Are We “Hardwired” for Hatred?

Ronald W. Pies, MD

Even After the Pittsburgh Shootings, Our Ability to Empathize Suggests Otherwise

Many years ago, I treated a patient who had a diagnosis of chronic schizophrenia—one of hundreds I cared for at a state mental health facility. It happened that this particular patient hated Jews with a smoldering passion, and frequently made veiled threats against Jewish caregivers—including me. To make matters worse, this very intelligent man—a former Jesuit—refused to take adequate doses of his antipsychotic medicine. He never quite met legal criteria for involuntary hospitalization or treatment, despite sending me many letters with chilling statements like, “Jews don’t live long.”

The horrific murders of 11 people at the Tree of Life synagogue in Pittsburgh have rekindled memories of my patient and how much I dreaded checking my clinic mailbox, for more than a year. Fortunately, I was never physically harmed by this man and actually managed to forge something resembling a therapeutic alliance, as I have described elsewhere. Tragically, the people killed or

Solving the Mystery of Military Mental Health: A Call to Action

Jeffrey A. Lieberman, MD

In the wake of the recent Veterans’ Day observances (November 11, 2018), I had a strangely disquieting feeling. At first, I attributed it to binge-watching too many war movies that had been broadcast for the occasion (including All Quiet on the Western Front, Saving Private Ryan, Patton, Patton). But there was also the fact that the holiday coincided with the 100th anniversary of the Armistice of WWI, the “Great War,” punctuated by the indignity of our POTUS being deterred by the weather from attending the ceremonies at the French cemetery where US soldiers were buried. But then, in a burst of insight, I realized what so upset me was when George C. Scott slaps the soldier with PTSD in Patton and calls him a “yellow-bellied coward.” This iconic scene resonates with the historic and continued ambivalence of the military toward the psychological wounds of war. Is it the military equivalent to the stigma of mental illness that pervades our society—but on steroids.

Because of this stubborn aversion to the reality of psychic injuries in the military, active duty and veteran military personnel have been denied effective mental health care, and limited progress has been made in understanding the pathological basis of psycho-
wounded in the Pittsburgh attack were not so fortunate.

All this—as well as the recent pipe bomb incidents involving numerous Democratic politicians—has sparked some somber reflection on my part, regarding the nature and origin of hatred. In digging through the literature, I came across an intriguing study from 2008, by Semir Zeki and John Romaya, at University College, London.

Zeki and Romaya recruited 17 people who expressed strong hatred for a specific individual. The subjects underwent fMRI scans while they viewed the face of the person they hated as well as faces of acquaintances for whom they had neutral feelings. The gist of the study was that “there is a unique pattern of activity in the brain in the context of hate,” which is distinct from that seen in the context of other strong emotions, such as fear, anger, aggression, and danger, even though hatred shares common areas with these other sentiments.

Most notable was the press coverage of this research, which boldly announced the identification of the brain’s “hate circuit”—a term Zeki and Romaya did not use in their study. The clear implication was that our brains are “hardwired” to experience hatred. Yet this small study—which, to my knowledge, has not been replicated—did not demonstrate that we are born with a hate circuit, or that we cannot mitigate the effects of these neural structures.

To be sure, there is substantial evidence that our brains are biologically predisposed to distinguish “Us” from “Them”—and this applies, for example, to our perception of race. Stanford University biology professor Robert Sapolsky, PhD, has written extensively on how our brains react, more or less automatically, when we are shown pictures of people who don’t resemble us—the “Others” and “Thems” of the world. Sapolsky writes:

**Briefly flash up the face of someone of a different race (compared with a same-race face) and, on average, there is preferential activation of the amygdala, a brain region associated with fear, anxiety, and aggression.**

Critically, Sapolsky notes, the reaction is preconceived; it “…comes long before (on the time scale of brain processing) more cognitive, cortical regions are processing ‘Them.’ The emotions come first.” And yet, Sapolsky cautions that these emotional reactions are not etched in stone—or irremediably encoded in our brains. We can modify our emotional reactions to “Them”—the feared “Other”—in various ways. For example, Sapolsky points to “…a powerful cognitive tool—perspective taking. Pretend you’re a ‘Them’ and explain your grievances. How would you feel? Would your feet hurt after walking a mile in their shoes?”

In effect, Sapolsky is describing one way to develop empathy for “Them”—whether another race or religion, or someone whom we regard with anger or loathing. And here we find support in a number of our spiritual traditions. Thus, the Tibetan Buddhist teacher Chagdud Tulku Rinpoche (1930-2002) asks, “How do we generate compassion [in Sanskrit, karuna]? We begin by contemplating the difficulties of others, and we put ourselves in their shoes.”

In the Judaic tradition, we have the profoundly empathic statement in the Book of Exodus (22:20): “You shall not wrong a stranger, nor oppress him; for you were [once] strangers in the land of Egypt.” In effect, we are urged to remind ourselves what it is like to be “a stranger in a strange land” (to borrow from Robert Heinlein’s 1961 novel).

And in the Stoic tradition, Marcus Aurelius urges us to “Acquire the habit of attending carefully to what is being said by another, and of entering, so far as possible, into the mind of the speaker.”

Perhaps the most moving example of overcoming our tendency to despise the “Other” is the response of the Jewish physicians who treated the wounds of the man accused of the Pittsburgh shootings, according to the Washington Post:

**“We’re not here to judge you. We’re not here to ask, ‘Do you have insurance?’ or ‘Do you not have insurance?’ We’re here to take care of people that need our help.”**

—JEFFREY K. COHEN

The reasons for the burgeoning rates of mental health problems among military personnel deployed to the Middle East—more than in any other war—are as yet undetermined. The possibilities include the asymmetric type of warfare, repeated tours of duty, lack of clearly defined mission. But then the rates had begun to rise during Vietnam when the army was conscripted and possibly before-hand and gone unnoticed. Regardless, the unique psychological dangers faced by our military personnel take their toll and make re-entry into civilian life difficult.

The mental health consequences of military trauma are often distressing, disabling and persistent unless there are timely interventions. Symptoms of PTSD include re-experiencing the traumatic event, avoidance of thoughts of the traumatic event and people, places, or other stimuli that evoke the
trauma; changes in cognition regarding the world and one’s self; hypervigilance; hyperarousal (including irritability, concentration difficulties, and disrupted sleep); and increases in disturbing thoughts and negative feelings. PTSD is commonly associated with functional impairments, substance abuse, suicidal ideation, impulsivity and violence, as well as increased utilization of medical care.

Treatments: too few, too late, and not good enough

Despite treatment with the available psychotherapies and pharmacotherapies, PTSD never fully remits in more than half of patients. Meta-analyses of psychotherapy for PTSD has found short-term improvements compared with baseline only in about 50% to 60% of patients, with the majority continuing to have substantial residual symptoms. The efficacy of medication in PTSD is also sub-optimal, with few patients experiencing a complete remission following pharmacotherapy. Moreover, there is a lack of psychopharmacologic advances in its treatment.

Because early symptoms of combat-related mental problems are a reliable predictor of chronicity and impaired social and occupational functioning, early treatment is most advantageous. Early intervention can increase functional capacity, rapid symptom recovery, prevention of maladaptive coping behaviors, and prevention of chronic PTSD and other psychopathology, including complicated grief. Unfortunately, while models of early intervention have been tested in non-military populations, they have rarely been implemented in military personnel.

Coming home: reconnecting and reintegrating

Research indicates that as many as 50% of veterans experience significant difficulty acclimating with a third developing mental health problems including PTSD, anxiety disorders and depression. Reconnecting with loved ones after repeated exposure to traumatic events and combat stress, coping with physical injuries sustained during combat, and renegotiating roles as civilians in the midst political, social, and economic crises can present an emotionally challenging experience for service members and their family members. If the psychopathology causing these problems goes untreated, chronicity develops that leads to significant social impairment, marital dysfunction, job instability, suicide, substance abuse, and violent behavior.

To compound the problem, there is an acute shortage of services, trained clinicians, and lack of expertise in evidence-based treatments, which limits the care of large numbers of redeployed veterans and their families. Moreover, the quality of services and the effectiveness of treatments are not optimal and limited federal funding has imposed much-needed progress that could derive from psychobiological research on the effects of physical and psychological trauma on the brain. Indeed, current treatments for trauma-related mental health disorders, such as PTSD, suicidality, and traumatic brain injury, have yet to be proven effective for large populations of war veterans.

The lack of available quality mental health care is compounded by the fact that active duty personnel and veterans are too often reluctant, indeed often deterred from seeking mental health care because of shame, stigma, and adverse career impact. For those who do seek help, a variety of logistical, cultural, and professional barriers may interfere with care access and delivery. To add insult to injury, family members of military personnel are not eligible for mental health care in VA settings. Ignoring the needs of these populations is both unfair, given their great sacrifices, and unwise, as family support is critically important for optimal adjustment of returning veterans.

A call to action

Given the scope of mental health problems among military personnel, better and more accessible mental health services must be developed. Evidence-based interventions are needed in multiple and diverse settings (in basic training, on the battlefield, following injury and upon and after discharge) and special efforts must be made to address and overcome the deterrents of stigma, guilt and impact to career by at least ensuring that all are informed how and encouraged to obtain services if needed. Provision of social services and establishment of resource and resilience-building programs will facilitate treatment and reintegration into effective social and occupational roles.

It has long been known that war produces overwhelming psychological stress that can indelibly alter a person’s brain function and mental state. Despite the long history of PTSD (previously known as “Soldier’s Heart,” “Shell Shock,” “Battle Fatigue,” and “Combat Neurosis”), evidence-based treatments have not been widely available. In addition, the stigma associated with seeking help for mental health problems remains a significant deterrent for many veterans.

Medication in PTSD is also sub-optimal, with few patients experiencing a complete remission following pharmacotherapy. Moreover, there is a lack of psychopharmacologic advances in its treatment. Because early symptoms of combat-related mental problems are a reliable predictor of chronicity and impaired social and occupational functioning, early treatment is most advantageous. Early intervention can increase functional capacity, rapid symptom recovery, prevention of maladaptive coping behaviors, and prevention of chronic PTSD and other psychopathology, including complicated grief. Unfortunately, while models of early intervention have been tested in non-military populations, they have rarely been implemented in military personnel.

Coming home: reconnecting and reintegrating

Research indicates that as many as 50% of veterans experience significant difficulty acclimating with a third developing mental health problems including PTSD, anxiety disorders and depression. Reconnecting with loved ones after repeated exposure to traumatic events and combat stress, coping with physical injuries sustained during combat, and renegotiating roles as civilians in the midst political, social, and economic crises can present an emotionally challenging experience for service members and their family members. If the psychopathology causing these problems goes untreated, chronicity develops that leads to significant social impairment, marital dysfunction, job instability, suicide, substance abuse, and violent behavior.

To compound the problem, there is an acute shortage of services, trained clinicians, and lack of expertise in evidence-based treatments, which limits the care of large numbers of redeployed veterans and their families. Moreover, the quality of services and the effectiveness of treatments are not optimal and limited federal funding has imposed much-needed progress that could derive from psychobiological research on the effects of physical and psychological trauma on the brain. Indeed, current treatments for trauma-related mental health disorders, such as PTSD, suicidality, and traumatic brain injury, have yet to be proven effective for large populations of war veterans.

The lack of available quality mental health care is compounded by the fact that active duty personnel and veterans are too often reluctant, indeed often deterred from seeking mental health care because of shame, stigma, and adverse career impact. For those who do seek help, a variety of logistical, cultural, and professional barriers may interfere with care access and delivery. To add insult to injury, family members of military personnel are not eligible for mental health care in VA settings. Ignoring the needs of these populations is both unfair, given their great sacrifices, and unwise, as family support is critically important for optimal adjustment of returning veterans.

A call to action

Given the scope of mental health problems among military personnel, better and more accessible mental health services must be developed. Evidence-based interventions are needed in multiple and diverse settings (in basic training, on the battlefield, following injury and upon and after discharge) and special efforts must be made to address and overcome the deterrents of stigma, guilt and impact to career by at least ensuring that all are informed how and encouraged to obtain services if needed. Provision of social services and establishment of resource and resilience-building programs will facilitate treatment and reintegration into effective social and occupational roles.

It has long been known that war produces overwhelming psychological stress that can indelibly alter a person’s brain function and mental state. Despite the long history of PTSD (previously known as “Soldier’s Heart,” “Shell Shock,” “Battle Fatigue,” and “Combat Neurosis”), evidence-based treatments have not been widely available. In addition, the stigma associated with seeking help for mental health problems remains a significant deterrent for many veterans.
and the increasing number of psychological casualties, there has been limited progress in the scientific understanding and ability to treat PTSD. So why hasn’t more been done to address the psychological wounds of war and its sequela? It is not for the lack of ability to achieve great progress. The military has already demonstrated its capacity to make extraordinary advances in the medical care of its soldiers. Rates of severely wounded combatants went from 80% who died to 80% who survived between WW-I and the Iraq and Afghanistan wars. Whereas wounded soldiers writhed in pain and died from infection and exsanguination in WWI, medics now stabilize soldiers in-the-ater, airvac them to field hospitals where they undergo emergency surgery, then airlift them when able to travel to military hospitals in Germany for more sophisticated treatments. When recovered they are transported to the US and, if further treatment is needed, to Walter Reed National Military Center. I believe there are three reasons why the same has not been done for the psychological wounds of war. First, the idea of psychological weakness is antithetical to military culture with its ethos of strength and invulnerability. Thus, military leaders were disinclined to recognize and accept the possibility of psychic injury. As a result, many soldiers were accused of cowardice and in some cases punished, even executed, for their infirmity. Second, mental disorders are not tangible and have no visible physical signs or diagnostic tests by which they can be confirmed. Hence, they are not seen as real, and are thus minimized—you don’t get a Purple Heart for PTSD. Third, PTSD was considered a military problem and thus the responsibility of the Defense Department and Veteran’s Administration. Consequently, the NIH did not see this as within the scope of their mission and thus the best and the brightest biomedical researchers at academic medical institutions were not engaged in the research effort to address PTSD. Until recently, most funding for PTSD research was provided through the Veteran’s Administration and predominantly to researchers at VA hospitals.

There are two grievous flaws of logic in this scenario. One is that just because there is no physical lesion associated with PTSD, does not mean that it’s not a distressing and disabling condition. The other is that psychological trauma is not limited to the military but also occurs in the civilian population—though less commonly and dramatically. Therefore, this should be considered a medical problem of importance to the NIH and the whole biomedical research community, but that would have diverted funds from other disorders.

There is another reason why the measured response of our government to address mental military health is so tragic and reprehensible. Of the 265 disorders described in DSM-5, only two have known etiologies and can be readily studied in animal models—substance use disorders and PTSD. The biology of PTSD can be studied in the laboratory through fear conditioning paradigms and therapeutic approaches developed to alleviate the symptoms and potentially even prevent its development by “immunizing” those who regularly go into harm’s way.

A “Manhattan Project” for PTSD

What is needed is a “Manhattan Project” to elucidate the pathophysiology, develop effective treatments, and ultimately find a cure for PTSD. While this is a formidable scientific challenge, it is achievable.

The first step is for the Administration and Congress to empanel a task force of leading scientists to develop a strategic plan for research on the pathological basis of PTSD and develop treatments. Next, Congress must allocate funding to support the necessary research to be carried out under the auspices of the National Institutes of Health in partnership with the VA and Department of Defense. The NIH Director’s office would be responsible for monitoring progress and reporting to the President and the Congress. This effort would be sustained until sufficient progress has been made. The final step would entail establishing a network of medical centers in addition to the VA Hospitals to provide specialized mental health services for veterans, and mechanisms for reimbursement.

It is time for our government to right this historic wrong. Amidst the political gridlock in Washington and polarized opinions of the electorate, there is one thing on which everyone agrees, it is our respect and concern for US military personnel. Images and statistics of returning vets with lost limbs, injured brains, and traumatized psyches have seared the public consciousness and evoked an outpouring of compassion. We are light-years away from the Vietnam era vilification of the military. Let us pledge that not another Veteran’s Day shall pass without our government, biomedical research, and medical communities committing to solve the mystery of psychological trauma and remove this scourge from those who place themselves in harm’s way to defend us and our freedoms.

Jeffrey Lieberman, MD, is the Lawrence E. Kolb Professor and Chairman of the Columbia University Vagelos College of Physicians and Surgeons Department of Psychiatry and Psychiatrist-in-Chief of the New York Presbyterian Hospital-Columbia University Irving Medical Center. Dr Lieberman is a member of the National Academy of Medicine and past president of the American Psychiatric Association. He is the author of Shrink’s: The Untold Story of Psychiatry (Little Brown 2015).

