World Report. We work in close collaboration with Columbia University College of Physicians and Surgeons and Weill Cornell Medicine in a shared mission to advance the field of diagnostic precision and develop the most effective treatments for individuals of all ages. Our multidisciplinary treatment teams are driven by our mission to restore patients to living healthy and functional lives. From early onset through late life, we provide expertise across all psychiatric disorders. Across the lifespan and over a vast spectrum of illnesses, NewYork-Presbyterian is growing our ability to respond to the most complex behavioral health needs of the diverse communities we serve.

The NewYork-Presbyterian Office of Physician Recruitment is currently recruiting BC/BE Psychiatrists and experienced Psychiatric Nurse Practitioners for a variety of positions at NewYork-Presbyterian facilities with specialized psychiatry programs throughout NYC and Westchester.

We offer a competitive salary and comprehensive benefits package.

For further details, please contact: Laura Screaney, FASPR, Director of Physician Recruitment, las9150@nyp.org

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NATIONWIDE

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  Please contact: Sandra Williams
  Director of Recruitment
  P: (818) 584-1785
  Email: swilliams@alignedth.com

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THE DOCTORS OF TRADITIONS BEHAVIORAL HEALTH are the largest provider of MD psychiatric services to adult populations in institutional and community based programs in California. We provide services to the seriously and persistently mentally ill and have openings in the San Francisco Bay Area, Santa Barbara, San Diego and Los Angeles. Overall we plan to add 50 more Fulltime psychiatrists in California to bring our medical staff team to 400 psychiatrists. Our packages vary from a minimum of $300,000 per year plus $10,000 in bonuses and a benefit package valued at approximately $90,000, to up to $500,000, for the industrious physician. Our generous benefit package includes almost 7 weeks paid time off per year. If you are creative and think outside the box, if you value diversity and cultural competency, if you like innovative programs that are patient driven, using a rehabilitative, rather than illness model, if you want more time to work with patients, to get the best results, then TBH is the company for you. To learn more about the specific job openings and salary and benefit packages, check out our Website at: www.tbhcare.com or Email your letter of interest and CV to our company President, Gary A. Hayes, Ph.D. at: Drehayes3@tbhcare.com

TBH is an equal opportunity employer
Outpatient Adult and Child Psychiatrists are needed for Stanislaus County Behavioral Health & Recovery Services, in the Central Valley less than two hours from San Francisco and Yosemite.

Recovery-oriented treatment provided in a multidisciplinary setting with friendly and dedicated staff members. Recently revised rates with full malpractice coverage and pension plan (PARS) as a Personal Service Corporation with an income potential of over $325 K per year for adult psychiatrist and over $355 K per year for child psychiatrist for F/T work.

P/T options and the opportunity to combine Tele-Psych with limited onsite work are also available. Excellent work environment with NO Call Requirement, lower than average case load and comprehensive nursing & ancillary support makes this a very pleasant and rewarding opportunity. J 1 applicants are welcome.

Fax CV to Uday Mukherjee, MD at (209) 538-4326 or Email: umukherjee@stanbus.org

San Diego-Coastal Psychiatric Medical Associates is looking for an adult psychiatrist and a child and adolescent psychiatrist to join a rapidly growing group practice. Please contact Robert J. Solomon, M.D. at (760) 753-5283 or robertjayssolomon@yahoo.com.

PACIFIC COAST PSYCHIATRIC ASSOCIATES has openings for Adult, Child and Adolescent Psychiatrists (full and part-time). Our physicians have the opportunity to practice both therapy and med management without restrictions in our San Francisco, Lafayette, and Los Angeles (in the West Hollywood, Beverly Hills, Century City and Culver City area) offices. We are a collaborative practice of psychiatrists and therapists with full-time office staff to provide complete administrative support.

Founded in California's technology center, we benefit both internally and externally from the industry's advances. Internally, our doctors' familiarity with EMRs, online scales/charts and electronic prescriptions is an important component of our culture. Externally, our patients have the ability to schedule appointments through our website, manage their accounts through the patient portal, and meet with their provider over the internet (via telepsychiatry or tele-health appointments). We strive to simplify records management for our patients, our providers, and the environment.

