The Opioid Epidemic Settlements: Who Will Benefit?

Judgements and settlements are starting in Oklahoma against various pharmaceutical companies for their alleged roles in that state’s opioid crisis. During these judgements and negotiations with three major companies, the financial liability potentially ranged from a judgement for more than $500 million in this single state case to negotiations that might reach $10 billion for each company to resolve national claims. In this most recent Oklahoma case, the judge stated that one company “engaged in false and misleading marketing of both their drugs and opioids generally, and the law makes clear that such conduct is more than enough to serve as the act or omission necessary to establish the first element of Oklahoma’s public nuisance law.”

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Dungeons and Back Alleys: The Fate of the Mentally Ill in America

My career is ending on a sour note. It is hard to be complacent when 600,000 people who should be our patients are instead languishing as prisoners or sleeping on streets. County jails are now the biggest providers of psychiatric care for people suffering from severe mental illness. And our patients do particularly poorly in jail—enduring long stays, frequently in crazy-making solitary confinement and often targeted for physical and sexual abuse. I have seen long rows of cells, in each of which is a desperate mentally ill occupant who has smeared excrement all over the walls and windows.

We have no excuse for collectively failing the patients who need us most. It is easy enough for each of us to blame the system—the government neglect, professional association passivity, and advocacy groups’ loss of mission—but I also blame myself for having done far too little, far too late. We are all part of the system and must take personal responsibility for its miserable performance.

We won’t be able to correct this horrible mess without understanding CONTINUED ON PAGE 8
FROM THE EDITOR

“Off Label” Does Not Mean “Off Limits”

John J. Miller, MD | Editor in Chief

It happened so slowly we initially didn’t notice. Soon it declared itself as a nemesis. But by then, it had established itself as a powerful force with which to be reckoned. Today it is a false mythology, designed to wreak misery on any prescribers in the US who want access to all FDA-approved medications to provide the best clinical treatment for their patients. This mythology has constructed numerous obstacles to interfere with a competent medical prescriber’s intent to choose the best dosage of the most appropriate medication to get our patients better. The primary work horse of this mythology is the dreaded medication formularies designed to limit drug prescribing to a subset of available medications. Regrettably, this subset of medications often excludes the preferred medication that competent clinicians would choose as part of a treatment plan that they deem best for their patient.

The false mythology, which remarkably is believed as fact by a minority of prescribers, is that a trained medical professional, duly licensed and with prescribing privileges, CANNOT prescribe a medication off label. This mythology interferes with good clinical practice and often contributes to poor outcomes for patients. There are many corollaries to this false mythology:

1. A drug cannot be prescribed in doses that are outside of the doses listed in that drug’s FDA-approved product insert.
2. A drug cannot be prescribed for an indication for which it is not FDA approved.
3. Some drugs can only be prescribed after numerous failed trials of other drugs, which often include drugs with more adverse effects, poorer tolerability, or with contraindications for a particular patient.

This, of course, is the short list. In my editorial in last month’s issue of Psychiatric Times I focused on all of the clinical facts that render corollary 1 a false mythology.¹ This editorial will elaborate on corollary 2, which can be simply restated as the false narrative that a drug is off limits for diagnoses that are off label.

One of my favorite articles, “An Analysis of the High Psychotropic Off-Label Use in Psychiatric Disorders: The Majority of Psychiatric Diagnoses Have No Approved Drugs,” published in 2009, nicely places corollary 2 in its clinical perspective.² The authors report that only 11.8% of DSM-IV-TR diagnoses have an FDA-approved drug. So, do we not treat the 88.2% of DSM-IV-TR diagnoses that do not have an FDA-approved medication? Also, with the publication of DSM-5 in 2013, it is likely that the percentage of FDA-approved drugs for DSM-5 diagnoses has dropped even further. A good example is the lack of any FDA-approved drugs for the DSM-5 novel diagnosis Disruptive Mood Dysregulation Disorder. Does that mean we cannot treat this disorder with medication?