References

2. Hoge CW, Auchterlen JL, Miliken CS. Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. JAMA. 2006;295:1023-1032.
When Your Child Is Sick is the work of psychologist Joanna Hare Breyer, PhD. She is the wife of Supreme Court Justice Stephen Breyer. Her professional career has followed the less public path of compassion, empathy, and helping children and their families deal with the demon of cancer. Upon her retirement, instead of a memoir, she set out to distill and pass allowed the less public path of compassion, empathy, and helping children and their families deal with the demon of cancer. Upon her retirement, instead of a memoir, she set out to distill and pass through a vocation of caring in the presence of death. Dr Breyer’s writing aims at parents, but her reach touches every person and professional involved in the care of very sick children. Hospitals that treat children with cancer are divided among many subspecialties each with its own teams and technicians so that fragmented care seems inevitable. This is surely bewildering to children and their families when life threatening illness strikes and all that high powered medical science has to offer is brought to bear. Dr Breyer, untrained in medicine, has managed to understand it all and translated it into a language that can be understood. One is reminded as one reads her book of Emerson’s well-known quote, “Common sense is genius dressed in work clothes.”

A diagnosis of cancer in a child breeds helplessness, bewilderment, and despair. If there is a red thread in this deeply informative book it is the many pragmatic and creative ways Dr Breyer has devised to help children and their families overcome those feelings of helplessness and despair. Dr Breyer has the skills, empathic and professional, to grasp all the parameters of treatment and help the family to understand, to cope, and to participate in the treatment.

She calls herself a psycho-social counselor, but she is more than that. She knows every resource that can support the family and every psychological device that can help the child cope with pain, disfigurement, and even suicidal despair. Working with children in pain who fear the next procedure, she finds ways to give them a sense of mastery.

Each chapter has a case example that explains what she does. In a particularly touching example, she created a game to help a suicidal ten-year-old find ways to give them a sense of mastery.
Comprehensive Depression Center Debuts New Tool for Managing Mental Health

Danielle S. Taubman, MPH
Arbor, MI; Clinical Neuroscience, and Professor of Greden Professor of Depression and of Michigan Depression Center, John F. Depression Center, Ann Arbor, MI.

Dr Parikh

Managing Mental Health

DECEMBER 2018 5

PSYCHIATRIC TIMES

I'M NOT FEELING WELL

I Want to Stay Mentally Healthy

I Want to Support Someone

I Want to Be a Mental Health Advocate

I'm Looking for More Resources

DEPRESSION CENTER

I'M NOT FEELING WELL includes information about depression and related disorders and treatment options

I WANT TO STAY MENTALLY HEALTHY provides tips for adopting a healthy lifestyle, strategies for sticking with a treatment plan, managing mood, and staying healthy, and advice for coping at work

I WANT TO SUPPORT SOMEONE includes tips on how to support different individuals with a mental illness, tips on how to support yourself as a caregiver, strategies to support someone in a crisis, and advice on how to support a suicide loss survivor

I WANT TO BE A MENTAL HEALTH ADVOCATE provides information on raising awareness and fighting stigma as well as participating in mental health research

I'M LOOKING FOR MORE RESOURCES includes links to websites with additional information about mental health and self-assessment tools (e.g., PHQ-9, GAD-7), over 50 printable fact sheets, and charts to learn more and track treatment progress

P atient education materials such as the Depression Center Tool- kit can play a central role in shifting a patient from that of a pas- sive recipient of health services to an active and engaged participant in managing his or her own health. The University of Michigan Comprehensive Depression Center launched the newly revised Depression Center Toolkit for patients, families, and caregivers in July 2018. The Toolkit provides information, support, and resources to manage one’s mental health and promote recovery from depression and other mental health conditions.

It also offers help to family members and caregivers of those who suffer from mood disorders, and all people who wish to understand mental illnesses. For example, the partner of someone with depression can refer the person to Toolkit resources that can be used to help manage medicadation use and prepare for an upcoming appointment with a clinician. The Toolkit can also equip the partner with strategies to offer support in case of a crisis. The previous version of the Toolkit (developed in 2009), provided this kind of information and guidance to more than 250,000 people annually (1,040,005 unique visitors from 2015 to 2018) from more than 200 countries across the globe, making it a leading international resource for mood disorders.

To maintain the validity of recommendations and incorporate new insights in the field, improve user experience, and enhance understandability, the site’s organization and content was fully updated. The Toolkit adheres to Federal Plain Language Guidelines to ensure comprehension by all site visitors regardless of literacy level. The Toolkit also follows best practices in web design and navigation, and the new website design is responsive to a variety of devices and screen sizes (e.g., tablets, phones) for an optimal viewing experience.

What steps were taken to develop the Toolkit?

To ensure maximal utility and accuracy, a comprehensive group of stakeholders—both those who have personal experience with mental illness and mental health experts—served as Toolkit advisors throughout the development process. The stakeholders were viewed as an integral part of the planning and writing process. The Project Leads first conducted a needs assessment to identify gaps and organizational issues in the existing Toolkit. More than 20 experts then reviewed the entirety of the site’s content to ensure that it reflects current medical knowledge and practice. Moreover, two patient and family focus groups provided feedback on content completeness as well as the understandability and actionability of the materials. Finally, a Beta version of the site was assessed by six external professional content experts and 48 online patient advisors.

What does the Toolkit include and how is it organized?

The Toolkit provides detailed educational information, tools to better manage a mental illness, strategies to incorporate into a health regimen, and steps toward making lasting lifestyle changes. The Toolkit also nurtures open communication about mental health and prioritizes earlier recognition, treatment adherence, and the significance of overall health. Finally, it emphasizes the importance of secondary prevention, i.e., the prevention of recurrences of bipolar, depression, and related conditions.

The Toolkit is logically organized into five major sections or “entry points” on the site’s homepage according to the user’s primary purpose for visiting the site.

- I’m Not Feeling Well includes information about depression and related disorders and treatment options.
- I Want to Stay Mentally Healthy provides tips for adopting a healthy lifestyle, strategies for sticking with a treatment plan, managing mood, and staying healthy, and advice for coping at work.
- I Want to Support Someone includes tips on how to support different individuals with a mental illness, tips on how to support yourself as a caregiver, strategies to support someone in a crisis, and advice on how to support a suicide loss survivor.
- I Want to Be a Mental Health Advocate provides information on raising awareness and fighting stigma as well as participating in mental health research.
- I’m Looking for More Resources includes links to websites with additional information about mental health and self-assessment tools (e.g., PHQ-9, GAD-7), over 50 printable fact sheets, and charts to learn more and track treatment progress.

Why you should recommend the Toolkit to your patients

Patients who use educational resources are much more likely to follow physician instructions, adhere to medication regimens, and make necessary lifestyle changes. The Toolkit’s content is logically organized into sections and written in plain language, to ensure that the material is understandable and not overwhelming. The Toolkit not only incorporates evidence-based, credible, and up-to-date medical information, but it includes user-friendly, patient-centered, action-oriented materials and provides practical tools for managing mood disorders and anxiety.

The Toolkit will be updated over time with the latest developments in the field. The on-site survey will also enable the Toolkit’s developers to incorporate feedback from all audiences. The Depression Center Toolkit is available to the public for free at depressioncenter.org/toolkit.
We are living in a pressing time of transition in our nation. Even while attitudes are opening up about mental health and suicide prevention, the rate of suicide continues to rise in the United States, in fact by nearly 30% over the past two decades. After a century of progress as a nation, overall mortality particularly in the middle years is increasing as a result of the so-called deaths of despair due to suicide, alcohol, opioids, and liver disease. In an era with greater technologic advances and potential connectivity, the science of suicide demonstrates that many forces are still active, including human experiences of isolation, struggle, loss, and unmet expectations, and concurrently, low mental health literacy. Although 94% of US adults believe mental health is equally important to physical health, most do not know how to identify changes in mental health that signal serious risk, or what to do in response, let alone have feasible access and mental health coverage anywhere near parity.

Additionally, overreliance on a sense of self-sufficiency and fear of judgment are barriers to achieving deeper connections in our relationships and fully integrating suicide prevention into actionable steps in our homes and communities. The truth is that interpersonal connectivity is a basic need for humans. When we lose that experience of connection, whether due to changes in culture and modern frenetic living or shame that drives people to hide their true internal experiences, then the prevalent experience of unaddressed mental health conditions and other types of suffering can lead to the problems we are seeing in the rising suicide rate.

We must be ready for the fact that all of us as members of the human condition will face incredible challenges, at times pushing beyond our own sense of capability in a given moment. Most will experience varying degrees of isolation. The full continuum of mental health spans a wide range from joy to terrible anguish, and ambivalence between hope and hopelessness (and many other risk factors for suicide) is fairly common human experiences. If we can learn to discuss these human experiences without shame, we can become more sophisticated at recognizing the potential avenues for effective intervention to lead a person in trouble down a healthier path. Additionally, by sharing these experiences more freely with trusted others, our sense of connectedness can lead to better health outcomes in many arenas including suicide risk reduction.

Imagine a society in which a common, basic understanding of neuroplasticity and epigenetics are fact, not fiction, informing a more compassionate, trauma-informed approach to K to 12 education and workplace wellness. With this basic, foundational knowledge of neuroscience, children and adults can be taught strategies that protect and enhance cortical brain development, prevention for psychiatric illness can start early, and suicide prevention can be built into every school and pediatric clinic. Envision a society in which front-line citizens (eg, first responders, teachers, health professionals, legal/financial advisors, probation/corrections officers, addiction counselors) are trained in basic mental health first aid and suicide prevention; in which we move beyond stigma related to distress or suicide loss; and in which the RAISE early prevention/intervention model is applied to prodromal or burgeoning mental illness with treatment and self/family strategies as part of recovery. Further, envision a society in which biomarkers for suicide and predictive analytics are further refined and scaled to national level so that every patient in primary care has the benefit of mental health screening and suicide preventive interventions, as they do for other leading causes of death (eg, cardiovascular disease, cancer, infectious diseases). Finally, envision a society in which health systems have become suicide-safer systems of care.

These advances are at various stages of progress. New recommended care standards were recently released for better detection and clinical care that reduces suicide risk. At the American Foundation for Suicide Prevention, we fund research, provide
community education, and serve as a catalyst for cultural transformation and suicide rate reduction through initiatives like Project 2025. We remain hopeful because we see the seeds of change glimmering around the US. Through the leadership of our scientific community and our delivery mechanism for education, advocacy, and loss support through a chapter network in all 50 states, we see that suicide prevention is not only possible, but the foundation is being built. We must all work together in the field of psychiatry with partners of many types, including health system leaders, tech and corporate leaders, media, education, and policy makers, to mount the effective suicide prevention plan that is necessary to stem this rising tide.

In this Special Report, new developments and current thinking in suicide prevention are presented, including:

- **Recommended language changes that can speed the eradication of stigma** (eg, the recommendation to stop using the phrase “commit suicide” because suicide is a complex health outcome, not a moral failing)

- **One physician’s powerful personal experience of suicide loss and lived experience that has led to newfound freedom**

- **Treatment modalities with evidence for reducing suicide risk in high-risk patient populations: cognitive behavioral therapy for suicidal cognitions and behaviors, dialectical behavior therapy for adults with borderline personality disorder and for adolescents with elevated suicide risk, among other modalities**

- **New methods in suicide prevention research aimed at better risk detection**

- **An approach to clinical suicide risk assessment that incorporates underutilized tools like the Reasons for Living Inventory**

- **Integration of suicide prevention practices into primary care**

- **A health system framework called Zero Suicide that specifically aims to better identify at-risk patients and provide the warm handoff and care, follow-up contact, and evidence-based treatment that can save lives**

- **Research about the impact of media and social media in particular related to mental health and suicide prevention**

Suicide prevention is a complex challenge, but we remain resolute. The nation’s readiness for effective pro-mental health and suicide prevention strategies is growing like never before, and the scientific field of suicide has matured enough to provide answers. In this issue and the next issue, we share highlights from the growing science.

**Dr Moutier** is Chief Medical Officer, American Foundation for Suicide Prevention, New York, NY.

Dr Moutier reports no conflicts of interest concerning the subject matter of this Special Report.

**References**


---

**REMISSION ACCOMPLISHED**

The largest pharmacogenomics clinical trial in mental health found that using GeneSight® Psychotropic to aid in prescribing resulted in a 50% improvement in remission rates for depression after 8 weeks versus treatment as usual in treatment-resistant depression patients. By 24 weeks, 30% of patients were in remission.1

Understanding your patients’ genetics with the GeneSight® Psychotropic test allows you to choose more optimal medications and helps more patients achieve remission.

Learn more at genesight.com/rct
Words Matter: The Language of Suicidal Self-Directed Violence

Ryan Holliday, PhD, Hal Wortzel, MD, and Bridget Matarazzo, PsyD

Dr. Holliday is Advanced Postdoctoral Research Fellow, Rocky Mountain Mental Illness Research, Education, and Clinical Center for Suicide Prevention, and Instructor, Department of Psychiatry, University of Colorado, Anschutz Medical Campus; Dr. Wortzel is Director, Neuropsychiatry Consultation Services, Co-Director, Suicide Risk Management Consultation Program, Rocky Mountain Mental Illness Research, Education, and Clinical Center for Suicide Prevention, and Associate Professor, Departments of Psychiatry, Psychology, and Physical Medicine and Rehabilitation, University of Colorado, Anschutz Medical Campus; Dr. Matarazzo is Clinical/Research Psychologist and Director, Clinical Services, Rocky Mountain Mental Illness Research, Education, and Clinical Center for Suicide Prevention, and Associate Professor, Department of Psychiatry, University of Colorado, Anschutz Medical Campus.

In the wake of the unfortunate passing of several high-profile individuals, media headlines illustrate a long-standing and persistent challenge regarding how best to speak and write about suicidal self-directed violence. This includes both suicidal thoughts, or suicidal ideation, and behaviors including preparatory behavior, suicide attempt, and death by suicide. Despite the Centers for Disease Control and Prevention advocating for uniform definitions of self-directed violence, coupled with guidelines by leading suicide prevention experts and organizations (eg, American Association of Suicidology, American Foundation for Suicide Prevention) to facilitate understanding and reporting of suicidal self-directed violence in the media, idiosyncratic, even troubling, turns of phrase continue to feature in the popular discourse.

The incongruity between recommended reporting guidelines and the language often utilized by the popular press provides evidence of a significant disconnect between the field of mental health and the media. The problem is perpetuated in part by challenges faced within the clinical and research sectors in terms of widespread education and implementation of the preferred suicidal self-directed violence nomenclature. Indeed, a quick online search will produce a litany of headlines featuring what is now considered antiquated language for suicidal self-directed violence, such as an individual who “committed suicide” or experienced a “failed suicide attempt.” Unfortunately, similar language not infrequently still appears in clinical records and communications offered by mental health professionals.

Consequences of biased and negative terminology

Although at surface level these phrases may appear rather benign relative to other outdated terms, such as “suicidal manipulation” or “rational suicide,” these terms, as well as others that are inconsistent with the proposed universal nomenclature, risk maintaining stigma and bias. Illustrative is the Merriam-Webster dictionary definition of “commit,” denoting an action that is deliberate, with “crime” and “sin” being the referent of deliberate action. The use of “committed” (often unintentionally) thus imbues suicide with a sense of badness or moral infirmity. Similarly, a “failed attempt” suggests that dying by suicide equates with success. The use of such biased suicidal self-directed violence terminology may reframe the negative quality and heighten stigmatization of suicidal thoughts or behavior.

The persistent use of suicidal self-directed violence terminology inconsistent with proffered universal nomenclature carries with it several downsides that are inconsistent with the proposed universal suicidal self-directed violence nomenclature. Within clinical, research, and public health settings. Of course, such language is then all the more likely to feature in the popular discourse among the general population. This sets up a cycle of continued use whereby mental health professionals, media, and lay persons mutually influence one another, normalizing terms and phrases that are inherently biased, vague, and at times detrimental to patients’ treatment engagement and recovery.

Suicidal self-directed violence is often a devastating event that touches both the patient as well as those within their social support system including family and friends. Lack of patient-centered wording in these circumstances thus has the potential to further exacerbate grieving and complicate the recovery process. For example, headlines reporting on suicidal self-directed violence in a manner that fails to adhere to the current reporting guidelines (eg, “actor uses knife in failed attempt to commit suicide”) not only sensationallyizes such events but also has the potential to vilify an individual in crisis as being a “failure” for not “completing” the suicide attempt, or as morally defective for “committing” thoughts or actions involving suicide. This likely results in further stigmatization around mental health, and suicidal self-directed violence in particular, which is especially alarming given the significant public health concern that suicide remains.