Our competitive compensation includes:
- Malpractice/Disability Insurance
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For more information, contact
Steven Dingle, M.S., MD., Chief Medical Officer at steven.dingle@azdh.gov, or 602-220-6007.

ADHS
ARIZONA STATE HOSPITAL
Psychiatrist Position
Arizona State Hospital
Phoenix, AZ

The Arizona State Hospital has an opening for an adult BE/BC psychiatrist for full time inpatient duties. The duties revolve around managing 18-23 inpatients, who have been admitted for long term treatment. The psychiatrist can expect to do 1-2 admissions per month on average. Call is from home, and the hospital does not routinely do after hours or weekend admissions. Call is elective shared among the psychiatry group, and if the psychiatrist does not wish to routinely participate in the call system, they can expect to be assigned on average 1-2 times per month. Call is compensated as a separate stipend. The hospital functions on a “co-attending” model, with primary care practitioners providing routine medical care. Benefits are excellent and include:
- Yearly compensation 215K BE, 220K BC
- Health insurance $115 per pay period for family PPO plan ($47 for individual

Earn over $350K/Year
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www.psych-doctor.com

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Classifieds

May 2018
CA medical license or ability to obtain.

The position pays a highly competitive salary, including health benefits for you and your family, and requires no hospital work and minimal after hours work freeing you up for more leisurely activities.

The successful candidate diagnoses and treats patients with mental, emotional, and behavioral disorders. Qualified candidate must have a medical license or ability to obtain.

Send CV to Imperial County Behavioral Health Services, 202 North 8th Street, El Centro, CA 92243.

J-1 applicants welcome.

For additional information, please contact:
Kristen Smith (442)265-1606 kristensmith@co.imperial.ca.us

Butte County Behavioral Health Department is seeking a Medical Director based in Chico, California to manage department programs. The incumbent will perform approximately 50% direct services and 50% administration work. In collaboration with the Assistant Director – Clinical Services, directs, evaluates, plans, establishes, and implements the medical services component and all clinical services of the department; participates in coordination of services across county departments and agencies; provides medical direction and consultation to all mental health programs and consultation to contracted agencies; particularly in the areas of quality improvement, medication monitoring, and peer review. Starting salary is dependent on experience and is negotiable. The Department will also consider a Medical Director on a contract basis. Salary for a contracted Medical Director is negotiable. For additional information please contact Geoff Davis, at (530) 891-2986 or gdavis@buttecounty.net for a recruitment packet and appointment to speak with the Behavioral Health Department Director. Please visit the Butte County Human Resources Department website for more information, to review the recruitment packet, and to apply for the opportunity:

http://www.buttecounty.net/humanresources/Employment.aspx

EOE M/F/V/Disability
Meridian Behavioral Healthcare, Inc. is a CARF accredited community mental healthcare facility located in the heart of Florida. Currently, we have full time position Staff Psychiatrist position available with an excellent salary and benefits package. Looking for someone who can work with a flexible schedule – preferably Adult and Child, with the mixture of inpatient and outpatient to be discussed. Meridian has been a part of the lives of thousands since 1972; providing a safety net for those in crisis. Since then, Meridian has expanded to 16 sites across Central Florida, touching over 22,000 lives through over 325,000 direct care visits a year. Gainesville is home to over 22,000 lives through over 325,000 direct care visits a year. Gainesville is home to over 22,000 lives through over 325,000 direct care visits a year. Gainesville is home to over 22,000 lives through over 325,000 direct care visits a year. Gainesville is home to. Since then, Meridian has expanded to 16 sites across Central Florida, touching over 22,000 lives through over 325,000 direct care visits a year. Gainesville is home to over 22,000 lives through over 325,000 direct care visits a year. Gainesville is home to over 22,000 lives through over 325,000 direct care visits a year. Gainesville is home to. With over 1,700 employees, we are one of the largest employers in Westchester County. Our facility offers specialized programs for adults, senior adults, suicide prevention, chemical dependency rehabilitation as well as community-based programs. Our individualized treatment approach offers targeted treatments for our patients. We provide inpatient hospitalization for individuals in an acute stage of psychiatric illness as well as outpatient services for those requiring a less intense level of care. Our outpatient programs also offer services to those who need psychiatric rehabilitation as well as those with substance abuse problems in need of day rehabilitation or clinic care. We offer a highly competitive compensation and benefits package. Academic appointment with The Zucker School of Medicine at Hofstra/Northwell is commensurate with credentials and experience. For further information and to apply, please contact Office of Physician Recruitment, Northwell Health: OPR@northwell.edu