Can you imagine working in an ICU, where you are likely to treat many patients suffering from acute delirium, and the hospital pharmacist and the patient’s insurance company tell you that there are no FDA-approved drugs to treat delirium, so don’t prescribe any; or if you do, the insurance company will not pay for the medication. Or maybe you work in a long-term care facility with a large population of individuals suffering from behavioral or psychotic complications of advanced dementia—too bad—there are no drugs that you can prescribe.

Let me state very clearly that I am not saying that a prescriber can use any FDA-approved drug to treat any condition—this would result in prescribing anarchy, which is both unethical and dangerous. However, when a disorder or condition does not have a FDA-approved drug, it is our duty to prescribe a medication that has been shown to be helpful in this setting. Additionally, there should be a consensus from experts in each specialty to recommend a subset of medications that are reasonable and show effectiveness in these situations. Even when these recommendations from experts exist, it is common practice for insurance companies to deny payment if these medications are not on their formulary. However, the prescriber is always invited to begin the time-intensive and frustrating process of submitting a prior authorization form.

A second common scenario is when a patient has a specific diagnosis for which there exists one or more FDA-approved drugs. In this setting, the FDA-approved drugs should be used first. Once all of the trials of FDA-approved drugs have failed, or the remaining FDA-approved drugs are contraindicated for a medical reason, then it is our duty to move beyond the labels and prescribe medications that are considered to be reasonable by our peers and that show evidence of being effective.

This approach of prescribing FDA-approved drugs off-label has been supported by the American Medical Association, established law in the US, and by the FDA. Fury and Wilkins¹ published a case of an older woman with dementia, which gets complicated by waxing and waning symptoms of confusion, agitation, and paranoia.³ Her psychiatrist begins an atypical antipsychotic that significantly helps these symptoms. The case explores the initial conversation between the patient and her psychiatrist, and then the subsequent conversation after the dementia has progressed and the patient is joined by her daughter to discuss treatment. The daughter is confused as to why the psychiatrist prescribed a medication to her mother that was off-label and had a specific black box warning about the increased risk of death when this drug is used in patients like her mother.

THE AUTHORS CONCLUDED: Off-label prescribing is a common and legal practice in medicine. This practice is justified when scientific evidence suggests the efficacy and safety of a medication for an indication for which it does not have FDA approval and when the practice is supported by expert consensus or practice guidelines.

Practicing clinical medicine is challenging and stressful enough without the additional burden of being handcuffed by ever-changing medication formularies. I am sure that we could fill an entire issue of Psychiatric Times with war stories from you, our readers, about fights with insurance companies and medication formularies to gain approval for the best medication for our patients. When we view this daily stress and frustration through the lens of the actual facts:

- Once a drug is FDA approved for one indication, a prescriber in the US can prescribe that drug for any indication.
- Most psychiatric diagnoses do not have FDA-approved medications.
- Experts agree that off label prescribing is usually utilized when it is the best option for our patients.
- Medication formularies change year to year, likely based on the cost of the medications to the formulary and not based on clinical effectiveness of the drugs.

We seriously need to ask ourselves why we allow this false mythology to perpetuate.

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Several aspects of this ruling seem remarkable and perhaps contradictory. From a conventional understanding of a “public nuisance,” this bland-sounding civil offense seems relatively minor and hardly the basis for a significant financial judgement. Police officers may issue fines for a public nuisance offense, which is a ticket with a payable fine that ranges from $100 to $300. From an international perspective, the Indian Penal Code states that a public nuisance “…shall be punished with a fine, which may extend to two hundred rupees,” which is equivalent to about $3. Is the severity of the alleged pharmaceutical manufacturer’s public nuisance offense consistent with the magnitude of the financial liability in this judgement?

Compared with the tobacco smoking settlement amounts for hundreds of billions of dollars or to the Wall Street analysts’ expectation of a fine up to $5 billion for this case in Oklahoma, this $500 million seems a relatively modest amount to pay. The importance of this initial landmark case is of course significant; however, we need to recognize that nationally more than 2000 additional court cases are still pending. Moreover, the recent Purdue offer to settle its 2000 pending opioid related lawsuits for $10 to $12 billion needs to be recognized.