Historically the discussion and documentation of suicidal ideation, suicide attempts, and death by suicide is laden with pejorative and biased nomenclature. In order to assuage the taboo that surrounds suicide, utilization of non-judgmental suicidal self-directed violence nomenclature is important among both mental health professionals and the media.

- While universal suicidal self-directed violence nomenclature exists, it remains underutilized by both providers and the media.
- Continued utilization of antiquated, inappropriate suicidal self-directed violence nomenclature perpetuates the use of pejorative suicide phraseology.
- Synergistic efforts by mental health professionals and the media are integral to increase the appropriate discussion of suicide.

Significance for Practicing Psychiatrists

Global use of appropriate suicidal self-directed violence nomenclature requires more than uptake and adherence within medical settings. Attenuation of use of antiquated suicidal self-directed violence terminology requires a multidimensional, multidisciplinary approach that reaches across multiple sectors of the community. Specifically, approaches that continue the public health dialogue among mental health clinicians, researchers, and media personnel are necessary to facilitate consensus. Extended research continues to suggest a significant gap between aspirational language and actual reporting of suicidal self-directed violence, with a 2010 study finding that approximately 36% of reported stories continuing to use repudiated language (eg, commit suicide, failed suicide attempt, suicidal gesture) identified by the recommended media reporting guidelines.

Continued attention to how suicidal self-directed violence is discussed, within both the clinical and media sectors, remains important if we are to understand how nomenclature may influence suicide risk, especially in terms of how biased or stigmatizing language may provoke stigmatizing and dysphoric reactions among patients and those bereaved by suicide. There is some progress: revisions by the Associated Press Style Book in 2015 advocated for discontinued use of the
term “commit/committed suicide” in favor of “died by suicide, killed him/herself, took his/her own life,” reflecting a continued culture of change. Further, at the time of this writing, a recent media report described the passing of a celebrity singer due to death by suicide, doing so in accordance with the recommended media reporting guidelines.

Scientific advances can inform clinical care for youths suffering from suicidal and self-harm behaviors and tendencies.

Clinical strategies provide care that helps youths build lives they want to live.

Child and Adolescent Suicide and Self Harm: Treatment and Prevention

I received a message from the parent of a patient that read, “He finally did it.” Tragically, the boy was found dead in his college dorm room after hanging himself. I had treated the boy when he was 15 years old following a suicide attempt. At that time, the boy was suffering from depression and suicidal thoughts. These problems remitted with treatment, and there were no other suicide attempts during high school. He went to college, and saw a psychiatrist near the college for follow-up care.

Suicide prevention is perhaps our greatest challenge. Among youth ages 10 to 24 years, suicide is the second leading cause of death. Over 6000 individuals in the 10- to 24-year age group lost their lives to suicide in 2016.1 Although still a rare event statistically (nearly 15,000 individuals in the same age range died by unintentional injuries in 2016), many of us providing psychiatric care will lose patients to suicide.1 Despite the recognition that as much as we try it is not possible to prevent all suicides, there have been substantial advances in knowledge regarding treatment. This article reviews some of these advances, which have been selected to inform clinical care.

Developmental considerations

Adolescence offers a developmental window when early effective intervention may prevent potentially deadly patterns from becoming established. Although rare in childhood, rates of suicide deaths in the United States more than double from adolescence to young adulthood and, unlike other causes of mortality for adolescents (eg, motor vehicle accidents), suicide rates are increasing.3 The first onset of suicidal behavior often occurs during adolescence, and the rate of suicide attempts (SAs) and self harm more generally (including nonsuicidal self injury [NSSI], self harm with ambiguous intent, and SAs) also increases. For those of us who work with adolescents and/or their parents, the hope is that early recognition and intervention can prevent suicidal behavior and premature deaths.

Etiology, risk, and protective processes

Suicide has no single cause, and the causes and predictors of suicide and SAs vary across individuals. Due to this heterogeneity, most risk factors account for a small proportion of the variance in predicting suicide deaths. The variation in risk and protective factors across individuals has led to interest in machine learning and related approaches to identify individuals with heightened imminent risk for suicide, with the goal of intervening to prevent deaths. Application of machine-learning algorithms within health systems could potentially be used to identify high-risk individuals and provide monitoring and care to prevent suffering and deaths.2

A previous SA or self-harm history (hereafter referred to as SASH) is the most consistently replicated risk factor for suicide deaths and a strong predictor of premature death by unnatural causes (eg, drug overdose, car accidents, homicide).3 Prior SASH history, including NSSI particularly when associated with suicidal ideation (SI) and/or depression, is also a significant predictor of nonfatal SAs. Suicide deaths increase during the young adult years, are more common in males, and are often high among American Indians and Alaskan Native populations. SAs are more common in females. Depression, substance abuse, bipolar disorders, emerging psychosis, schizophrenia, sexual and gender minority status, bullying, exposure to suicide, and other forms of psychosocial stress are associated with increased risk for fatal and nonfatal SAs. Some medical treatments may also be associated with increased suicide risk (eg, steroids and steroid withdrawal). Sleep disturbance may be an indicator of imminent suicide risk. See reviews for more information on risk and protective factors.4

Emergency evaluation/management: when a patient expresses a desire to die, cuts, or engages in other forms of self harm “If this is an emergency, call 911 or go to your nearest emergency room.” Referral to the emergency department (ED) is often the chosen option when there is a concern regarding patient safety. Once seen in the ED, patients are assessed and triaged to inpatient care when further evaluation and acute treatment are judged to be needed, with EDs serving as gatekeepers to care for many patients. This service pathway, however, is too frequently associated with negative experiences that can decrease the willingness of youths to come forward in the future when experiencing suicidal urges and the willingness of parents to seek care when they have concerns. The increasing number of children and adolescents presenting to EDs with mental health crises combined with a limited number of psychiatric beds places stress on ED resources, often leads to extended boarding in the ED, and, as illustrated by the following quote, can contribute to inadequate care and poor outcomes5:

“Once I told my school counselor I had taken pills to kill myself, she wouldn’t let me leave. Then the police came, put handcuffs on me and took me out of the school in front of all the other kids. They took me to the emergency room where they kept me for 12 hours. Then they sent me to a hospital. It was awful. One thing I learned was never tell anyone if you are thinking of killing yourself.”

Both enhanced mental health interventions in the ED and inpatient hospitalization from the ED are associated with higher rates of linkage to outpatient follow-up treatment compared to discharge home, a first step for adequate continuity of care.6,7 This is an important goal and listed as Objective 8.4 in the US National Strategy for Suicide Prevention due

References
6. Talman FT, Canetto SS, Slater MD. Suicide coverage in US newspapers following the publication of the media guidelines. Suicide Life Threat Behav. 2010;40:524-534.
to the relatively low rates of follow-up treatment seen among patients presenting with SI and SAs. Hospitalization is necessary in some instances for further evaluation, treatment, and safety. Nevertheless, hospitalization can lead to lost opportunities to support patients in coping in their usual environments and possibly worse outcomes if patients learn that they can escape stress in their lives through hospitalizations. Hospital stays are also costly. Brief therapeutic assessment in the ED or other settings may be both more effective and lead to more cost-effective care. 

For youths not requiring more intensive evaluation and protection, clinicians might consider brief emergency interventions such as the Family Intervention for Suicide Prevention/Safe Alternatives for Teens and Youths (SAFETY), therapeutic assessment, and other approaches. These brief emergency interventions generally aim to mobilize protective processes in the youth and environment, and the response of patients and parents/caregivers (hereafter referred to as “parents”) during these processes is key for healing. Originally developed/tested for treating suicidal adults with borderline personality disorder, DBT for adolescents includes individual psychotherapy with some family sessions, multi-family group skills training with adolescents and parents, therapist availability for phone coaching 24 hours daily for youths and parents, and weekly therapist consultation teams to support therapists in doing the best they can to provide effective treatment barriers, caring contacts) and can be integrated within a care process and triage model when there is a potential for discharge home (Figure). 

Research also indicates advantages of intensive community-based treatment, such as multisystemic therapy (MST). A randomized controlled trial (RCT) that compared MST to hospitalization among children and adolescents presenting with acute psychiatric emergencies found a potential for discharge home (Figure). 

The variation in risk and protective processes across individual youths and the complexity of pathways to suicidal behavior . . . highlight the importance of personalizing approaches to care.

Psychosocial treatment

The most promising outcomes are for intensive outpatient psychotherapies with a strong family focus such as dialectical behavior therapy (DBT), a “third wave” cognitive behavioral therapy (CBT). DBT begins with CBT strategies and adds a focus on acceptance and validation, dialectical processes such as the need to achieve a balance between acceptance and change strategies, addresses behavior that interferes with therapy, and emphasizes the therapeutic relationship

PSYCHOPHARMACOLOGIC TREATMENT

Because at least 50% of individuals who die by suicide meet criteria for psychiatric disorders, a logical approach is to treat the associated disorder using medication appropriate for that disorder. Depression and antidepressant treatments are common in suicidal/self-harming youths. Other common diagnostic presentations in youths include: bipolar disorder, borderline personality disorder/features, substance abuse, emerging psychoses, anxiety, and traumatic stress.
SUICIDE AND SELF-HARM: PART 1

Dr. Asarnow reports that she is a consultant/receives funding from the NIMH, the Substance Abuse and Mental Health Services Administration, the American Psychological Association, the American Foundation for Suicide Prevention, and the Klingenstein Third Generation Foundation. Dr. Fogelson and Hughes and Ms. Fitzpatrick report no conflicts of interest concerning the subject matter of this article.

morrances, co-occurring problems, potential lethality of medications, and side effects also need consideration when developing a treatment plan.

The FDA-directed black box warnings regarding a possible increase in the risk of suicidal thinking and behavior in children, adolescents, and young adults (<25 years) treated with antidepressant medications, led to decreased antidepressant prescribing.16 These warnings were based on evidence reviews indicating a small increase in rates of SI and SAs following antidepressant treatment. Analyses of risk differences for “clinical response” and for “suicidal ideation and attempts,” however, suggest that benefits of antidepressant treatment are greater than risks of SI and SAs, with 4% to 11% more depressed youths benefiting from antidepressants versus experiencing a suicidal event.16 Finally, in contrast to the clinical trials that generally exclude patients with high suicide risk, results of larger and more representative pharmacoepidemiologic studies point to a protective effect of antidepressant treatment, with several studies indicating lower suicide rates with higher antidepressant use.16

Given the collective evidence, the American Academy of Child and Adolescent Psychiatry recommends treatment for depression using medication and psychotherapy treatments supported by the evidence. As well, based on the evidence, it supports combined medication and psychotherapy treatment as the most efficacious option.17 Similarly, the Society for Adolescent Medicine (SAM) supports appropriate use of antidepressant medications in the treatment for adolescents with depression and the need to balance the risk of suicidality and clinical need.18

Prevention
Results on community-based, school-based, and health system approaches to prevention are also promising. The Garrett Lee Smith Memorial Youth Suicide Prevention Program (GLS) is a major US initiative that funded multiple community-based suicide prevention programs across the nation. Although programs used diverse components (eg, training, community partnerships, infrastructure for improved service linkage, crisis hotlines), gatekeeper training in which teachers/ others with frequent youth contact were taught to identify and refer suicidal youths was a core feature, and served as an indicator of program exposure in the evaluations. Comparisons of data from counties with GLS programs with those for similar/control counties indicated both significantly lower rates of suicide deaths and nonfatal SAs in GLS counties.19 School-based prevention programs that offer skills and work to reduce stigma associated with help seeking have also shown promise for reducing SAs.20 The Zero Suicide initiative in the US aims to support health systems in making system-wide commitments to suicide prevention using a continuous quality improvement process to identify, treat, and provide care for at-risk patients using evidence-based tools and strategies (https://zerosuicide.sprc.org/toolkit). This approach stems from promising results from the Henry Ford Health System indicating that when the health system organized around the zero suicide goal and delivery of “perfect depression care,” a decline in suicide rates was observed.14

Conclusion
We now have psychotherapeutic and prevention strategies with demonstrated benefits for reducing SH and SAs, effective medication treatments for disorders associated with suicide risk, and emerging care process and triage models for improving emergency evaluation and care for youths presenting with suicide and SH risk. A combination of evidence-based psychotherapy augmented by medication as appropriate when a psychiatric disorder is present is likely to be beneficial. The variability in risk and protective processes across individual youths and the complexity of pathways to suicidal behavior present challenges and highlights the importance of personalizing approaches to care to match individuals to care strategies that will be most beneficial and to time interventions optimally. Combining clinical wisdom, skill, and knowledge gained from our science offers a way forward and may allow us to shift the trend toward increasing suicide rates, successfully prevent SAs and premature deaths in our youth, and provide care that helps youths build lives they want to live.

POETRY OF THE TIMES

Dr. Richard M. Berlin, MD

They love to talk like air traffic controllers: “Angle the spinal needle 20 degrees and push gently toward the midline.”

And though I don’t say “Roger” or “I copy that” loud enough for patients to hear, that’s what I whisper to the dead.

Sometimes they tease me about mistakes I’ve made—pneumonia I called heart failure, thyroid disease I diagnosed as depression.

They niggle me about lab tests I forgot to order, forms sent without signatures, all the phone calls waiting to be returned.

Their voices are the hum I hear at night and at dawn’s first light. Rarely, they are kind enough to praise my skill or allow me to take pleasure in my work.

But all my dead patients love to laugh and remind me, no matter what I do, I will join them all too soon.
Most clinicians are not aware that suicide risk should be addressed specifically and separately from the primary psychiatric diagnosis.

Reducing Suicide Risk

The Role of Psychotherapy

Dr. Sudak and Dr. Rajalakshmi

In the past 30 years, a considerable body of research has been amassed regarding the use of psychotherapy to manage suicidal behavior. Much of this research included the premise that suicidal behavior must be dealt with as a problem separate from a primary diagnosis (e.g., depression) and that techniques must be used to both manage the risk in the present and prevent recurrences in the future. Most clinicians are not aware that suicide risk should be addressed specifically and separately from the primary psychiatric diagnosis. Practi- cal, evidence-based approaches have been developed that decrease the risk of present and future attempts. We aim to provide a brief synopsis of the research evidence, followed by several examples of strategies that such treatment employs.

Cognitive behavioral therapy for suicide

Several systematic reviews have analyzed existing data on the effect of therapeutic interventions to reduce suicide risk. In 2008, Tarrier et al. examined 28 randomized controlled trials (RCTs) involving adults and adolescents. The researchers concluded that cognitive behavioral therapy (CBT)-based interventions demonstrated effectiveness in reducing suicidal behavior. A subsequent systematic review by Mehlum et al. (2014) and Tarrier et al. (2008) included 28 randomized controlled trials (RCTs) examining the benefits of standard CBT in adults. Their conclusion agreed with the observation of Harrit et al. Treatment is more effective when directly targeting suicidal thoughts and behavior as opposed to when treatment is designed to address mental illness with the assumption that benefits will also impact suicidal behavior. Hence, the literature underscores the need for specific interventions targeting suicidal behavior.

The meta-analysis by Ogutin and colleagues in 2015 supported the effectiveness of therapeutic interventions including CBT, dialectical behavior therapy (DBT), and constraint-based therapy in reducing self-harm in adolescents. The dearth of independently replicated studies impedes drawing firm conclusions on the comparative benefit of specific therapeutic strategies. Independent trials have looked at the effectiveness of DBT in adolescents who are at high risk for suicide. The CBT by Mehlim et al. in 2014 and the recently published RCT by McCauley and colleagues suggest definite benefits of short-term DBT in adolescents with borderline personality traits who had engaged in prior self-harm and suicide attempts. The latter study also showed superiority of DBT with respect to treatment retention.

Engagement and retention of patients is a significant challenge in managing suicidal behavior. Often, such patients do not seek outpatient therapy and present for emergency care with suicidal crises. The emergency department (ED) must therefore be a key site for intervention. The Emergency Department Safety Assessment and Follow-up Evaluation (EDSAFE) study by Miller and colleagues designed interventions for screening and provision of safety plans with follow-up phone calls to patients and significant others. Stanley et al. discussed the benefits of such ED-based interventions in reducing suicidal risk. Their comparative cohort study showed that safety-planning interventions coupled with structured follow-up reduced the risk of suicidal behavior by 50% and achieved a twofold increase in the odds of treatment engagement over a 6-month period. The safety-planning intervention consisted of six specific strategies: identifying early warning signs, encouraging internal coping strategies, reaching out to family/friends, identifying other individuals who can provide support during suicidal crises, contacting mental health professionals, and lethal means planning. This large-scale study illustrates a feasible, pragmatic approach to suicidal behavior that does not demand extensive resources and can be easily delivered in an ED setting.