Assistant/Associate Professor of Clinical Psychiatry
The Department of Psychiatry and Behavioral Medicine at the University of Illinois College of Medicine at Peoria is seeking full-time faculty positions at the rank of Assistant or Associate Professor to join our expanding department. Two Clinician-Educator (CE) positions and one Psychiatry Residency Program Director (PD) position are open. Competitive applicants to the CE positions should value providing and teaching high-quality patient care and supporting the scholarship efforts of residents and medical students. The PD position is a planned changeover in leadership and available to applicants with experience and interest in educational administration and quality teaching. Highly competitive salary and benefits are commensurate with rank.

Responsibilities for the CE position include leading an interdisciplinary general psychiatry adult inpatient teaching unit composed of residents, medical students, nurses, social work and support staff. The PD position includes directing our 16-resident, ACGME-approved training program, promoting a culture of excellence, resident recruitment, teaching and resident evaluation. Other duties for both positions will be tailored to the interest of the applicant and include opportunities in adult and child outpatient clinics, partial hospitalization program, electroconvulsive therapy (ECT), transcranial magnetic stimulation (TMS), community outreach, college student mental health, geriatric and forensic psychiatry, among others. Faculty members have protected time to pursue professional interests including clinical or educational program development or research. Our department values a positive, collegial culture and supports the growth, development and advancement of its members. The department has high faculty and resident satisfaction and low turnover.

Peoria and the surrounding Central Illinois area offer an attractive mix of small town charm and big city offerings. The large, diverse and supportive medical community is the area’s top employer. Peoria offers a diverse population, entertainment, arts, cuisine, low cost-of-living, excellent schools and an array of recreational activities with convenient access to larger cities such as Chicago, St. Louis and Indianapolis.

To inquire confidentially about a position, please contact Dr. Timothy Bruce, Search Chair, at (309) 495-1647 or tjbruce@uicomp.uic.edu. Minimum requirements: graduation from an ACGME-approved psychiatry residency training program, board certification or board eligibility in general psychiatry and eligibility for an unrestricted Illinois medical license. UIC is an EOE/AA/FE/D/VT/Veterans employer. For fullest consideration, please apply by April 5, 2018 at the following link: https://jobs.uic.edu/job-board/job-details?jobId=78315

The University of Illinois may conduct background checks on all candidates upon acceptance of a contingent offer. Background checks are performed in compliance with the Fair Credit Reporting Act.
Addiction Physician – NYC Suburban Community

The Department of Behavioral Health of Northwell Health and The Zucker School of Medicine seeks a Board Certified/Board Eligible Addiction Physician to join the Department of Substance Abuse at Zucker Hillside Hospital in New Hyde Park, NY. The Northwell Health Behavioral Health Service Line is seeking a full or part-time Addiction Physician to lead an innovative, outpatient, buprenorphine induction center located at a brand new facility in Garden City, Long Island. This high visibility, leadership position offers the right candidate an opportunity to work with a committed team of professionals to provide increased access to those suffering from opioid dependence to evidence based treatments. The ideal candidate will be a Board Certified/Board Eligible Physician in Addiction Psychiatry or Addiction Medicine, a buprenorphine waiver holder and extensive experience prescribing buprenorphine. Highlights include:

- Evaluating patients for medication assisted treatment
- Coordinating patients’ progress and treatment plans with the treatment team
- Responsible for prescribing buprenorphine and other medications as indicated
- Supervise residents, fellows and medical students
- Participate in community and professional education/consultations around medication assisted treatments