States collected major pharmaceutical companies and wholesale distributors are defendants in these national, potentially persisive cases, how large could the ultimate pool of funds be? If each of these 20 to 30 companies was required to pay even $500 million over 2000 lawsuits the national settlement would be about $10 billion each. The $10 billion from a single company would lead to about $6 million for each of the municipal plaintiffs, which, when multiplied by the 20 to 30 companies with pending lawsuits, would result in hundreds of billions of dollars to distribute.

What is the implication of having hundreds of billions of dollars available for addiction disorders, mental health, and other health care services? Would these be the only beneficiaries of these funds? In 2017, the White House Council of Economic Advisors estimated the national health care costs related to the opioid epidemic to be about $500 billion, but that estimate is of money already spent and does not offer a framework for spending new funds from a settlement with the pharmaceutical companies.

Furthermore, by 2017 much of the fatal and catastrophic outcomes associated with opioids were attributable to heroin and illicit fentanyl, not pharmaceutical company sources. Thus, what portion of any final settlement would health care components deserve to provide care for the estimated 11 million current and potentially future substance use disorder patients? We might learn something from the tobacco company financial settlements and their distribution across the US, when the period of being a public nuisance lasted considerably longer and had an impact on a substantially larger proportion of the population.

A look back on the benefits for addictions prevention and treatment and for health care broadly is not encouraging on this 20th anniversary of the Master Settlement Agreement (MSA), which is an accord reached in November 1998 between the state Attorneys General of 46 states, five US territories, the District of Columbia, and the five largest cigarette manufacturers in America. This MSA settlement required the tobacco industry to pay the settling states billions of dollars annually forever. Specifically, the MSA also had the original participating manufacturers agree to pay a minimum of $206 billion over the first 25 years of the agreement. Over the years, the states have collected tremendous amounts of revenue related to the MSA, but are spending little of it on tobacco prevention and cessation programs.

States collected an estimated $27.3 billion from the MSA and taxes in fiscal year 2019, yet today no state funds tobacco prevention at the level recommended by the Centers for Disease Control and Prevention (CDC). Overall, states spend less than 3% of MSA funds on programs to prevent kids from smoking and help smokers quit. Twenty-nine states and the District of Columbia spend less than 20% of the CDC recommendation.\(^1\) Alaska and California spend more than 70% of the CDC recommended funding—$655 million annually on prevention and cessation programs. Tobacco companies, on the other hand, spend more than $14 to market tobacco products for every $1 the states spend to reduce tobacco use.

Despite overall progress in reducing smoking rates to 14%, smoking rates are highest among people with lower income and less education, American Indians/Alaska Natives, LGBT Americans, those who are uninsured or on Medicaid, and those with mental illness. These differences are in part due to the misallocation...
of these MSA funds to many other conditions unrelated to health care, prevention, and biomedical research.

New challenges have also evolved in the spread of nicotine abuse and dependence among youth. Enter e-cigarette usage, which has skyrocketed to epidemic levels; the CDC and FDA show that from 2017 to 2018, e-cigarette use increased by 78% among high school students (to 20.8%) and by 48% among middle school students (to 4.9%). The obvious parallel for opioids with the many other DEA scheduled medications such as stimulants and sedatives strongly argues that investments of these settlement funds in prevention, treatment, and research in related types of addictive substances and their delivery systems is essential. However, how likely is it that this can happen based on our experience with the MSA for tobacco and nicotine?

The funds are available to put into health care, particularly for the youth of America, but our state leaders are not funding these programs at levels recommended by the CDC. Thus, the upcoming challenge will not be in the courts, but in the state legislatures, which are likely to get a substantial influx of financial resources to address the current epidemic with opioids. The fatalities associated with this epidemic have indeed shifted to an illicit market of heroin and fentanyl and away from the original challenges with marketed commercial opioids. Nevertheless, financial resources are clearly on their way to states and communities, and we need appropriate planning for wisely spending—not wasting these resources by missing the mark for which they were intended.