Cognitive behavioral therapy for suicide prevention is another short-term intervention designed to specifically address suicidal behavior that has significant effects in reducing future suicide attempts. It is composed of three phases: an initial phase promoting treatment engagement, an intermediate phase focused on cognitive and behavioral strategies targeting suicidal thoughts and mobilizing reasons to live, and a final phase that targets relapse prevention and consolidates the ability to effectively use strategies in the setting of future suicidal crises.

Each of the preceding studies have common psychotherapeutic strategies that may be employed by any clinician. All are rooted in the fundamental principle of the therapist as an empathic partner who forms a strong therapeutic alliance with patients and who acknowledges their suicidal thoughts and behaviors as a response to intolerable pain or acute subjective distress. The patient is enlisted as an active partner in the process of understanding personal risks for future suicide crises and developing remedies for such occurrences.

The following section describes four specific strategies common to these approaches, including lethal means reduction, safety planning, developing reasons for hope, and inspiring delay.

Lethal means reduction

Lethal means reduction is the process of assessing whether patients have access to firearms or other lethal means to commit suicide and then working with them and their support network to restrict access to such means. It is one of the most important and most supported interventions to reduce suicide attempts. Collaborating with the patient by expressing genuine concern about his or her safety, explaining that reducing access will lower the risk of suicidal actions, and then negotiating with the patient and supportive others to make the environment safer is critical for success. In the event that the lethal means available is a firearm, one must assess for multiple firearms and then advocate for removal of all of them. Gunlocks, removal of ammunition, or gun safes are also possible ways to restrict access if the patient
refuses to remove the gun(s) from the home.

Methodical inquiry about possible methods and what might limit the ability of the patient/family to remove them is the central task for the clinician. If the patient is hesitant, it helps to assess the pros and cons of restricted access, reminding the patient that this may be time-limited. As in all work with suicidal patients, the more collaboration that is possible with supportive others, the better.

Safety planning
Generally, suicidal behavior occurs as a reflexive response to certain triggers. It is common for patients who engage in such behavior to regard suicide as a means of solving problems that they view as insolvable. Such patients often have significant problem-solving deficits. When patients have no relief from relentless worry or concern about problems, and they think of suicide, the relief it may provide reinforces suicidal thinking and increases the risk for further action. Skill deficiencies that patients have—in problem solving, distress tolerance, emotion regulation, and conflict resolution—may increase their risk for future vulnerability to suicidal behavior.

A particularly good strategy is to plan alternatives that keep the patient safe until skills can be learned or other solutions put into place. Safety planning, as described by Stanley and colleagues, is an intervention with which the clinician actively and collaboratively determines with the patient a prioritized and personalized list of warning signs that a crisis is beginning to occur. The clinician then finds coping strategies and internal and external resources that the patient can use at this time. This plan is derived from a risk assessment and the narrative description of the patient’s crisis. It is designed to be over practiced (like a fire drill) so that the plan will be available for use during a suicide emergency. Making a safety plan begins with a chain analysis of the suicidal thoughts, the barriers that led to suicidal thoughts or an attempt and the subsequent consequences. The patient must understand that suicidal thoughts are transient and vary in intensity.

The plan provides time for these urges to decrease before permanent harm occurs. The patient is consulted as the expert on his or her own suicidal behavior: “What have you done on your own to decrease suicide urges?” and “How do you get your mind off of it?” If the patient cannot generate options, the clinician may provide suggestions. These may include distractive activities, alternative thoughts, or strategies to decrease painful emotions. After formulating a plan for distractions, the patient is asked to identify two groups of social contacts: a group with whom she or he may be distracted from the suicidal thoughts, and a group that can help with suicidal thoughts. Finally, emergency services are identified that the patient can access if a crisis is imminent.

At each step of the safety planning intervention, the patient is asked about the likelihood of using the intervention, the obstacles he or she anticipates to its use, and those obstacles solved. If the patient cannot solve obstacles or commit to the use of the plan, then more restrictive care is indicated. Once the plan is completed, the written plan is given to the patient and the patient is asked where it will be kept for review and use.

In later sessions, the therapist may provide training in skills that are absent and that increase the patient’s vulnerability to suicide and then mentally rehearse the deployment of those skills in a similar setting in the future. Patients must repeatedly practice new ways of thinking and behavior so that they have other solutions besides suicide available at times of future stress. Patients who develop better ways of coping in a crisis and repeatedly practice such skills (even in their imagination) have greater resilience during stressful circumstances and reduce their reliance on suicide as a solution.

CASE VIGNETTE
A 45-year-old construction worker sustained a crush injury of his right arm 2 years ago. He has had four surgical procedures and extensive physical therapy, but has continued to experience intractable pain and has been unable to return to work. His family has struggled to make ends meet. He has used opiate pain medication since the accident but never exceeds what is recommended. He needs help with all of his activities of daily living, including dressing.

After his last surgery, he has been more despondent. He meets the full criteria for major depression. He has started to drink to fall asleep at night. His wife brought him to the ED after he told her that he thought she and the family would be better off without him.

After assessing him in the ED, the psychiatrist determines that there are no weapons in the home. The patient indicates that he had plans to overdose on his oxycodone when he got his monthly prescription this week. He and his wife agree that she will keep the pills locked at her place of work and give him access to only a day at a time. The psychiatrist then turns her attention to making a safety plan with her husband. They first discuss all the triggers that produce his intense thoughts of suicide. The patient is asked what would prevent him from using the plan. He says that if he were unable to contact a friend or his wife, he might have trouble. They review professional help that he can contact. He discusses his feeling that this makes him “weak” but eventually commits to doing so.

When asked for reasons to stay alive, the patient says, “My children.”

The psychiatrist asks for more detail: “What is important to your children that you do together? What do you value about being with your children? What would you miss in the future with your children if you died today?” As he describes more about their relationship, he becomes tearful, and the psychiatrist probes further about what he might miss in the future with his children were he to die. He is much more certain about using the safety plan reliably after this discussion.

Developing reasons for hope
Most CBT/DBT interventions approach suicidal patients with an eye toward managing hopelessness. A cornerstone of DBT is the idea that the patient must build a life worth living, even when the patient has many life problems and a wish to die. In CBT, a core premise is monitoring and managing hopelessness, because the presence of hopelessness is a significant risk factor for suicide even in the absence of depression.

Methods that improve hopelessness generally connect patients to core values and attachments to inspire the patient to tolerate current pain and stay alive. Making a list of reasons to live generally is a part of the safety plan. The psychiatrist must ask the patient to describe vividly the attachment the patient has to these reasons to strengthen resolve.

Another technique is to build a hope box. This is a tangible collection of items that remind the patient of reasons to stay alive. It may include photographs, inspirational scripture or quotes, poetry, letters, meaningful mementos, and reminders of things that the patient wants to do in the future. These items inspire more emotional connections to the commitment to stay alive. Such items can be actual or virtual (ie, in a phone app) so that the patient has easy access.

Inspiring delay
Generally, the impulse to suicide is momentary. If the patient can delay action on the impulse, it may be life-saving. Several strategies facilitate delay. First, the patient can be asked to reflect on the things that will be missed if they die, year by year. This brings to light the finality of death and the reality of what the patient will miss. Second, the patient can be asked to commit to “taking suicide off the table.” Many patients who are suicidal are beset with a significant number of psychosocial problems and experience relief when they think about dying as an escape. The patient needs time to begin to resolve these problems.

Working with such patients is a challenge because it is impossible to discuss anything except suicide if that is a genuine possibility. Thus, it is often necessary to agree that the patient will commit to a delay to determine if things can improve enough to allow work on psychosocial problems to occur.

Conclusion
These are just a few examples of how it is possible to use psychotherapeutic interventions to more effectively manage the patient with suicidal thinking and behavior. Although these patients are challenging, there are some tools that we know make a difference.

The authors report no conflicts of interest concerning the subject matter of this article.

References
Jacques Lacan
The Best and Least Known Psychoanalyst

Jacques Lacan was a Parisian psychiatrist who was born in 1901 and who died in 1981. He gained an international reputation as an original interpreter of Sigmund Freud’s work. He visited the United State three times, twice in 1966 and once in 1975, where he lectured at a dozen American universities.

Lacan’s written work and transcribed lectures are often difficult, if not impossible, for most American (and other) mental health professionals to comprehend. His ideas are novel and complex and many seem obscure and enigmatic. Despite the difficulties, Lacan has a devoted following throughout much of the non-English-speaking world (where he is the best-known psychoanalyst) but he is mostly unknown to the English-speaking psychiatric community (where he is the least-known psychoanalyst). This paradox can also be accounted for by the fact that Lacan’s mother tongue, French, is closer to the romance languages of Spanish and Italian.

About five years ago, a colleague of mine asked me to review a book by Bruce Fink, a Lacanian psychoanalyst who splits his time between the University Medical Center, Washington, DC, and his younger brother entered a monastery. Lacan excelled in psychiatry and studied under Gaëtan de Clerambault, after whom De Clerambault’s Syndrome, or Erotomaniac, is named, and who had an important influence on Lacan’s decision to become a psychoanalyst. Lacan’s MD thesis, “On Paranoiac Psychosis and its Relationship to the Personality,” previewed his later interest in the psychotherapeutic treatment of patients with psychosis.

In the 1930s, Lacan became acquainted with a group of Avant-gard writers and artists in Paris. He became friends with Salvador Dali in whose paintings he saw expressions of the unconscious in dreams, and Lacan became Pablo Picasso’s personal physician. At the end of his career Lacan developed a renewed interest in James Joyce and attended the first public reading by Joyce of Ulysses. Lacan was analyzed by Dolf Lowenstein between 1932 and 1938 and gained the status of “psychoanalyst” in 1936.

The Mirror Stage and the imaginary register
In 1936, Lacan presented a paper to the International Psychoanalytical Association in Marienbad, Germany on the Mirror Stage of development. Human beings are born in an immature state, only gradually being able to walk and talk, and Lacan wondered how children developed their relationship to their bodies. He postulated, based on animal behavior and child observation studies, that children between the ages 6 and 18 months, identify with their image in a mirror and that this gives the child the jubilant perception of itself as whole and complete, in contrast to the child’s inner experience of being fragmented and disconnected.

Lacan called this false image of wholeness in the mirror, the “ego.” His use of the word “ego” was different from Freud’s as Lacan frequently put “new wine into old bottles.” At the same time, Lacan called his entire work a “return to Freud,” believing that his was a closer and more accurate reading of Freud than how others understood Freud. “Aliteration” was the term that Lacan used to describe the tension between the child’s inner uncoordinated and disconnected perception of self and the integrated image in the mirror.

Following his description of the Mirror Stage, Lacan made a profound leap. He postulated that the child’s false perception of self in the mirror is characteristic of one of the three so-called registers, or orders, in which human beings experience the world. He called this first register the “Imaginary” register, related to the word image and not to “imagination” or “imaging.” The “imaginary” register is the world of sensations—visual, olfactory, auditory, and tactile—and is the register we use to compare ourselves to others. When we meet a patient for the first time, or anyone else for that matter, our initial impression takes place in the “imaginary” register. We are indeed “judging a book by its cover.”

Symptoms and speech
In 1895, Freud made a close association between symptoms and speech in his Studies on Hysteria. Lacan took this further, describing symptoms literally as “words trapped in the body.” This is not as strange as it sounds. We all believe that when patients speak to us—and their words leave their mouths and their bodies—this has something to do with them feeling better and making positive changes in their lives over time.

Lacan even suggests that: “We are our words, rather the other way around.” It is not we who speak our words, but instead the words that we speak define who we are. A novel thought indeed! And yet, as soon as we speak, we are immediately misunderstood by the listener, for we all attach our own individual meanings to the words we use, that are always going to be more or less different from how the listener understands them. To quote Lacan: “Language is meant to be misunderstood.” Much of psychotherapy consists of asking our patients to clarify and elaborate on what they have just told us, so we can have a closer understanding of what they have in mind.

In the illustrated book, Introducing Lacan, the example is given of a girl who repeatedly banged her head on the wall next to her bed each morning. This symptom disappeared when she connected her behavior in therapy to her mother having told her that her father often “woke up on the wrong side of the bed.”

When we meet a patient for the first time, or anyone else for that matter, our initial impression takes place in the “imaginary” register. We are indeed “judging a book by its cover.”

Signifier and signified
Lacan became particularly interested in the work of Ferdinand de Saussure, one of the founders of 20th century linguistics. De Saussure described the linguistic sign composed of (1) a signifier, ie, acoustic image of the word we hear, connected to (2) a signified, ie, concept. For example, the sound of the word “ox” will make an acoustic impression on the listener. Each of us, however, will have a somewhat different idea of what this “ox” is like. For some of us it will be Paul Bunyan’s sidekick, Babe the Blue Ox, for others, the meat in oxtail soup, and for others the ox in Johann Heinrich Roos’s 15th century painting of an ox, and so on. Therefore, the signified, in this example, is the concept of an ox, and not a particular ox.

Lacan famously said, “The unconscious is structured like a language.” He meant that the unconscious is made up of “chains of repressed signifiers” that relate to
one another through their own rules of metaphor and metonymy. These repressed signifiers express themselves through slips of the tongue, associations to dreams, mistaken actions, and through psychiatric symptoms.

By punctuating—a Lacanian term meaning emphasizing—signifiers that stand out to the therapist, the patient will often associate to other signifiers in the signifying chain. For example, when one of my patients used the word “challenging,” referring to her job several times within a brief period I interjected, “challenging”? She replied, “I used to challenge my brother to checkers when we were little and, since he was younger than me, I usually beat him and made him cry. And, I remember exactly where I was when the Challenger blew up and all seven astronauts died.” This allowed the patient to put into words her previously unconscious aggression.

Lacan pointed out that some signifiers have special importance to us, he called these “master signifiers.” These are the limited number of signifiers that most define who we are. A little girl, Susan, showed me a school poster on which she had been asked to write some important things about herself: that her name is Susan, that she is four and a half years old, that she has red hair and green eyes, and that she likes to eat potato chips. These are some of Susan’s master signifiers.

Proper names are special and different from all other signifiers: they only point to one unique signified—the person with that name! I routinely ask patients where their names come from—both their first and last names—and I immediately learn about the symbolic register (see below) into which they were born.

The symbolic register
In the 1950s, Lacan developed the idea of the “symbolic register,” that part of human existence that includes language, culture, laws, traditions, rituals, and religion. This symbolic register is waiting for us when we are born. Our parents have often already selected a name for us, we learn the language of our family, we take part in our family’s traditions and rituals, etc. Even a vision of our future has often been mapped out for us. It is no accident that the children of musicians, physicians, and even morticians, often follow in their parents’ careers.

The symbolic register increasingly takes its place alongside the imaginary register. In another example from the book, *Introducing Lacan,* a mother is telling her child who is being held up in front of a mirror: “You’ve got grandma’s eyes,” “You look just like your father,” etc. The child will later identify with, rebel against, or do some of each, with what it has absorbed through the symbolic register.

One of Lacan’s therapeutic goals was to help the patient increasingly move from the imaginary to the symbolic register. Martin Luther King, Jr. expressed this idea well: “I look to a day when people will not be judged by the color of their skin, but by the content of their character.”

The real register
In 1953, Lacan identified a third register of human existence, the “real.” Whereas, the imaginary is the world of immediate sensory perceptions, and the symbolic is based on language and gives meaning to everything around us, the real is whatever else there is that is devoid of meaning. Quoting Lacan: “The real is all that cannot be symbolized and that is excluded from the symbolic and imaginary registers.”

Before and soon after a baby is born and has not yet acquired words or language, it is living entirely in the real register. As soon as it learns to say “mama” and other signifiers, the baby has begun to take part in the symbolic register that “makes a cut in the real.”

Whenever we speak, there is always much more that remains unspoken, and whatever is left unsaid and unsymbolized, exists in the real. At the other end of the life spectrum, for patients with advanced Alzheimer disease for whom words have mostly lost their meaning, they are increasingly living in the register of the real.
Lacan’s diagnostic categories

Lacan, following Freud, had three major diagnostic categories: (1) Neurosis – that he divided into the Obsessive and the Hysteric personality; (2) Perversion; and (3) Psychosis. All DSM V categories collapse into these three major categories of diagnosis for Lacan.