Zucker Hillside Hospital is a 225-bed not-for-profit behavioral health facility which is one of the leading behavioral health organizations in the nation. The Zucker School of Medicine offers services in Substance Abuse Services of The Zucker Hillside Hospital, offering a wide range of treatment options including ambulatory opioid detoxification, opioid treatment programs and comprehensive community-based outpatient clinics. We offer a variety of services including Comprehensive Assessment & Referral, Group therapy, Individual Therapy, Medical Services, Medication management, Methadone Maintenance Services, Nursing Services, Psychopharmacological services, Psychiatric Assessment and Treatment and Vocational Assessment and Counseling. With a commitment to training medical students, residents and fellows, research engagement, standardized diagnostic assessment and measurement-based outcomes, as well as the use of new technologies, the environment at Zucker Hillside is one of the most sophisticated in the nation.

The Zucker Hillside Hospital is conveniently located just minutes from NYC via private or public transportation, and a short distance from beaches, wineries, waterfront towns, villages and parks. The region surrounding the hospital also boasts some of nation’s top school districts.

Chairperson, Department of Behavioral Health and Psychiatry, Staten Island University Hospital

Staten Island University Hospital (SIUH), the Staten Island medical center of Northwell Health, is seeking a new Department of Psychiatry Chairperson. This exciting position offers the opportunity to lead and continue to develop an academically-oriented behavioral health center of excellence on Staten Island.

The Department serves diverse patient populations on its adult inpatient units, New York State Office of Mental Health (OMH) and New York State Office of Alcoholism and Substance Abuse Services (OASAS)-licensed outpatient clinics serving adults, consultation-liaison service for SIUH’s 400+ medical-surgical inpatient at SIUH North and South sites, and emergency psychiatry program.

A growing psychiatry residency training program, SIUH also serves as a training site for several regional medical schools, and for psychiatric nurses, PAs, and social workers. Interested and qualified candidates may initiate projects in and/or collaborate with Northwell’s Center for Psychiatric Neuroscience at its Feinstein Institute for Medical Research and Zucker Hillside Hospital sites.

Through collaboration with Northwell’s Behavioral Health Service Line, the SIUH Department of Psychiatry is able to interact with many innovative system-wide activities including emergency tele-psychiatry; a CMS-funded practice transformation network; the behavioral health performance improvement coordinating group, pharmacy and therapeutics committee, and incident review committee; the digital behavioral health workgroup; collaborative care initiatives; and an ambulatory provider network, IPA, and behavioral health group practice.

Interested candidates must have or be eligible for a NYS medical license; be ABPN board-certified in Psychiatry; possess consummate leadership skills, program development experience, financial acumen, and a strategic vision to help shape the future direction of a dynamic multi-faceted department; possess an academic portfolio in clinical service delivery, education, or research; be motivated to engage developing value-based payment methodologies and other health care reform initiatives; drive optimal quality, patient satisfaction, and staff engagement indices; and thoughtfully interact with both SIUH and Northwell Health clinical and administrative leaders.

Salary – competitive for the New York market

Academic appointment at the Zucker School of Medicine at Hofstra/Northwell commensurate with experience.

To learn more and apply, please send your CV to OPR@northwell.edu

EOE M/F/D/V

Northern Westchester Hospital of Northwell Health is seeking FULL-TIME BC/BE Psychiatrists to join the Behavioral Health Hospitalist team.

- Shifts are 9A-5P & 5PM-11PM on weekdays, 11AM-11PM on weekends
- We have a need for three 12 hour days or 5 days (flexible)
- Holiday coverage also available
- Emergency Department and Inpatient Psychiatry Unit coverage
- 45 Minutes North of Manhattan and only 5 minutes from Metro North Rail Station

Founded in 1916, Northern Westchester Hospital is committed to providing high-quality, patient-centered care close to home through a unique combination of medical expertise, leading-edge technology and a dedication to humanity that ensures our patients and their families receive treatment in a caring, respectful and nurturing environment. Improving and protecting the health of community members through programs that promote wellness and prevention remains central to our mission.