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Dungeons

Continued from Cover

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The 20th century witnessed a rapid and thorough degradation of the system, with cattle-careroverloading and system-wide patient neglect. Professionalizing the staff depersonalized the care. Growing cities surrounded and swallowed up hospital grounds, restricting patients to endless days in ugly, packed, stench-filled wards. Unions resented job competition from unpaid or low paid patients and pressured to have workshops closed. The well-meaning asylum had degenerated into dreadful snake pits.

My first experience in psychiatry occurred 55 years ago as a medical student in one of these state hospitals. It was degrading and disgusting—an overwhelming smell of urine, neglected patients screaming and posting, a demoralized and disengaged staff, disappearing doctors.

Deinstitutionalization

The deinstitutionalization movement meant to correct this chaos arose from a strange combination: public outrage; a new model of community psychiatry; the discovery of powerful new drugs; Kennedy family guilt; and state government greed. Three books were especially influential. The Snake Pit, a semi-autobiographical 1946 novel by Mary Jane Ward (made into an acclaimed 1948 movie), vividly presented a first-hand account of the sufferings of terrorized patients. The Myth of Mental Illness, written in 1961 by libertarian psychiatrist Thomas S. Szasz, MD, made the moral and legal argument that patients are citizens with civil rights that must be respected. Published in

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Six Ways to Protect the Kidneys While Prescribing Lithium

When lithium works in bipolar disorder, it tends to work for the long term. That is a good thing for the 30% to 40% of bipolar patients who are lithium responders.1 It means they can stay well longer with fewer medication changes. They can also benefit from lithium’s medical perks, which include a lower risk of stroke, heart disease, cancer, neurologic illnesses, dementia, and all-cause mortality.2 Unfortunately, all of these benefits come at a cost to the kidneys.

Does lithium harm the kidneys? While most studies suggest that long-term lithium use can impair renal function, the link is not 100% clear. Bipolar disorder itself is a risk factor for renal impairment, as are the medical conditions that tend to co-occur: cardiovascular disease, hypertension, and diabetes.3 About one-third of the research has failed to confirm the association between lithium and renal impairment, and two large studies found that anticonvulsants posed a greater risk to the kidneys than lithium.4-5 The reason for this confusion is that nearly all of the available data are uncontrolled. It takes about 30 years for renal problems to develop in patients taking lithium, and we are unlikely to see controlled trials that last that long.

Limitations aside, here is what we can glean from the available data:

1. Lithium can impair the kidneys, mainly by lowering the glomerular filtration rate.
2. These impairments rarely progress to end-stage renal disease.
3. Anticonvulsants, and possibly antipsychotics, are also implicated in renal dysfunction.6-8

Avoiding toxicity

The link between lithium and renal dysfunction may be explained by exposure to toxic lithium levels. Toxic levels kill renal cells, and that damage builds up every time the level rises above the toxic line. This theory is confirmed by a handful of study findings, which indicate that lithium does not seem to harm the kidneys when kept below 0.8 mmol/L, but that renal impairments rise with the number of toxic exposures.7 This is welcome news if proven true, because the recommended level for lithium maintenance is 0.6 to 0.8 mmol/L. Higher levels (up to 1.2 mmol/L) are usually only necessary for acute mania.8

Keeping the lithium level as low as possible can prevent renal impairment. The ideal level needs to be personalized and tends to fall with age. For patients over 60, the recommended level is 0.4 to 0.6 mmol/L, compared with 0.6 to 0.8 mmol/L for younger adults.9 The brain is more porous in later life, allowing more lithium to enter the CNS even when the serum level is relatively low.10 Dosing lithium once in the evening reduces the risk of renal problems.11,12 It also makes pharmacologic sense: Lithium’s half-life is 18 to 24 hours. There is no specific cap on the number of milligrams that can be given in a single dose, because lithium’s risks depend on the serum level rather than the dosage. If high serum levels are needed to treat active mania, dosing twice a day may be necessary to avoid toxic peaks. The line of toxicity is different for each patient because it’s defined by symptoms. Older patients may experience toxicity at a 0.8 level, while younger adults may show no signs of toxicity—or even adverse effects—at 1.2 mmol/L.