Neurosis: the obsessive. The obsessive asks: “Am I alive or am I dead?” and procrastinates interminably about getting things done, in an unconscious attempt to forestall the eventual certainty of his or her death.

A man in his 40s was still living at home with his parents and had struggled to complete his bachelor’s degree for many years. He increased the frequency of his appointments with me from once to twice a week but then became increasingly quiet in the sessions. When I said “You’re quiet,” he replied, “Now that I’m coming twice a week, it doesn’t matter if I talk as much as before, since I’m here twice as often.” I remarked: “You act as if you have all the time in the world to get done what you say you want to accomplish in life.”

Lacan’s psychodynamic formulations

Each of Lacan’s three major diagnostic categories is based on how the child resolves the Oedipal complex. The neurotic accepts that the “father” is the object of mother’s desire and hopes to find a “mother” substitute (an intimate partner) in the future. The pervert also accepts that the “father” is the object of mother’s desire but denies (disavows) this traumatic reality and uses a fetish object as a partial substitute for the mother to satisfy his desires. The psychotic maintains a dyadic relationship with the mother because the father figure is absent during the early years of the child’s development. In Lacanian terms, this results in a foreclosure of the paternal function with the psychic person developing/experiencing feelings of omnipotence, grandiosity, and terror.

When needing to cross the street: The obsessive acts as if he has all the time in the world and waits at the corner until there are absolutely no cars coming. The hysteric puts herself in the place of the other and will only cross the street when others are also crossing the street. The pervert acknowledges that he should cross at the light but disavows the law andjaywalks. And the psychotic acts as if there is no law (there has been a foreclosure of the paternal function) and crosses without paying attention to whether there is traffic.

Lacan believed there was no “normal person” and that we all fall into one or another (or a combination) of the three diagnostic categories. In this regard, Lacan agreed with Elvin Semrad who defined a psychotherapist as: “One big mess treating a bigger mess.”

Wish, need, demand, and desire

To Lacan, a “wish” is something we consciously want—for example, a million dollars or a new pair of shoes. A “need” reflects a physiological necessity, such as needing water, food, or sleep, but also love. “Demands” are endless requests for specific things, for example a baby pleading for a balloon, a teddy bear, or a coloring book. But as soon as one demand is fulfilled, a new demand takes its place. A parent who tries to keep up with all of the child’s demands, ends up with an extremely spoiled child. The demand for love is also never fully satisfied and requires repeated expressions of reassurance. “Desire” is unconscious and can never be fulfilled but it directs the trajectory of our lives. In addition, according to Lacan: “The subject’s desire is the Other’s desire,” or “A person’s happiness comes from making the other person happy.” A major goal of Lacanian therapy is to help the patient discover his or her own (unconscious) desire. When a patient is five or ten minutes late, I email and phone the patient, letting him know that I am waiting for him and that I hope to see him soon: I want my desire to see the patient become the patient’s desire to be seen by me.

The borromean knot

Later in his career, Lacan began to express his ideas in mathematical formulations and diagrams, wanting to make them more precise. Using the three interlocking rings of the 16th century borromean crest, Lacan called this the “RSI knot,” each ring representing the real, the symbolic and the imaginary registers. They all need each other to hold the knot together—if any one of the rings is removed, the other two will come apart. Like a Venn diagram, they all have overlapping and separate surface areas. This design also suggests an equivalence between the three registers.

The sinthome

Toward the end of his life, in the 1970s, Lacan proposed adding a 4th ring to the borromean knot that he called the “sinthome”—an old French word for symptom and making a word play on “Saint Thomas.” This fourth ring held the knot together if one of the other three rings was broken. This suggested that a patient’s symptom is adaptive, often keeping the patient from decompensating. Lacan was introduced to James Joyce early in his career, and he later suggested that Joyce’s writing, itself chaotic and disturbed (eg, Finnigan’s Wake) was a sinthome that kept Joyce from becoming psychotic.

The idea that a patient’s symptom serves a purpose is reflected in the admonition that we should not immediately try to take the patient’s symptom away before we understand what role it plays in the patient’s life.

The short, or variable length, session

Relatively early in his career, Lacan introduced the variable-length, also known as the “short,” session for which he was severely criticized by his non-Lacanian colleagues. Lacan believed that sessions should end unexpectedly to emphasize an important point or interpretation, to prevent the patient from filling up the session with trivia until the last minutes, and to avoid having the patient script the session in advance. His critics attributed his “short sessions” to financial greed and to gain additional adherents to the Lacanian cause.

Lacanian psychoanalysis today

In 1980, a year before he died, Lacan dissolved the Ecole Francoise de Psychoanalysis that he had founded 16 years earlier and a new school, the Ecole de la Cause Freudo-Janne, continues his work. In the US, there are three “Lacanian Forums” or study groups, one in Washington, DC, one in Denver, Colorado, and one in San Francisco, and there are many Lacanian groups in Europe and three major Lacanian schools in South America.

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

References

Giving Thanks for These Psychiatrists

H. Steven Moffic, MD

Dr Moffic is an editorial board member and regular contributor to Psychiatric Times. Before he retired from clinical work for the underserved population, he was a tenured Professor at the Medical College of Wisconsin.

U

nally, we do a series of year-end eulogies at Psychiatric Times. This year I sat down to write this a little earlier, just as we were approaching the Thanksgiving holiday. Why? Not only have we seen a large number of losses this year, but the most recent passing shook me to my core and offered a rare public example of a major challenge facing our profession.

Suicide
Alvaro Camacho, MD, MPH
Quarterly, the American Psychiatric Association posts an In Memoriam list of members who have died. The most recent one was shared on October 31st, which ironically begins the Hispanic Day of the Dead celebrations. While Halloween may be a holiday of trick and treats, the Day of the Dead remembers, honors, and celebrates ancestors no longer with us.

As I perused this list, I was surprised to see the name of Dr Camacho. Having presented with him on panels at APA meetings in recent years, I knew he was young, so I wondered (with some dread), what caused this seemingly premature death.

In searching for his obituary and contacting colleagues in community psychiatry, it quickly became clear that this was a suicide. After his death on September 23, the news was conveyed publicly, both in his local newspaper as well as at the beginning of the annual APA Psychiatric Services meeting in early October.

I questioned whether to include him in these eulogies. On the one hand, could it be done in such a way to protect whatever privacy remained? On the other hand, his death is an example of a major challenge for psychiatrists and other physicians—that is, our rate of suicide is higher than the rates for other professions. How could we frame this to respect our profession, while staying true to his memory as a leader in integrated care and as a member of the APA Work Group on Psychiatry and Wellness?

Homicide
Steven E. Pitt, DO
There are two outcomes that every psychiatrist dreads—suicide and homicide. Both, whether in patients or in ourselves, not only result in death but also the end of potential help. This year one of our own was a victim of homicide, which thankfully is rare for our profession.

Dr Pitt was a nationally known forensic psychiatrist based in the Phoenix area. He advised on such high-profile cases as that of JonBenét Ramsey, the Columbia High School massacre, and other homicides. Paradoxically, he, too, was a victim of a risk that he understood so well.

Dr Pitt was shot outside his office on May 31, 2018. He allegedly had evaluated his killer for domestic assault in the past. The perpetrator died by suicide a few days after killing Dr Pitt and others involved in his divorce.

Dr Pitt’s Jewish and Michigan roots were honored at his funeral. Rabbi Harold Loss flew in from his home state of Michigan to conduct the funeral service. He concluded by saying Dr Pitt “would want you to remember his life with joy.”

Accidental Death
Diana J. Lampsa, MD
Sometimes the unexplainable happens, and even psychiatrists are not immune to accidents. Dr Lampsa died in a car crash in Chicago on June 20. She was a passenger in a taxi when a stolen SUV crashed into it while fleeing from police. She was a well-known psychiatrist in my home state of Wisconsin. I knew her fairly well; we shared a mutual concern about managed care. She served as a member of the Wisconsin Psychiatric Association Executive Council and had her own psychiatric center in Manitowoc.

Most notably, she used humor and music to educate the public about our obstacles in providing the best treatment. An example is the song she wrote called Suicide Is Cheaper, after a patient complained about her insurance not paying for treatment. The macabre chorus lines reads:

“Now if you’re gonna get sick it better not be in your head. In case you’re feelin’ low, some folks rather see you dead.”

Dr Lampsa was a devoted Christian and loved angels. Many who knew her would say that she herself was an angel.

Leadership for the Underserved
Marcia Kraft Goin, MD, PhD
Dr Goin represents a long life, well-lived. She died on April 26, 2018, at the age of 85 from cancer.

I first met Dr Goin when I was an intern at the University of Southern California in 1971-1972. During my psychiatric rotation, she was a caring and supportive educator. In talking, we learned we had both attended the same medical school at Yale.

Over time she became an educational leader, sharing lessons in teaching psychotherapy; she also focused on the poor, who she recognized often did not receive individual psychotherapy.

Given her warmth and expertise, it was no surprise that she became one of the first women leaders of psychiatry, becoming president of the American Psychiatric Association and the Group for the Advancement of Psychiatry, where once again she helped me find my way.

Anthropology and Psychiatry
Edward Francis Foulks, MD, PhD
Another well-lived life is that of Dr Foulks, who died on September 1, 2018, of a blood disorder at the age of 81. Early in my career, I developed an interest in cultural psychiatry at Baylor because my community mental health clinic had so many Hispanic and African American patients. Besides benefiting from our own faculty anthropologist, I could not help but be drawn to the Society for the Study of Psychiatry and Culture, which he co-founded. The organization incorporated his rare combination of psychiatry, anthropology, and psychoanalysis. He also led numerous organizations in New Orleans and Louisiana.

Dr Foulks lived in the French Quarter of New Orleans. He volunteered at many festivals and assisted citizen groups, including the Catholic Cultural Heritage Center. Although he received numerous awards in psychiatry, I wonder if his...
Our most seriously ill. and he leaves a legacy that will continue to help Milwaukee. He was deservedly a legend in his time, at the Medical College of Wisconsin in Madison, just down the road from a leaky roof. It is not clear if the staff deemed it to be emergency department complaining of his leaky roof. There was a patient who kept coming to the hospital for substance abuse and dependence. Dr. Kleber not only understood substance abuse and dependence. His vision was never imagined in the original federal funding for community mental health in the sixties. His innovation was meticulously researched and replicated successfully around the world. I recall one story that inspired him to develop ACT. There was a patient who kept coming to the emergency department complaining of his leaking roof. It is not clear if the staff deemed it to be delusional or out of the realm of psychiatric help, and the patient was repeatedly sent home. Until, that is, the patient said that he was suicidal. Dr. Stein realized that in order to keep patients in the community, psychiatrists would need to do whatever was needed to help the patient thrive in the community, even if that meant helping to address a leaky roof. Dr. Stein’s home base was the University of Wisconsin in Madison, just down the road from me at the Medical College of Wisconsin in Milwaukee. He was deservedly a legend in his time, and he leaves a legacy that will continue to help our most seriously ill.

One of Dr. Kleber’s insights was that cocaine users did not need rehabilitation but instead needed habitation; that is, they needed to develop skills that they previously lacked to cope with society. This is as much an educational model as a therapeutic one.

A Forensic Psychiatrist
Douglas Mossman, MD

Dr. Mossman was a well-known forensic psychiatrist based at the University of Cincinnati College of Medicine. He emphasized to students that understanding forensic issues made one a better psychiatrist, no matter the psychiatric specialty. Like his colleague Dr. Pitt, Dr. Mossman had a strong relationship with his Jewish roots. Indeed, he often joked that he was a cantor trapped in a psychiatrist’s body. Perhaps his interest in the laws of the Torah—and the morality associated with them—nurtured his interest in forensic psychiatry. Dr. Mossman was a prolific writer, and his 1994 article “Assessing Predictions of Violence” was especially influential. It is a subject that is still of utmost importance, eerily so in view of the death of his forensic colleague Dr. Pitt. However, my favorite article is “How a Rabbi’s Sermon Resolved My Tarasoff Conflict.”

The Tarasoff decision, of course, is a landmark one in psychiatry. Tarasoff tends to be viewed as a duty to warn someone when a patient appears dangerous and when there is a clearly identified target. Dr. Mossman was long troubled that psychiatric patients were being singled out unfairly as especially violent and that psychiatrists were supposed to “control them.” What he learned—or was reminded of—from a Rabbi while attending a Bar Mitzvah was that Jewish tradition instructs everyone to do what he or she can to save others from danger. Moreover, this is a moral obligation beyond any relevant legal one. Here, it is clear that the Tarasoff decision goes beyond a legal one to be an ethical one that fits both Dr. Mossman’s professional ethics as well as his religious morals.

References
10. Carroll B, Feinberg M, Greden JF et al: A specific laboratory test for severe depression early in his career, he became a trailblazer in exposing corruption in academic research. The irony is that his test, never disproven, became ignored or pushed aside as other biological aspects of psychiatry exploded. However, not only was the subsequent biological findings of variable use, he also reported sloppy research and conflicts of interest. From his own research, he knew how undisclosed payments to researchers could potentially sway research. Under the pseudonym of Adam, he wrote a limerick to describe this process:

“And then we have just across campus
The medical guys playing scammers.
They’ve learned to beguile,
To increase their ash pile.
Once grant funds are safe in their clammers.”

Not surprisingly, his strong criticisms ranked some colleagues. As I also know all too well: telling truth to power often comes with negative personal repercussions.

Thankful reflections
With Dr. Carroll’s idea of seeking reliable information, how reliable is the information in these eulogies? Besides the cited publications, I relied upon publicly released obituaries, collegial knowledge of those who died, and my own personal relationships with some. So, these eulogies are subject to my subjectivity.

Whatever the limitations in my own eulogy research, it is clear that all of the psychiatrists have made major contributions to many aspects of our field. They deserve our utmost thanks. As we look forward to next year and a new set of pioneers and opportunities for the field of psychiatry, I would like to thank our editors at Psychiatric Times who help create this forum to share insights and information with one another, and to you, the reader, without whom the writing would seem meaningless.
As I contemplated cooking the big Thanksgiving meal and the arrival of family from distant places, I was compelled to pause . . . what was there to be thankful for this season of sharing, joy, and blessings?

My northern California neighbors will not be counting their blessings. They did not bake turkeys to serve at Thanksgiving tables. They have no dining rooms left; no ovens in which to prepare the feast and for some, lost loved ones to mourn.

They will have no Christmas trees. In fact, there are no trees left in their forests. They have no living rooms where Christmas trees can be trimmed, and decorations can be hung. Santa Claus will not come down their chimneys. They have no chimneys. They will not display menorahs in windows. They have no windows. In fact, they have no homes, no community and many have lost loved ones; the final death toll is not yet counted.

They will not even have burials for many of the lost, since remains are sparse or impossible to identify, with only fragments of bones left of many who perished.

And as I write this, I sit 175 miles from the ravaging fires that continue to burn. I look out my window and wonder about a white Christmas. But, no, the white sky is not snow but air pollution; air pollution so severe that San Franciscans are wearing respirator masks, stores have run out of supplies and everyone seems an expert on the distinction between levels of respiratory protection. My hometown looks like Beijing.

Many of my patients are in distress. I am sitting with “eco-anxiety” in ways that I have up to now not experienced. My patients are scared, fearful of not being able to protect their children and confused about what to do. The “rainy day” schedule imposed by schools to prepare to respond to such overwhelming needs.

Yet, we have real skills to bring to the effort. Psychological first aid and recovery are essential. We must increase our training and availability for what will be required as we face more climate-driven crises. Triage and identification of those most vulnerable to long-term psychiatric symptoms of PTSD or depression as well as early intervention techniques must be in our toolbox. Protecting the most vulnerable, the elderly and children, and persons with preexisting mental illness must be high priority strategies.

But this is not enough. We must develop and implement public health prevention strategies. This includes helping communities, states, and nations to develop the means to mitigate, prevent, and reverse the impacts of climate change. We, as psychiatrists, have a role in helping those communities accomplish these overwhelming tasks while maintaining and improving psychological health, so that the inhabitants of those communities will remain committed for the long haul to healing their communities and the earth.

The recent Intergovernmental Panel on Climate Change report underscored the urgency of climate disruption, warning that we have less than 20 years to make dramatic changes in how we do business throughout the world. As physicians, we must heed the call. We must develop policies and practices that address the underlying causes of this massive public health threat. And, we must reduce and eliminate our reliance on fossil fuels that drive greenhouse gas emissions and climate chaos.