Northern Westchester Hospital’s Department of Behavioral Health provides comprehensive psychiatric care in a private, patient-centered environment. Services include:

- Inpatient psychiatric hospitalization for adults age 18 and over on a dedicated unit of the hospital
- Emergency Department coverage 24-hours a day provided by board certified psychiatrists
- Consultation on the medical and surgical units of the hospital provided by psychiatric and social work staff

15-bed inpatient unit provides short term hospital care to evaluate and stabilize patients with acute psychiatric disorders. There is a strong focus on returning patients to normal functioning as soon as possible while rebuilding self-esteem and improving socialization.

For more information and to apply, please email: OPR@northwell.edu

EOE M/F/D/V

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Cape Fear Valley Behavioral Health is one of the largest comprehensive, multi-tiered behavioral health services in North Carolina. Behavioral Health Care’s mission is to meet and respond to the mental health needs of the community. We offer evidence-based, best practice treatments. Staffed by psychiatrists, psychologists, clinical social workers, psychiatric nurses, licensed professional counselors, and other mental health professionals, Cape Fear Valley Behavioral Health Care provides a team approach to mental wellness. Behavioral Health Care is accredited by The Joint Commission and licensed by the State of North Carolina.

The Health System is seeking providers for the following due to regional volumes and commitment to expand services:

Emergency Opportunity
- Two BE/BC providers with experience in ED or trained in ED/Psychiatry.
- The Emergency Department maintains a Psychiatric Unit of 9 beds for patients in crisis. Support team is specialty trained. Schedule consists of 16 hour shifts, approximately 10 shifts per month.

Adult Outpatient Opportunity
- BE/BC Child & Adolescent providers.
- The current structure is for 90% outpatient Monday through Friday work week.
- We offer best in class compensation plus generous benefits including Paid Malpractice, CME Time and Allowance, Accrued Paid Time Off, 403(b) match and 457(b), Health, Dental, and other desirable benefits.

Child Outpatient Opportunity
- BE/BC Child & Adolescent providers.
- The current structure is for 90% outpatient Monday through Friday work week.
- We offer best in class compensation plus generous benefits including Paid Malpractice, CME Time and Allowance, Accrued Paid Time Off, 403(b) match and 457(b), Health, Dental, and other desirable benefits.

Please contact Suzy Cobb, Physician Recruiter for more details at (910) 615-1889 or scobb2@capefearvalley.com.

PENNSYLVANIA

EASTERN PA - SCHUYLKILL COUNTY – Independent Contractor Position, or Full-time Staff Psychiatrist position if preferred, on Adult inpatient psychiatric unit and C/A psych unit in the Lehigh Valley, Schuylkill Hospital in Pottsville, PA. Independent Contractor arrangement available for those in practice who want part-time work; or if employment is preferred, can offer salary with benefits.

Please contact Terry Good, 804-684-5661;
terry.good@horizonhealth.com;
Fax: 1-804-684-5663.

Please stop by Booth #1501 and see me at the APA Conference in New York, NY in May.

The Penn State Health Milton S. Hershey Medical Center Department of Psychiatry is currently recruiting board eligible/certified psychiatrists for inpatient and outpatient positions in both adult and child psychiatry.

We are a growing, vibrant department in a strong academic medical center. We host specialty clinical and research programs, including research that crosses the translational spectrum. Our educational programs include adult psychiatry residency, child fellowship, psychology internship, externship and post-doctoral fellows. We have a strong collaboration with basic and clinical science in other neuroscience disciplines across several Penn State campuses.

With our clinical partner, the Pennsylvania Psychiatric Institute, the Department staffs several outpatient and partial hospital programs for children and adults, 89 inpatient beds, ECT and other neuromodulation services, specialty sleep and eating-disorders programs, and expanding psychiatric consultation and integrated care programs for Hershey Medical Center.

Successful candidates should have strong teaching as well as clinical skills and, optionally, potential for scientific and scholarly achievement. We offer an attractive compensation package commensurate with qualifications. Tenure-track positions are possible.