Monitoring needed

For every patient taking lithium, renal function should be monitored every three to six months. Older patients benefit from more frequent monitoring, as do those with a history of toxicity, high serum levels, or drug interactions. Creatinine is usually sufficient, but a more accurate measure of renal function should be monitored every three to six months. Older patients benefit from more frequent monitoring, as do those with a history of toxicity, high serum levels, or drug interactions. Creatinine is usually sufficient, but a more accurate measure of renal function is the estimated glomerular filtration rate (eGFR), which can be easily calculated from the creatinine (you will also need the height and weight to adjust for “body surface area”). Laboratory changes that should prompt a nephrology consult include: eGFR < 30 ml/min/1.73m², Creatinine ≥ 1.5 mg/dL, A decline of eGFR by more than 4 ml/min/1.73m² per year.13

Beware of polyuria and polydipsia

Polyuria and polydipsia are common adverse effects of lithium (30% to 80%), and they are not always benign. When severe, they may indicate nephrogenic diabetes insipidus (NDI), which means that changes in the renal tubules are impeding the kidneys ability to concentrate the urine. Those changes raise the risk of future renal impairments.

NDI is diagnosed by testing urine osmolality, urine sodium, serum sodium, serum creatinine, and a 24-hour urine for volume.

Besides stopping lithium, the main treatment for NDI is amiloride, a potassium sparing diuretic (5mg po qd). Amiloride may prevent further renal problems by reducing fibrotic changes in the kidneys.14,15 This medication is best managed through consultation with the medical team because it carries a risk of hyperkalemia, particularly in patients with renal insufficiency or diabetes.

Consider N-acetylcysteine

N-acetylcysteine (NAC) is an antioxidant that can protect and even reverse renal toxicity, including toxicity from lithium.16 NAC is part of a healthy diet; the capsule form is safe, well-tolerated (the main risk is constipation), and inexpensive. Sounds like a winner, but there’s one catch. The previously cited renal studies were all done in animals.

However, there is another reason to use NAC in bipolar disorder. This supplement is effective for bipolar depression in some, but not all, studies, and those benefits are more pronounced in the medically ill.17-19 The dose in bipolar disorder (2000 mg/d) is about twice the amount that was used for renal protection (10 mg/kg). Brands that stand out for their purity and economy include: Doctor’s Best, Life Extension, NOW, and Nutricost. (As tested by Consumer Labs and priced on Amazon.com.)

Conclusion

Among the vital organs, the brain, heart, and kidneys are the big three. When oxygen is scarce, the body attempts to preserve them at all cost, diverting blood flow their way through autoregulation. The decision to stop lithium can also hang in that balance, and for some patients it is a perilous one. On one side is the risk of renal failure; on the other, depression and suicide.

That is why there is no absolute contraindication to lithium, and no level of renal function where the medication must be stopped. When to stop lithium is a tough call, but how to stop it is more clear. Tapering slowly over at least a month, and preferably over several months, significantly lowers the risks of relapse and suicide.20

References


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RESEARCH UPDATE: BIPOLAR DISORDER

OCTOBER 2019
On August 5, 1962, Marilyn Monroe was found dead of an overdose of barbiturates. I was a second-year psychiatry resident in New York City at the time, and I remember exactly where I was when I heard of her death. The sad news shook the staff and dazed the patients in our all women’s hospital ward. The ripple effect of Marilyn Monroe’s death can still be felt today simply by counting the number of books and films dedicated to the stories of Marilyn’s deprived childhood, her astonishing Hollywood career, and the fame and glamour of the men in her orbit, not to mention the psychiatric theories about her mental illness and the many conspiracy theories that continue to surround her death.

The female patients for whom I was responsible were particularly devastated by the news of her death because they identified with her in so many ways. Many had experienced similar childhoods in foster care, had aspired to be film stars, and had suffered through difficult relationships.