The American Psychiatric Association (APA) has begun some of this work by joining with other health organizations to address this through participation in the Medical Society Consortium on Climate and Health and by the recent passage at the APA Assembly Action Plan for Health and by the recent passage at the APA Assembly Action Plan for the APA to divest from fossil fuels, which only awaits approval from the APA Board of Trustees before becoming official APA policy.

I continue to hope that psychiatrists, physicians, and citizens will join together and bring our expertise and creativity to face this enormous threat to local, regional, national, and global health. Join us in our efforts to truly bring joy to the world through the Climate Psychiatry Alliance, www.climatepsychiatry.org.
A Common Antioxidant Shows Promise in Bipolar Depression

Chris Aiken, MD

The antioxidant coenzyme Q10 (CoQ10) was found to be effective for the treatment of bipolar depression. The effect size was large (0.87), although it took eight weeks to separate fully from placebo.

The finding builds on two open label studies of CoQ10 in geriatric bipolar depression, which saw improvement with 800 mg to 1200 mg daily in 29 patients. The current study used a lower dose (200 mg/d) and the authors speculated that higher doses might yield a greater response. CoQ10 has also been studied in depression with multiple sclerosis, where a randomized-controlled trial found significant effects at 500 mg daily. The nutrient has improved well-being, vitality, and energy in small controlled trials of specific populations such as patients with breast cancer, the elderly, and Gulf War veterans.

Details of the Study
Mehrpooya and colleagues randomized 89 patients with moderate bipolar depression to receive CoQ10 or placebo as an add-on to their usual regimen. Other medications, which included mood stabilizers and some antidepressants, were kept stable for two months prior to the study and during the study. The study participants were Iranian, with a mean age of 38; and an even ratio of men and women.

Assessments were double-blind and used the Persian version of the Montgomery-Asberg Depression Rating Scale (MADRS). Both groups improved to a similar degree in the first four weeks, but after eight weeks, the CoQ10 group had marked improvement over placebo. Only three patients achieved full remission (all were in the treatment group), and the response rate was significantly higher with CoQ10 than placebo (72% vs 12%).

A limitation of the study was the small sample size: 69 patients were analyzed after 20 dropped out. Although the discontinuations were evenly distributed among the two groups, they were not accounted for in the final data, which may inflate the results.

Mechanisms
CoQ10 occurs naturally in the human body, but levels decline with age, depression, and medical illness. The coenzyme plays a role in several processes that are impaired in bipolar disorder: mitochondrial function, inflammation, and oxidative stress. CoQ10 is also neuroprotective, and prevents neurodegeneration in Alzheimer, Parkinson, and Huntington diseases. It raises brain-derived neurotrophic factor and protects hippocampal cells against injury. Serotonin is another possible avenue for its antidepressant effects.

Risks and Benefits
CoQ10 has few risks and caused no adverse effects in the depression studies. Possible adverse effects may include gastrointestinal discomfort, which is improved by spreading the dose throughout the day and taking with food, and insomnia, which improves with morning dosing. In patients with diabetes, CoQ10 improves glycemic control but can also cause low blood sugar. CoQ10 may also be of potential medical benefit to cardiac disease, hypertension, cancer, migraines, dementia, Huntington disease, Parkinson disease, and fibromyalgia. The major risk is an interaction with warfarin, whose anticoagulant effects may be impeded by CoQ10.

How to Use It
CoQ10 can be started at 200 mg daily and titrated if no response is seen after two months. Dosages seen in studies on depression have been as high as 1200 mg daily without adverse effects, although it is not known whether there is a dose-dependent response. Most studies used regular CoQ10, but absorption can be an issue and some products are formulated to enhance absorption (eg, with polysorbate 80, black pepper extract, Nano, and Q-Gel). Consumer Labs tests supplements for safety and quality, and I have listed a few of their cost-effective options in a patient brochure (as low as 16 cents a day).

The Bottom Line
This is the first controlled study of CoQ10 in bipolar depression. What’s missing is replication, an important step given the drop-out rate and small sample size. On the other hand, CoQ10 has a well-established safety record. It lacks the medical risks that accompany most mood stabilizers, and it can prevent some of the medical problems that tend to accompany bipolar disorder. If patients have not recovered with standard therapeutics, it is worth a try.

References
Medical Aid in Dying: Ethical and Practical Issues for Psychiatrists

Terminally ill patients confront difficult end-of-life choices, which can include determining how and when they wish to hasten their death. Patients with less than six months to live, for whom suffering becomes unbearable, may opt for medical aid in dying. Medical aid in dying (MAiD), also known as “assisted suicide or physician-assisted suicide,” “medical assistance in dying,” “physician-assisted death,” “hastened death,” “right to die,” or “death with dignity,” entails lethal drugs being prescribed or supplied by a physician at the patient’s request and then self-administered by the patient with the aim of ending his or her life.

While suicide is defined by the act of intentional self-inflicted death, MAiD distinguishes itself from death by suicide in that the primary (although not proximal) cause of death is from a foreseeable underlying terminal illness. MAiD also differs from euthanasia, which is the active and intentional ending of a patient’s life by medical means with the active assistance of another person, usually a physician. Although psychiatrists would almost never serve as the attending physician to facilitate a MAiD request, psychiatrists may be asked to help assess a patient during the MAiD process. For a psychiatrist asked to participate in MAiD, this request can create ethical, moral, and clinical dilemmas.

Background
As of 2018, 10 countries including the United States (in some jurisdictions), have enacted laws permitting physician-assisted suicide; only 5 countries have legalized voluntary active euthanasia (Table 1).

In June 1997, the US Supreme Court decided that physician-assisted suicide did not violate the US Constitution and left it to the states to decide the legality of MAiD. Oregon, Washington, Vermont, California, Colorado, the District of Columbia, and Hawaii have enacted MAiD legislation—Montana legally permits MAiD based on a court decision (Table 2). In May 2018, a Riverside County Superior Court decided that the California physician-assisted suicide law was passed unconstitutionally during a special legislative session; the law is presently overturned but is undergoing appeal by the California Attorney General. Based on a judicial ruling that physicians participating with MAiD could not be prosecuted, Bernalillo County in New Mexico briefly permitted MAiD from 2014 to 2015, but this decision was struck down in the New Mexico Court of Appeals in August 2015, making physician-assisted suicide illegal in Bernalillo County and all of New Mexico.
Table 1. Countries with physician-assisted suicide and with or without voluntary active euthanasia

<table>
<thead>
<tr>
<th>Countries</th>
<th>Physician-assisted suicide legal</th>
<th>Voluntary active euthanasia legal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Colombia</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Netherlands</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Japan</td>
<td>Yes*</td>
<td>Yes*</td>
</tr>
<tr>
<td>Canada</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Germany</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>South Africa</td>
<td>Yes*</td>
<td>No</td>
</tr>
<tr>
<td>Switzerland</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

*Based on court determinations and rulings, not on formal legislation.

Table 2. States with legalized medical aid in dying (MAiD) and websites for state MAiD information

<table>
<thead>
<tr>
<th>State</th>
<th>Laws and statutes</th>
<th>Websites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Montana</td>
<td>Montana Supreme Court in Baxter et al v Montana</td>
<td><a href="http://www.compassionandchoices.org/in-your-state/montana/">http://www.compassionandchoices.org/in-your-state/montana/</a></td>
</tr>
<tr>
<td>Hawaii</td>
<td>Our Care, Our Choice Act: HB 2739</td>
<td><a href="http://health.hawaii.gov/">http://health.hawaii.gov/</a></td>
</tr>
</tbody>
</table>

*Website not affiliated with the state of Montana and there is currently no official website for MAiD information in Montana.

Demographics and statistics

Data from Washington, Oregon, Colorado, and California indicate that most patients prescribed MAiD medications have tended to be older than 55 years, white, presently or formerly married, educated beyond high school or GED, enrolled in hospice, medically insured, and have used MAiD medications to die at home. The most cited underlying illnesses for prescribing MAiD medications based on the four states plus Vermont were malignant neoplasms (eg, breast, lung, pancreas, prostate) followed by neuromuscular illness (most commonly amyotrophic lateral sclerosis), followed by non-cancer lung respiratory diseases or heart disease.

Washingtonians and Oregonians who died by MAiD indicated their top three end of life concerns to be: “losing autonomy,” “less able to engage in activities making life enjoyable,” and “loss of dignity.” Other reasons included “losing control of bodily functions,” “being a burden on family, friends/caregivers,” and “inadequate pain control or concern about it.” Their lowest rated concern was the “financial implications of treatment.”

In these states, referrals to psychology or psychiatry for patients undergoing MAiD were rare. In Oregon (1998 to 2016), only 57 of 1127 Death with Dignity Act patients who died via MAiD (5.1%) were referred for psychiatric evaluation whereas in Washington (2009 to 2016), only 44 (4.2%) of 1056 were referred for psychiatric/psychological evaluation. In Colorado (2017) only one out of 69 patients prescribed MAiD medication required a mental health provider’s confirmation of capacity. No data are available from any state regarding the number of people who requested MAiD but were declined because of findings from a psychiatric or psychological evaluation.

Regarding public support for doctor-assisted suicide, a 2017 Gallup poll found that 67% of 493 randomly sampled adults favored MAiD. Among physicians, 57% of an (unscientific) online Medscape survey (N=7505) agreed that physician-assisted suicide or physician-assisted dying be allowed for terminally ill patients. In Canada, 72% of 528 psychiatrists surveyed supported MAiD under certain conditions, while 61.2% did not sup-

As of now, 36 states have enacted laws prohibiting assisted suicide and 3 states prohibit assisted suicide by common law; in 4 states (Nevada, North Carolina, Utah and Wyoming), ambiguities exist regarding the legality of assisted suicide. However, twenty-four states are considering MAiD laws this year and/or in the most recent legislative session.

For specific details about the MAiD process, clinicians are strongly advised to refer to their own state’s laws and statutes. Generally, to qualify for MAiD, a person must be:

- Aged 18 years or older
- Mentally competent
- Have a medically diagnosed terminal illness that will lead to death within six months or less
- A resident of the state with MAiD (no minimum length-of-residency requirements have been thus far imposed)

The requesting patient must be able to self-administer and ingest the medications. Two physicians must agree in the determination that the above criteria have been satisfied without exceptions. The patient must navigate the process steps as laid out by state law to enact MAiD (Table 3).

Patients can choose to rescind their request to participate at any time during the MAiD process. They can also decide to use the medications at any time once the process is completed or to never use the medication or fill the prescription. In some instances, patients may be unable to take the medication after it has been prescribed (eg, if the patient is in a coma or dies, loses the neurological function to ask for and be cognizant of MAiD medication, or cannot physically swallow the 4 ounces of liquid containing MAiD medication within 2 minutes or less).

MAiD medications have usually consisted of lethal doses of barbiturates, but due to cost and access issues, physicians have more recently turned to specific cocktails of other medications to initiate MAiD. If patients complete all steps required by law to obtain MAiD medication, life insurance benefits should be unaffected. Life insurance documentation and death certificates will list the terminal disease that was expected to result in the patient’s death.

Aside from MAiD, patients may also try to hasten death by avoiding or withdrawing treatment(s), palliative sedation, and voluntarily stopping eating and drinking.
The role of the psychiatrist
Psychiatrists should first familiarize themselves with laws and institutional risk-management policies relevant to their personal situations. MAiD-participating physicians are protected if they comply in good faith with the specific laws of their state. Prudent psychiatrists should document all relevant conversations about MAiD, limitations in available therapeutic options, consultations with others, and any rationale for their decisions and actions. Psychiatrists participating in MAiD for states lacking MAiD laws potentially open themselves to civil penalties and/or criminal charges and/or the possibility of public consequences as a MAiD participant.

Psychiatrists should consider whether they wish to participate in MAiD, based on their personal values and level of competence in conducting capacity evaluations; no psychiatrist is obligated to do so. Participating in MAiD can elicit strong emotions and may result in conflicting interests between patients and psychiatrists; psychiatrists need to be aware of any personal cognitive, emotional, and/or social biases about MAiD that may impede their fiduciary role to the patient. Due to potential conflicts of interests, psychiatrists should be independent of the referral source (ie, not part of the same practice group) and not serve dually as both the treating clinician and as a MAiD evaluator.

The mental health MAiD evaluation
The main goal of the mental health evaluation is to determine whether the patient has decision-making capacity to pursue MAiD and to evaluate whether the patient can make rational decisions about MAiD, and if so, to what degree (Table 4). The mental health MAiD evaluation should entail a detailed review and a full psychiatric interview that includes:
- The patient’s chief complaint(s)
- A history of terminal and other illnesses
- Detailed psychiatric, medical, substance use, social, and cultural histories
- Family, religious, and spiritual backgrounds
- Formal mental status exam

A formal evaluation of a patient’s understanding of MAiD should also be documented and can be organized along Appelbaum and Grisso’s four aspects of medical decision-making capacities: choice, understanding, appreciation, and reasoning. Although no validated instruments specific to MAiD currently exist, several assessment measures may assist in evaluating and rating salient symptoms (but these instruments by themselves do not suffice for comprehensive MAiD evaluation). The mental health MAiD evaluation should be formally documented, and all forms necessary for state law completed. Documentation should clearly state the patient’s capacity (or lack thereof) to pursue MAiD and can include treatment recommendations if germane (eg, referrals for psychotherapy, medication treatment). For especially challenging cases, psychiatrists can consider recommending second opinions or further testing, additional visits necessary to adequately complete the mental health portion of the MAiD evaluation, treatment recommendations that may restore capacity, and/or seek out consultations with professional colleagues. Providers who want to learn more about conducting a mental health MAiD evaluation can refer to available guides online or the academic literature (see Additional Reading).

Psychological considerations worth exploring
Studies show that most Oregonians requesting MAiD do not have a mental disorder such as depression but tend to have long-standing personality features of determination, persistence, wanting control, and avoiding dependence (as reflected in the top 3 reasons for pursuing MAiD). Whether through psychotherapy or the mental health MAiD evaluation, it is worth exploring patients’ perceptions of what MAiD will accomplish prior to and following their death, and what emotions drive their push for MAiD. Psychological approaches to patients exploring MAiD can tap strategies of motivational interviewing or therapies such as meaning centered-psychotherapy, dignity therapy, and other existentially oriented psychotherapies to help clarify patients’ perspectives about their goals of care, quality of life, terminal illness, and pending death.

Because family members and significant others of patients pursuing MAiD will invariably be affected, it is also worth exploring the patients’ relationships, whether they’ve communicated with others about MAiD, and MAiD’s anticipated consequences on others.
Everywhere, palliative psychiatric care should be considered where treatment is not due to mental illness (or where treatment of such illness falls beyond the same as “Physician aid in dying.”

CONCLUSION

Ethical concerns

Psychiatrists asked to participate with MAiD can experience moral distress as to what is being asked of them, especially as psychiatrists are ordinarily expected to do their best to help prevent death by suicide. Conventional views hold that the desire for death by suicide in the context of a mental illness signifies compromised reality testing and is irrational, and that treating the mental illness may theoretically restore patients’ capacities to not have suicidal ideation.

However, terminally ill patients wanting MAiD challenge clinicians’ usual perspectives for thinking about individuals who want to hasten death. For these patients, the mere presence of a mental illness does not automatically preclude the patient’s ability to be rational or to have capacity to make medical decisions. The patient would also want to avoid hastening death if not for the terminal illness and its resulting consequences.

Involuntary psychiatric hospitalization or involuntary treatment of rational, terminally ill patients who want to hasten death, may also be unnecessarily harmful and not in the patient’s best interest. Clinicians may find further assurance in an official position statement published on October 31, 2017 by the American Association of Suicidology (AAS), “Suicide” is not the same as “Physician aid in dying.” This statement recognizes that “Although there may be overlap between the two categories, legal physician assisted deaths should not be considered to be cases of suicide and are therefore a matter outside the central focus of the AAS.”

Challenges remain concerning what psychiatrists ought to do regarding patients who are rational, terminally ill, and whose wishes to pursue MAiD are not due to mental illness (or where treatment of such illness falls beyond realistic treatment parameters). What psychiatrists will do ultimately rests on their personal beliefs and inclinations, and what local legislation allows. Everywhere, palliative psychiatric care should be considered where treatments focus on what the psychiatrist can do to help alleviate or mitigate any psychiatric symptoms of distress. Beyond palliation, as patients request MAiD in the US, mental health professionals will play an increasingly important role to help those who are suffering with a terminal illness.
Immediate openings for Psychiatrists

Join the largest, most dynamic mental health department in the nation and make a difference in the lives of those who need it the most. We are expanding and have new opportunities for psychiatrists who are ready for a rewarding career. We are recruiting our psychiatry leaders of the future and we provide multiple avenues for advancement and professional development. Flexible work schedules, unparalleled work-life balance, and highly competitive benefits await you.