For consideration, send your CV to:
Jenna Spangler Physician Recruiter
Phone: 717-531-4271
Email: jspsangler2@pennstatehealth.psu.edu

The Penn State Milton S. Hershey Medical Center is committed to affirmative action, equal opportunity and the diversity of its workforce. Equal Opportunity Employer – M/W/V/D

OPENINGS IN PHILADELPHIA AND DARBY – Mercy Philadelphia Hospital, Philadelphia – opening on 16-bed Dual Diagnosis Unit, Mercy Fitzgerald Hospital, Darby – Crisis Service, Day and night shifts available (8am to 5pm or 5pm to 8am). Please contact Terry Good, Horizon Health, at 804-684-5661.

Email: terry.good@horizonhealth.com;
Fax: 1-804-684-5663. EOE

Please stop by Booth #1501 and see me at the APA Conference in New York, NY in May.

TENNESSEE

MEDICAL DIRECTOR POSITION, NEW 18-BED GEROPSYCH UNIT, ROCKY TOP (Lake City), TN – Slated to open in July 2018; connected to nursing home with a separate entrance. This is a part-time position so it fits in well with the Psychiatrist group in practice in the area who wishes to incorporate some inpatient work into their practice, or for someone at a mental health center who wants to do some IP work and be Medical Director. Stipend available for part-time administrative duties. Please contact Terry Good, at 804-684-5661, Fax#: 1-804-684-5663.

Email: terry.good@horizonhealth.com;
Fax: 1-804-684-5663.

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VIRGINIA

MEDICAL DIRECTOR - PSYCHIATRIST

Southwestern Virginia Mental Health Institute (SWVMHI), located in Marion, Virginia, is seeking a Medical Director. We are a progressive Joint Commission accredited behavioral health hospital, with 179 beds serving adult, geriatric, and forensic patients offering a team oriented environment, medical school affiliation, and an excellent compensation and benefits package including sign-on bonus, moving and relocation, and loan repayment. We seek a board certified Psychiatrist with strong leadership/management experience in a psychiatric hospital with a commitment to recovery principles. With the assistance of the Associate Medical Director, the position is responsible for directing all providers in the practice of quality care according to standards and benchmarks set by the Virginia Department of Behavioral and Developmental Services, licensing boards and accrediting agencies. Occasionally, the Medical Director will provide backup coverage in a clinical role as a treatment team Psychiatrist. The Medical Director participates in facility and state-wide strategic planning and improvement initiatives through membership on the SWVMHI Executive Team and the Commonwealth of Virginia’s system of health and quality care. The chosen candidate must be licensed to practice medicine in Virginia, SWVMHI is an equal opportunity employer. Persons with disabilities are encouraged to apply.

We invite you to visit our website at www.swvmhi.dbhds.virginia.gov for more information, or if interested, please submit your curriculum vitae to: Kim Sayers kim.sayers@dbhds.virginia.gov
(276) 783-1204

WISCONSIN

PSYCHIATRIST

Clinical excellence and quality living, Winnebago Mental Health Institute (WMHI), is seeking a Board Certified/Board Eligible (BC/BE) psychiatrist. This position provides diagnosis and treatment of assigned patients and works with a multidisciplinary treatment team on an inpatient unit. Excellent fringe benefit package.

Winnebago Mental Health Institute is a 280-bed psychiatric facility accredited by the Joint Commission located near Oshkosh, the center of the Fox River Valley, one of the fastest developing areas of Wisconsin. The Oshkosh area offers a safe environment, rich in cultural and recreational opportunities. Excellent public and private schools with three universities in the area. Oshkosh is within 1 hour of Milwaukee or Madison. Information on WMHI can be found at http://www.dhs.wisconsin.gov/ MH_Winnebago/.

For application instructions, go to www.wiscjobs and search for Psychiatrist (Job Announcement Code: 17-02966).

Contact:
Medical Director’s office
P.O. Box 9, Winnebago, WI 54985-0009
Phone: (920) 235-4910 ext. 2210

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MEETINGS

35th Annual Conference & Exhibit Show (DD/MI)
10/31 – 11/2, 2018, Seattle, WA
For Information & Registration: www.thenadd.org/35th/

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