As it was summer when this happened, the head of our ward was on vacation in Europe. This left me temporarily in psychiatric charge.

Once I realized how deeply Marilyn Monroe’s death had affected my patients, I knew that some form of intervention was urgently needed. I immediately invited patients to join a support group that I would lead. I had led groups before—these were fairly routine on our ward. I knew how to be emotionally supportive and how to listen. I was confident that I was good at bringing people out. I had all the harsh self-assurance of the very naive.

Our group of eight got off to a good start. We cried and shared our self-assurance of the very naïve.

“Today, this is called the Werther effect after the widespread emotional reaction to the 18th century novel The Sorrows of Young Werther by the famous German writer Goethe.” The story is about an unhappy lover who ends his life with a pistol. At publication, the book precipitated a massive wave of imitative suicides throughout Germany and much of Europe. This response was not unlike what took place the month after Marilyn Monroe’s death when there was a 10% increase in suicides in the US. More recently, there has again been much discussion about the potentially contagious effect of celebrity suicide. According to one article, the suicide of film stars is especially dangerous because there are many facets of the person’s real life that are widely known because of extensive media coverage and that consequently serve as springboards for identification.

In addition, people identify with various aspects of the characters a film star has portrayed. Marilyn Monroe is a case in point. The obsession with her suicide continues to this day, almost 60 years after her death.

The sources of copycat suicides go beyond identification. By using new technology to analyze the emotional tone after celebrity suicide tweets, recent studies conclude that the unexpectedness of the suicide contributes to the likelihood of it being imitated. A surprising, unexpected suicide seems to shake people out of their habitual routine into serious reconsideration of their reasons for living and, at times, into impulsive action.

Are there lessons here for clinicians? I think there are. In the wake of a celebrity suicide, it is wisest to express neither shock nor surprise to one’s patients. Patients who are at risk need to be assessed, monitored, and seen often. Their grief needs to be acknowledged. They also need assurances that you understand, are available, and that there are ways, admittedly difficult, by which one can overcome adverse circumstances and survive anguish. Persuading someone that viable alternatives to suicide exist has been called the Papageno effect in honor of the character Papageno in Mozart’s opera The Magic Flute. In the plot, Papageno decides to hang himself because he is convinced that he has forever lost his one true love, Papagena. Three child spirits prevent his death, however, by showing him how he can summon her back.

My own experience suggests that overzealous intervention is not a good idea and that it is best to check with elders in the field who are more experienced before leaping into unknown therapeutic territory. Sensitive topics such as thoughts of suicide need private one-on-one discussion, not group therapy. Membership in a group transforms a person and the results of such transformations can be difficult to foresee.

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returned to the states, but it was mostly a death sentence. By 1960, most state hospitals were ended altogether. This was widely considered a mistake, as the new medications, combination of the new medications, flourished, away from the toxic state hospitals and eventual- ly were ended altogether. This was widely considered a mistake.

Advocacy for the mentally ill has been muted and impotent. It is sad testimony that the strongest pressure for better care comes from the police and sheriff associations that have been made responsible for people who should be within the mental health system. The psychiatric and psychological associations have been extremely passive—never making the shameful neglect of the severely ill their number one priority. The National Alliance on Mental Illness (NAMI) started as an advocacy group to fight for better treatment of the severely ill, but it has lost its way and diluted its mission—often distracted by unreal- istic faith in scientific research and the development of new drugs.

The reliance on research is a case of blind hope victorious over bitter experience. The National Institute of Mental Health (NIMH) has spent tens of billions of dollars doing fascinating science that has not yet helped a single patient. The human brain is the most complicated thing in the known universe and keeps its se- crets well hidden. Genetics and neu- roimaging have shown how remark- able complex and interacting are the biopsychosocial causes of mental illness and that there will likely never be magic bullets. Drug companies have stopped looking for them.