- Competitive starting annual salary with potential bonuses of $32,000 annually.
- Student loan repayment incentive up to $250,000.
- Reimbursement for eligible relocation expense up to $15,000.

www.psychiatristjobs.ca

Medical Consultants Needed

Join our team of professionals! The California Department of Social Services is seeking good psychiatrists and physicians who are interested in working with outside treating sources and other State professionals to evaluate medical evidence and determine its adequacy for making disability decisions as defined by the Social Security Regulations. This position is ideal for medical professionals looking to transition out of clinical settings and/or begin a second career.

- No patient contact and no malpractice insurance is required
- Work full or part time with a flexible schedule, Monday through Friday, no on-call duties
- Excellent health/dental/vision benefits, 401(K) and 457 deferred compensation plans, defined benefit retirement package
- Prorated reimbursement of medical license renewal fees and CME training costs, yearly CME stipend
- On-the-job training is provided

Interested applicants must have a current CA MD/DO License.

Full-time Salary ranges can start at $10,204.00 - $15,103.00 per month, depending on experience and credentials.

Job Locations: Covina, Fresno, Glendale, Los Angeles, Oakland, Roseville, Sacramento, San Diego, Stockton, and Rancho Bernardo.

If you are interested, please contact Ruby Chin at (916) 285-7593 or Ruby.Chin@ssa.gov or visit:
https://jobs.ca.gov/JOBSGEN/1BP21.PDF
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 evidence-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 (NCB) 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 76 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 evidence-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 NCB)
- PI Coordinator
- Attending Psychiatrist ER-CPEP (JMC)
- Inpatient Unit Chief (JMC)
- Attending Psychiatrist ER (NCB)
- Director of Psych Emergency Services (NCB)
- Collaborative Care (Psychiatrist within Adult Primary Care Services)
- Moonlighting opportunities also available! (JMC and NCB)

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 Velazquez - Office of Physician Recruitment. Velazquez@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.

ECE MTCV

Primary Responsibilities and Duties:
These positions include direct clinical care, teaching, supervision, administrative duties and a rich array of research opportunities. These positions are all active sites for IUSM medical students, IU Psychiatry residents, Psychology interns, and other learners. Creative thinking and collaboration with services within the academic health center and community organizations will be crucial components of these roles.

Interested applicants should send CV to Attn: Thomas W. McAllister, M.D.
Professor and Chair, Department of Psychiatry
majhugh@iupui.edu
Seeking Psychiatrists!

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:

- Recent inpatient salary increase: $247,087 - $268,311.
- Psychiatrist Loan Repayment Program offering up to $150,000 over 5 years.
- Flexible work schedules. Private practice permitted.
- Tele-psychiatry positions available at our VTC Suites.
- 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.
- Satellite Units located throughout NYS, within commuting distance of most major cities.

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

Steward Medical Group is seeking a Chief of Psychiatry to lead our comprehensive Psychiatry Program. This is a full-time position which involves administrative oversight and direct patient care for patients admitted to Carney Hospital. The ideal candidate will be a team player with strong verbal and written communication skills, as well as a track record of providing leadership and quality care. The ideal candidate will also work closely with hospital administration in helping grow the behavioral health services at Carney Hospital.

The Chief of Psychiatry will be part of an experienced and collegial team, and will be eligible for an academic appointment at Tufts University School of Medicine.

Carney Hospital, in the Dorchester neighborhood of Boston, MA, has a robust array of services, including a 20-bed adult unit for short-term crisis intervention, a 14-bed adolescent unit, and a 16-bed older adult / geriatric unit. We also have partial hospitalization and outpatient programs.

Carney Hospital has proudly served the City of Boston and neighboring communities since 1863. The 159-bed acute care hospital has more than 300 physicians and delivers quality care to approximately 37,000 patients annually. An affiliate of the Tufts University School of Medicine, Carney Hospital is a teaching hospital, training physicians in Internal Medicine. Carney Hospital provides Boston, Quincy and surrounding communities with convenient, local access to quality primary care, emergency medicine and a range of specialties and subspecialties, including critical care, family medicine, cardiology, neurology, oncology, orthopedics, ambulatory care, and adolescent, adult and geriatric psychiatry.

Steward Health Care, the largest private hospital operator in the United States, is a physician-led health care services organization committed to providing the highest quality of care in the communities where patients live. Headquartered in Dallas, Texas, Steward operates 35 community hospitals in the United States and the country of Malta, that regularly receive top awards for quality and safety.

If you are interested in learning more, or would like to apply, please contact:
Kerry Ciejk, Senior Physician Recruitment Specialist
Steward Health Care
E: Kerry.Ciejk@Steward.org
C: 781-551-5758
All inquiries will remain confidential.
Learn more about Steward at:
www.stewardphysicians.org

REAL WORK-LIFE BALANCE
Recipient of the Governor’s Sterling Award for Organizational Excellence
FLORIDA STATE HOSPITAL
SEEKING AN
INPATIENT PSYCHIATRIST AT THEIR CAMPUS IN BEAUTIFUL NORTH FLORIDA

Be the leader of your high-quality, multidisciplinary treatment team including:

- Nursing
- Social Work
- Art Therapy
- Music Therapy
- Psychology

A FULL COMPLIMENT OF BENEFITS

- Sovereign Immunity Federal
- Federal student loan forgiveness eligibility
- Relocation Reimbursement up to $5,000
- 45 days of combined paid annual leave, sick leave, and holidays
- Subsidized near-campus housing
- Low-cost health insurance for you and your family
- Vesting in Just 8 Years

FLORIDA HAS NO STATE INCOME TAX

Contact Kevin Bist, Recruiting Consultant
cell 850-274-4287, kevin.bist@myflfamilies.com
or apply at https://jobs.myflorida.com
Over PSYCHIATRIC RECRUITMENT

Our new psychiatry residency program will be a community-based program,” said Ramon Solhkhah, M.D., program director for psychiatry and founding Chair of Psychiatry & Behavioral Health at the Hackensack Meridian School of Medicine at Seton Hall University. “Our new psychiatry residency program will improve clinical care and ultimately encourage future health care leaders to build practices in the Jersey Shore area,”

In addition to our collegial work environment, we offer a highly competitive compensation package which includes: medical/dental plans, 403(b) retirement plan, and relocation assistance.

For immediate consideration, please contact Renee Theobald, at: Renee.Theobald@HackensackMeridian.org or call: 732 751-3597

HackensackMeridianHealth.org

NATIONWIDE

THE 1ST CHOICE IN PSYCHIATRIC RECRUITMENT

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

Aligned Telehealth, Inc. – California
Our mission is to be the leader in innovative, high quality, accessible behavioral health solutions. Explore opportunities in multiple states.

Hiring MULTIPLE Psychiatrist for Telemedicine and Onsite positions in the following states:
CA, TX, NV, AZ, FL and other states. Full time and Part Time positions.
We offer competitive salaries and excellent benefits!

Immediate Need for BC Psychiatrist with Texas medical license for evening teleposition.

Immediate Need for BC Psychiatrist with CA license for several outpatient sites

Contact Sandra Williams at 818-814-7790 or email me your current CV to swilliams@alignedhealth.com
To be considered for these great opportunities.

ALABAMA

General Psychiatrist

Riverbend Center for Mental Health, located in Florence, Alabama, has a current opening for a full-time General Psychiatrist. The practice responsibilities involve the treatment of adults (90% outpatient and 10% inpatient).

Riverbend is a Community Mental Health Center with approximately 160 employees serving an average of 7,500 individuals annually. This position is part of a medical staff consisting of three Psychiatrist and three Nurse Practitioners.

Riverbend offers a competitive salary and excellent benefit package. Riverbend is an approved National Health Service Corp site, and is eligible to employ J-1 and H1-B physicians.

For additional information regarding

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 contractor with an income potential of over $ 325 K per year for adult psychiatrist and over $355 K per year for child psychiatrist.

PT 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. J1 applicants are welcome.

Fax CV to Bernardo Mora, MD at (209) 558-4326 or Email: bmora@stanbhirs.org

California

Private Practice

Looking for the Freedom and Flexibility Earn over $350K/Year

Choose your own hours
Clinical Freedom Malpractice paid
H1 Visa Welcome

We are looking for Adult and Child Psychiatrists in San Francisco Bay Area
Los Angeles/Orange County Area
Sacramento Area

Comprehensive Psychiatric Services

Mansoor Zuberi, M.D.
(P) 925-944-9711 (F) 925-944-9709
druzberi@gmail.com
www.psych-doctor.com

Psychiatrists: Enjoy both a rewarding & lucrative work experience working as a FT Independent Contractor at Atascadero State Hospital or Coalinga State Hospital. Comp over $400K with malpractice & CA license assistance.

Contact:
Wonona Davis
MHM Services, Inc.
Tel: 707.266.7788
Email: wonona@mhmcareers.com
www.mhmcareers.com

Outpatient and Inpatient 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 contractor with an income potential of over $ 325 K per year for adult psychiatrist and over $355 K per year for child psychiatrist.

PT 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. J1 applicants are welcome.

Fax CV to Bernardo Mora, MD at (209) 558-4326 or Email: bmora@stanbhirs.org
Department of Psychiatry

With the continued growth of our Department of Psychiatry and our New General Psychiatry Residency Programs at Ocean Medical Center and Jersey Shore University Medical Center our vision for Behavioral Health is Bright.

As the area’s premier provider of psychiatric services, Hackensack Meridian Behavioral Health Services has provided comprehensive mental health and substance abuse services to the residents of Monmouth, Ocean, Middlesex, and Bergen Counties for over forty years. Due to continued growth and expansion, we are currently accepting applications for Psychiatrists to join our Mental Health and Addiction Interdisciplinary Teams in the following positions:

- Consultation Liaison Psychiatrists: Jersey Shore University Medical Center (Neptune, NJ) and Riverview Medical Center (Red Bank, NJ) and Hackensack University Medical Center (Hackensack, NJ)
- Staff Psychiatrist for Adult Inpatient Unit: Jersey Shore University Medical Center (Neptune, NJ) and Riverview Medical Center (Red Bank, NJ) and Hackensack University Medical Center (Hackensack, NJ)
- Outpatient Child & Adolescent Psychiatrist: Jersey Shore University Medical Center (Neptune, NJ) and Hackensack University Medical Center (Hackensack, NJ)
- Medical Director/Section Chief, Child & Adolescent Psychiatry: Jersey Shore University Medical Center (Neptune, NJ)
- Outpatient General Psychiatrist: Jersey Shore University Medical Center (Neptune, NJ), Riverview Medical Center (Red Bank, NJ), and Raritan Bay Medical Center (Perth Amboy, NJ)
- Medical Director of Adult Inpatient Unit Riverview (Red Bank, NJ)
- Emergency Psychiatry: Raritan Bay Medical Center (Perth Amboy, NJ)
- Geriatric Psychiatry – Hackensack University Medical Center (Hackensack, NJ)
- Outpatient/Consultation Liaison Psychiatrist – JFK (Edison, NJ)
- Per Diem/Tele-psychiatry – Hackensack University Medical Center (Hackensack, NJ)
- Staff Consultation Psychiatry – Bayshore Medical Center (Halstead, NJ)

In addition to our collegial work environment, we offer a highly competitive compensation package which includes: medical/dental plans, 403(b) retirement plan, and relocation assistance.

For immediate consideration, please contact Renee Theobald, at: Renee.Theobald@hackensackmeridian.org or call: 732 751-3597

HackensackMeridianHealth.org

Psychiatrist Position

J-1 Visa Opportunity in California

Imperial County Behavioral Health Services is currently recruiting for a full time psychiatrist. Imperial County is located 90 miles by freeway to the city of San Diego to the west, and 90 miles to Palm Springs to the north. Located in a rich farming area, Imperial County has a population of 180,000 and borders with Yuma, Arizona and with the metropolitan city of Mexicali, Mexico population 1.2 million. San Diego State University maintains a satellite campus in Calexico and there are a number of private and public universities located in Mexicali, the state capital of Baja California Norte. Imperial County’s location and diversity make it the perfect place for a psychiatrist to relocate under the J-1 Visa program or for any reason.

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 CA 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

www.scvcm.org www.sccmh.org

PSYCHIATRIST

$253,600 - $329,700 annually
7 weeks of annual leave
Full benefits & retirement
(Above annual salary includes additional pay for Board Certification and
Acute Settings)

Your Career in Paradise!

Psychiatrist Job Opening In Santa Barbara, CA

Enjoy flexible scheduling, tele-psychiatry, world-class benefits, incredible work-life balance, all while receiving a signing bonus and relocation assistance. Go from your office right to either the beach or the mountains in minutes! Treat patients in serious need while treating yourself to paradise! Live the good life in Santa Barbara County!

Visit: http://www.getpsychhelpsb.com/
Contact Tom Widroe at 805.680.7772 or tomwidroe@icloud.com

的质量保证：如果您在寻找...
BE or BC psychiatrist needed. Following locations have immediate openings:

- Placerville/Sacramento, CA: Schedule: 40 hrs per week. Pay Rate: $380,640 - $468,000 (Contractor Rate)
- Modesto/Ceres, CA: Schedule: Saturday/Sunday. Pay Rate: $182 - $205 per hour (Contractor Rate)
- Modesto/Ceres, CA: Schedule: 40 hrs per week. Pay Rate: $380,640 - $468,000 (Contractor Rate)
- Oakland, CA: Schedule: 20 hours per week. Pay Rate: $170 - $187 per hour (Contractor); $140 - $150 per hour (Employee)
- Elk Grove/Sacramento, CA: Schedule: 15 hours per Month. Pay Rate: $170 - $187 per hour (Contractor);
- Long Beach, CA: Schedule: 40 hours per week. Pay Rate: $345,000 - $389,000 (Contractor); $266,000 - $389,000 (Employee)
- For additional listings, please visit: www.telecarecorp.com/physician-jobs/

You will work as part of a multidisciplinary team. The staff is all very friendly and it is a supportive working environment.

Please email your resume to tlcrecruiting@telecarecorp.com

EOE M/F/V/Disability

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/human resources/Employment.aspx

Be The Psychiatrist You Are Meant To Be

Vituity is changing lives with innovative new programs. We are hiring part-time and full-time Emergency & Inpatient Psychiatrists in California:

- Greater Los Angeles Area
- San Francisco Bay Area
- Sacramento Area

Compensation

You become an equal and valued partner when you join the Vituity Partnership. We offer high compensation packages in addition to annual partner bonuses.

vituity.com/careers

Visit us online for a full list of opportunities or email us at careers@vituity.com.

Florida Licensed BE/BC psychiatrist and/or psychiatric ARNP needed for a Joint Commission Accredited community mental health center and psychiatric hospital. Excellent benefits and location (West Palm Beach and Belle Glade, FL).

Contact: Diana Brioso, Program Manager, Jerome Golden Center for Behavioral Health, 1041 45th Street, West Palm Beach, FL. Phone: (561)-383-5917; Fax (561) 514-1239

(203) 523-7026

County of Santa Cruz

Employment Opportunity:

Psychiatrist

To work full-time in Santa Cruz, CA, Health Services Agency. Must have CA medical license. Send CV to Santa Cruz County, 701 Ocean Street, Room 510, Santa Cruz, CA 95060 or email to: personnel@santacruzcounty.us

An Equal Opportunity Employer

California Department of State Hospitals

Quality of practice. Quality of life.

Join us! Are you a psychiatrist looking for a team-oriented, collegial practice supported by leading experts in psycho pharmacology such as Stephen Stahl, MD, Ph.D.? Look no further than the California Department of State Hospitals. We operate the largest forensic psychiatry hospital system in the nation, offering an unparalleled quality of practice while providing care to some of the most complex patients found anywhere. Email your curriculum vitae to DSH.Recruitment@dsh.ca.gov

Be The Psychiatrist You Are Meant To Be

Vituity is changing lives with innovative new programs. We are hiring part-time and full-time Emergency & Inpatient Psychiatrists in California:

- Greater Los Angeles Area
- San Francisco Bay Area
- Sacramento Area

Compensation

You become an equal and valued partner when you join the Vituity Partnership. We offer high compensation packages in addition to annual partner bonuses.

vituity.com/careers

Visit us online for a full list of opportunities or email us at careers@vituity.com.