The National Institute on Drug Abuse (NIDA) has similarly focused almost exclusively on brain mecha- nisms and has largely ignored practi- cal questions that would improve the lives of people suffering from addic- tions. Until recently, Substance Abuse and Mental Health Administration (SAMHSA) was funding mostly frilly projects completely divorced from the needs and sufferings of the severely ill. The Treatment Advocacy Center (https://www.treatmentadvocacynetwork.org) is the only group fully com- mitted to research the needs of the severely ill, speak truth to power, and to give voice to the voiceless.

What to do now?

We need a moon-shot mentality—and it doesn’t require rocket science or new research. We have known for 50 years how to provide good care for severe mental illness. There is nothing mysterious or complicated about it: decent housing; easily ac- cessible treatment; social clubs; voca- tional rehabilitation; positive re- gard, respect, and empathy; family support. The only thing new is apply- ing the internet as a powerful tool for education, for social networking, and monitoring symptoms.

The first priority is to get patients out of prisons and off the streets. Court diversion programs have pro- ven their worth in preventing impris- onment and deserve universal adop- tion. Prison diversion programs must now be developed to deinstitutional- ize the mentally ill who have been inappropriately imprisoned and pro- vide them with proper community housing and care.

Neglect of the severely ill is not only barbarically inhumane, it is also economically stupid. The rich- est country in the world is not only neglectful of its most vulnerable citizens? The simplest answer to this complicated question is the misplaced US faith that market forces are always the most efficient vehicle for solving problems. Adam Smith—the father of modern economics—knew better and strongly supported the role of govern- ment in providing vital public services undervalued by the market. Privatiza- tion of mental health has resulted in too much treatment for the well; cruel neglect for the severely sick.

My desperate—and so far un- heeded—plea is that we radically switch priorities. The two APAs (American Psychiatric Association and the American Psychological Association) and NAMI should devote their lobbying and public relations muscle exclusively to freeing the im- prisoned patients and providing de- cent housing. NIMH and NIDA should stop seeing themselves as nar- rowly focused brain institutes and widen their research agendas to proj- ects that might actually help people, not just advance scientific knowl- edge. SAMHSA should become a prison-release and ending-homeless- ness agency. And none of us should go to sleep without contemplating the fate of the patient in a prison bed or sleeping outside in the cold.

Dr Frances is Professor Emeritus and former Chair, Department of Psychiatry, Duke University; Chair, DSM-IV Task Force; and author of Saving Normal and Essentials of Psychiatric Research (Naneed—plea is that we radically switch priorities. The two APAs (American Psychiatric Association and the American Psychological Association) and NAMI should devote their lobbying and public relations muscle exclusively to freeing the imprisoned patients and providing decent housing. NIMH and NIDA should stop seeing themselves as narrowly focused brain institutes and widen their research agendas to projects that might actually help people, not just advance scientific knowledge. SAMHSA should become a prison-release and ending-homelessness agency. And none of us should go to sleep without contemplating the fate of the patient in a prison bed or sleeping outside in the cold.

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What Do Mass Murderers Have in Common? (It’s Not Mental Illness)

Mass shootings in America, whether in schools, places of worship, or entertainment venues, are now predictably followed by a call for gun control, which is almost immediately followed by an objection to gun control and a call, instead, for improved mental health services. (Along with thoughts and prayers, of course.) Then, nothing.

I began carrying my own concealed weapon after the Columbine High School massacre in April 1999. But that massacre was not why I did so; that was not my tipping point. And it was not the shooting at a local hospital by a surgeon who had encountered his wife’s lover when visiting her in her hospital bed, either. (He shot the lover dead on the spot; he had a license to carry.) It was not the home visits I was directed to make—I was a staff psychiatrist at a struggling Massachusetts mental health clinic with a state contract—to check on mentally ill people in recovery in our poor, high-crime community. They had stopped answering their phones or knocks at their doors by case workers, and their monitors were alarmed. And it was not my house calls to group homes where a client with a psychotic mental illness controlled by medications had been drinking alcohol and his state-employed supervisor had discontinued his antipsychotic medications, leaving him at the mercy of a psychotic relapse aggravated by alcohol—the result of a group home rule.