Practice and Benefits:

- Annual salaries to the high $200,000s
- Flexible workweek options may be available
- Voluntary paid on-call duty
- Substantial continuing medical education
- Generous defined-benefit pension
- Psychopharmacology support by leading experts and established protocols
- Medical, dental and vision benefits
- Private practice permitted
- Retiree healthcare
- Psychiatrist-led treatment teams
- Patient-centric, treatment first environment
- Relocation assistance may be available

To find out more, please contact Laura Dardashti, MD. at (916) 654-2609.
You can also email us at DSH.Recruitment@dsh.ca.gov or visit our website at www.dsh.ca.gov

TLC Telecare Physician Services Organization

Florida

Jerome Golden Center

30 December 2018

Qualify For A Free Subscription Online @ www.psychiatrictimes.com
TELEMEDICINE

Horizon Health is seeking a Medical Director to provide a continuation of telemedicine and on-site coverage for an 18-bed geriatric inpatient psychiatric program approximately one hour south of Atlanta. The Psychiatrist will provide rounding and treatment on patients for the inpatient program, as well as program administration and oversight services regarding service line policies, practice, development, compliance, and performance improvement. Some on-site coverage is preferred, but telemedicine is available and will be considered for daily rounding and call coverage. Excellent compensation. For more information contact:

Mark Blakney, Voice: 972-420-7473, Fax: 972-420-8233; email: mark.blakney@horizonhealth.com

EOE

HAWAII

Aloha! Wonderful opportunity for Board-Certified/Board-Eligible Psychiatrists to live in Hawaii and work on the beautiful Island of Oahu. Join a dedicated group of 13 other Psychiatrists, for this 202-bed State Hospital that overlooks the blue waters of Kaneohe Bay. Opportunity to work with Residents. Great Benefits. Great Lifestyle. Never have to travel for vacation again. Interested?

This is a full-time, non-civil service exempt appointment. The position primarily manages and provides psychiatric care to patients admitted to the Hawaii State Hospital (HSH). The psychiatrist provides direct clinical and consultative services for a variety of service programs within and outside the Psychiatry Services section and affiliated programs, and provides clinical guidance for other members of interdisciplinary teams. HSH has a diverse patient population with many admissions having a forensic context. A new 144 bed forensic hospital is now under construction which will expand current capacity and programming.

Employment with the State of Hawaii offers competitive salaries and benefits. New salary bands have been established that account for training and experience. Benefits include 21 days of vacation per year, 21 days of sick leave per year, 13 paid State holidays, liability insurance, medical/vision/dental insurance, and a generous pension plan.

Requirements: Graduate from an approved medical school in the United States or Canada or graduate from a foreign medical school and certification by the Educational Council of Foreign Medical Graduates (ECFMG). Completion of one (1) year of approved internship and three (3) years of psychiatric residency training. Have Board certification or meet the criteria to sit for the examination of the American Board of Psychiatry and Neurology.

Valid Permanent or Temporary license to practice medicine in the State of Hawaii. Valid State of Hawaii Narcotics Enforcement Administration Registration and Federal Drug Enforcement Administration Registration.

We would like to hear from you and discuss this exciting professional and personal opportunity.

For program information, call Dr. Run Heidelberg at (808) 236-8246 or Jodi Polendey at (808) 236-8228 or email jodi.polendey@doh.hawaii.gov

Visit the Dept. of Health website to view requirements and application packet: http://health.hawaii.gov/employment/job-opportunities/

Mail application packet to: Department of Health Hawaii State Hospital 45-710 Keahalalo Road Kanehoe, Hawaii 96744

Attn: Personnel Office – Jodi Polendey

Recruitment is continuous until needs are met.

An Equal Opportunity Employer

HAWAII STATE HOSPITAL

ASSOCIATE ADMINISTRATOR,
CLINICAL SERVICES

Kaneohe, Oahu

Aloha! Wonderful opportunity for a Board-Certified Psychiatrist to live in Hawaii and work on the beautiful Island of Oahu. Join a dedicated and professional hospital executive team for this 202-bed State Hospital that overlooks the blue waters of Kaneohe Bay. Opportunity to work with Residents. Great Benefits. Great Lifestyle. Never have to travel for vacation again. Interested?

The Hawaii’s State Hospital (HSH) is the only publicly-funded, state psychiatric hospital in Hawaii’s. HSH provides adult inpatient psychiatric services, is part of the Department of Health (DOH) Adult Mental Health Division (AMHD) and is accredited by the Joint Commission. HSH has a diverse patient population with many admissions having a forensic context. A new 144 bed forensic hospital is now under construction which will expand current capacity and programming. The Associate Administrator reports to the HSH Administrator and serves on the hospital executive team. This is a full-time, non-civil service exempt appointment. The primary purpose of this position is to provide clinical and administrative supervision of the following units: Psychiatry Services, Forensics Services, Social Work Services, Clinical Psychology Services, Psychosocial Rehabilitation, Occupational Therapy, Recreational Therapy, Medical Services, State Operated Specialized Residential Services, Clinical Safety, and ancillary services including pastoral care.

Employment with the State of Hawaii offers competitive salaries and benefits. New salary bands have been established that account for training and experience. Benefits include 21 days of vacation per year, 21 days of sick leave per year, 13 paid State holidays, liability insurance, medical/vision/dental insurance, and a generous pension plan.

Requirements:

Graduate from an approved medical school in the United States or Canada or graduate from a foreign medical school and certification by the Educational Council of Foreign Medical Graduates (ECFMG). Completion of one (1) year of approved internship and three (3) years of psychiatric residency training. Board certification from the American Board of Psychiatry and Neurology.

Applicants must have specialized experience: Three and one-half years of progressively responsible professional work experience in a psychiatric inpatient program directing the development, implementation and coordination of treatment and rehabilitation programming and services.

Supervisory Experience: A minimum of two (2) years of supervisory experience in an inpatient program setting, including performance evaluation and labor relations.

Valid Permanent or Temporary license to practice medicine in the State of Hawaii.

We would like to hear from you and discuss this exciting professional and personal opportunity.

For program information, call Mr. Bill May, HSH Administrator at (808) 236-8237 or email jodi.polendey@doh.hawaii.gov

Visit the Dept. of Health website to view requirements and application packet: http://health.hawaii.gov/employment/job-opportunities/

Mail application packet to: Department of Health Hawaii State Hospital 45-710 Keahalalo Road Kanehoe, Hawaii 96744

Attn: Personnel Office – Jodi Polendey

Recruitment is continuous until needs are met.

An Equal Opportunity Employer

INDIANA

NORTHWEST INDIANA!!

Excellent opportunity for adult psychiatrist interested in optimal setting for practice of community psychiatry: commutable from downtown Chicago.

Regional Mental Health Center is a private, non-profit mental health center that has successfully served Indiana for over 30 years. Experienced and collegial group of 12 mostly full-time psychiatrists, an extremely favorable malpractice environment. OP work, call 7-12 wks. Regional is a leader in psychiatrist-directed integrated care services. Incentive bonus available, full benefits.

Please contact Kbbie Douglas, MD: kbbie.douglas@regionalmentalhealth.org

219 736-7232

Our competitive rates can help you promote physician products and services.

MASSACHUSETTS

Psychiatrist Opportunities Cambridge Health Alliance

Cambridge Health Alliance (CHA), a well-respected, nationally recognized and award-winning public healthcare system is seeking Psychiatrists in our Inpatient and Out-patient services. CHA offers a wide variety of Psychiatry services for all ages. Our system is comprised of three hospital campuses and an integrated network of both primary and specialty outpatient care practices in Cambridge, Somerville and Boston’s Metro North Region. Exciting opportunities are available in our Adult, Child/Adolescent, Geriatric and Consultation-Liaison services. We are proud to offer a collaborative practice environment with an innovative clinical model. CHA is a teaching affiliate of Harvard Medical School (HMS) and academic appointments are available commensurate with medical school criteria. CHA offers competitive compensation and a comprehensive benefits package.

Qualified candidates may submit their CV through our website at www.CHAproviders.org, or by email to Melissa Kelley at mkelly@challiance.org.

The Department of Provider Recruitment may be reached by phone at (617) 665-3555 or by fax (617) 665-3553.

CHA is an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability status, protected veteran status, or any other characteristic protected by law.
BRAND NEW ADOLESCENT 15-BED INPATIENT PSYCHIATRY UNIT OPENING IN 2019 – Small Town Big Opportunity — Medical Director position available. Be in on the beginning of a new unit helping to mold and develop the program. Open to employment, or independent contractor arrangement. Located in south-east MO near Cape Girardeau, this is a low-cost of living, low crime rate area but close to a local airport that has direct flights to Chicago. It’s also only two hours from Memphis and St. Louis. This designated underserved area is also located in the Delta Regional Authority so J1 Waivers can also be obtained through the DRA as well as the state. Position can be inpatient, or inpatient and outpatient.

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

Our competitive rates can help you promote physician products and services like these:
• Medical transcription
• Practice management
• Medical billing
• Legal services

For details call (203) 523-7026

NEW JERSEY

OUTPATIENT PSYCHIATRY POSITION, JERSEY CITY — Seeking Psychiatrist to work with adults and children/adolescents in Christ Hospital’s outpati ent clinic. Full-time employment with benefits. Please call for details.
Terry Good, 804-684-5661.
terry.good@horizonhealth.com; Fax #: 1-804-684-5663.

NEW YORK

BEAUTIFUL SARANAC LAKE NEAR LAKE PLACID — Psychiatrist/Medical Director, 12-bed Geropsychiatric Unit – Adirondack Medical Center has an affiliation with the Olympic Training Center in Lake Placid. Saranac Lake, located in the Adirondack Park, is a nature lover’s paradise but the downtown area has an urban vibe. Open to either contracting with a local psychiatrist/group in practice for part-time work, or full-time employment with benefits. Part-time administrative duties such as meeting attendance, UK and policy & procedure questions can be handled while at the hospital.

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

CAPE FEAR VALLEY HEALTH

We Want You to Join Our Behavioral Health Team! 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 provider with training/experience in a variety of mental health treatment conditions as well as Chemical Dependency and Substance Abuse. Candidate with experience in treatment of Bipolar Disorder, Borderline Personality Disorder, and Mood Disorders is preferred. Additionally, ECT training and experience is highly desirable. Well established adult team is flexible and transpar ent for either or both inpatient and outpatient services. Clinic hours are Monday - Friday with limited call.

Child Outpatient Opportunity
• BE/BC Child & Adolescent providers. The current structure is for 90% outpatient Monday through Friday work schedule.
We offer best in class compensation plus generous benefits including Paid Malpractice, CME Time and Allowance, Accrued Paid Time Off, 401(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.

Find What You’re Looking For Now Log on to: www.psychiatrictimes.com/classifieds
OHIO

The University of Toledo is seeking candidates to serve as the Medical Director for the department’s Geriatric Psychiatry Unit, Senior Behavioral Health. The 18-bed inpatient unit is a flagship service for the University and is well regarded in the community. As part of an academic medical center, the Medical Director will participate fully in providing clinical teaching for medical students and residents.

The Department of Psychiatry is a growing Department in a highly collaborative academic medical center. Educationally, the Department teaches in all 4 years of the medical school and also has a strong residency program, as well as a child and adolescent fellowship.

The University of Toledo Medical Center has 246 licensed beds, is a Level 1 Trauma Center, and is located in Toledo, Ohio. The University of Toledo is the third-largest university in the state of Ohio with an enrollment of nearly 21,000 students. In 2017, Toledo was ranked #2 city in the country for people who love the outdoors (U.S. News). Toledo was also ranked #3 Most Livable Community in the World by the International Awards for Livable Communities, London, 2007.

For more information contact or send CV to: Mark Blakney, email: mark.blakney@horizonhealth.com, or phone: 972.420.7473

PennState Health

The Penn State 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 fellowships. 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, optimally, 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: jsplangler2@pennmhealth.psu.edu

MEDICAL DIRECTOR POSITION — 12-bed Geropsychiatric Unit in Greenville — 40.5 miles from Dayton. Seeking psychiatrist to work part-time in the hospital providing clinical care and administrative duties. Perfect for someone in a practice or in another part-time position as rounding can be done either in the morning or afternoon. Week on/week off arrangement is also open for discussion. There is an NP on the unit and other doctors in on the call schedule.

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

PennState Health Milton S. Hershey Medical Center

The Penn State 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 fellowships. 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, optimally, 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: jsplangler2@pennmhealth.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/F/V/D

Get Our FREE Online Newsletter!

Psychiatric Times

Quality For A Free Subscription Online @ www.psychiatrictimes.com

Pennsylvania

PennState Health

The Penn State 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 fellowships. 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, optimally, 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: jsplangler2@pennmhealth.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/F/V/D

Get Our FREE Online Newsletter!

Psychiatric Times

Quality For A Free Subscription Online @ www.psychiatrictimes.com

Tennesssee

EAST TENNESSEE STATE UNIVERSITY

QUILLEN COLLEGE OF MEDICINE DEPARTMENT OF PSYCHIATRY & BEHAVIORAL SCIENCES

ADULT PSYCHIATRISTS, CHILD PSYCHIATRISTS

Two full-time positions available for Adult Psychiatrists who are BE/BC at time of hire, and/or Child Psychiatrists who are BE/BC at the time of hire in the subspecialty of Child and Adolescent Psychiatry. Positions may include inpatient and/or outpatient. Program activities include clinical care of patients combined with teaching and supervision of residents and medical students. Research and academic activities are strongly encouraged. Salary and academic rank are commensurate with experience and qualifications. Salary is competitive with funding available through the Medical School and other sources.

ETSU is located in Johnson City, TN, which has the perfect blend of four mild and beautiful seasons, gentle mountains, a local theater, and a symphony orchestra. Come explore this ideal family location with college/urban sophistication surrounded by national forests and beautiful parks. No state income tax, low cost-of-living, low crime rate, golf courses, and lakes.

Apply to the position at https://jobs.etsu.edu. Telephone inquiries should be made at (423) 439-2225 or e-mail at lovedaye@etsu.edu. AA/EOE.

Virginia

Psychiatrist Opportunity

Southwestern Virginia Mental Health Institute is located in Marion, Virginia, sitting in the heart of the Blue Ridge Mountains. Our 179-bed behavioral health facility offers an exciting career in a wide range of interesting pathology in psychiatric treatment while providing a highly desirable work-life balance. We have opportunities in our inpatient setting for Psychiatrists for our Adult Admissions and Geriatric Units. These positions are employed positions offering a competitive salary with generous state benefits and paid malpractice insurance, loan repayment, CME stipend/leave, sign-on bonus, and relocation allowance. No on-call required, with compensated on-call available.

If you are licensed or eligible for licensure in Virginia, and have completed a psychiatric residency, please send your current CV to kim.sayers@dbhds.virginia.gov or you may contact a member of our Human Resources staff at 276-783-1204 to discuss this opportunity. We invite you to join a team of dedicated physicians and loyal staff who are committed to promoting a life of possibilities for all Virginians.

For more information, please visit:
www.swvmh/dbhds.virginia.gov
www.smythcounty.org
www.abingdon-va.gov

Wisconsin

PSYCHIATRIST

Clinical excellence and quality living! Winnebago Mental Health Institute (WMHI) is a 280 bed psychiatric facility associated with Medical College of Wisconsin’s North East Wisconsin Psychiatry Residency. We are seeking a Board Certified/Board Eligible Psychiatrist who wants to work with a Multidisciplinary Treatment Team to treat acutely ill Civil Patients and/or Forensic Patients. A strong commitment to excellence in clinical care and education of Residents, Medical Students and interns of all clinical specialties makes WMHI a great place to practice. Excellent fringe benefit package, strong collegial support, paid call, and a beautiful campus enhance your work days.

WMHI is located near Oshkosh, Wisconsin, which is the center of the Fox River Valley, one of the fastest developing areas of Wisconsin. Four seasons with all the outdoor opportunities of each, cultural and sports venues, outstanding public and private schools and three universities in the area make this a great place to raise a family.

In 1 1/2 hours you can be in Milwaukee, Madison, the Wisconsin Dells or up north.

Information on WMHI can be found at http://www.dhs.wisconsin.gov/
MH_Winnebago/

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

EOE
Focused on the latest developments in the field, *NeurologyTimes* is a key resource for neurologists and neurological care specialists, including:

- Resource libraries dedicated to: Alzheimer disease, multiple sclerosis, Parkinson disease, strokes, epilepsy and seizures
- Interactive features and webinars with thought leaders involved in the research and treatment of neurological disorders
- Educational quizzes that put your diagnostic skills to the test
- The sharing of best practices to help neurological professionals improve patient outcomes

…and more!

Visit NeurologyTimes.com today!