And it was not even the decision of that local hospital, where the surgeon had murdered his wife’s lover, to take a stand against gun violence by declaring guns absolutely forbidden inside the hospital, with hospital security guards no exception. Or, that my clinic’s director had decided that our own security guards be unarmed as well, even though there was direct access to doctors in their offices by walk-ins such as angry disability benefit seekers who blamed their psychiatrist for being denied benefits because the State Disability Office would tell them that the doctor’s report was the reason for their denial (ie, “don’t blame us”) abrupt into my office to vent their fury. No. My tipping point was the clinic’s emergency protocols for what to do in the event someone did enter our clinic with a handgun. The protocols were clear. Immediate notification of the psychiatrist on duty. That psychiatrist would approach the gun man and, in a “quiet, non-threatening voice,” ask for his gun. I recalled my medical school classmate who had done that very thing some years earlier at a different mental health clinic. He was shot dead on the spot.

I never told anyone other than my wife about my joining a gun club, talking safety lessons, and then practicing shooting at their range. I never shared with friends or colleagues that the police had granted me a concealed-weapon license to carry. They never knew that; for some of my professional tasks I went armed. What mattered to me was feeling safe. I felt safe.

Only later did I wonder what pushed me to that decision, what tipping point was followed by my against-the-rules behavior that ended my discomfort? It was obvious: frustration. I had felt vulnerable and helpless as a victim-in-waiting and against-the-rules behavior that ended my discomfort? It was obvious: frustration. I had felt vulnerable and helpless as a victim-in-waiting and unat peace—or at least feel safe and in control—is an overpowering and unbearable frustration? What are the implications?

One is obvious. Background checks might shift from reviewing mental health records, which are of zero predictive value, to something easily obtained, shared, and updated and with predictive value: the requirement that handgun license applicants have a record of being, and are currently, capable of recognizing, dealing with, and tolerating frustration—certainly no record of the converse—before being issued a firearms license.

Dr Climo is the author of Psychiatrist on the Road: Encounters in Healing and Healthcare, an account of his Locum Tenens experience.
Brain Glucose, Insulin Resistance, and Memory in Schizophrenia

Brian Miller, MD, PhD, MPH

Impairments in memory are associated with worse functional outcomes and quality of life in patients with schizophrenia. Alterations in glucose metabolism that are found in patients with schizophrenia, are also associated with memory impairment. Levels of insulin signaling molecules in blood extracellular vesicles (EVs) of neuronal origin can be measured as a marker of neuronal-specific insulin resistance. Complementary to this approach, magnetic resonance spectroscopy (MRS) is a non-invasive technique to measure brain glucose levels.

Wijtenburg and colleagues performed a study of EV biomarkers of neuronal insulin resistance and brain glucose levels using magnetic resonance spectroscopy (MRS), and their relationship to memory function, in 22 patients with schizophrenia and 24 healthy controls. Patients with schizophrenia were clinically stable with no changes in symptoms or medications in the past four weeks. Exclusion criteria were contraindication for magnetic resonance imaging (MRI) scanning, major medical illness affecting brain structure, diabetes, and current substance use disorder (excluding nicotine). Verbal and visuospatial learning and memory were assessed using the Hopkins Verbal Learning Task-revised (HVLT) and the Brief Visuospatial Memory Test (BVMT).

Functional capacity and quality of life were assessed with the UCSD Performance-Based Skills Assessment (UPSA). Fasting morning blood samples were collected for EV biomarkers, using an established protocol to isolate EVs enriched for neuronal origin. A principal component score representing six EV biomarkers was used as a measure of neuronal insulin resistance. All participants also had a morning brain scan on a 3T MR system for glucose levels. Between-group differences were analyzed using Pearson Chi-square test for categorical variables, and Wilcoxon rank-sum or Wilcoxon-Mann-Whitney tests for continuous variables. Linear regression analyses were used to examine relationships between brain glucose, neuronal insulin resistance, and memory function.

The mean age of participants was 38 years; 63% were male; 18% were smokers. Patients with schizophrenia had a mean duration of illness of 19 years, and the majority were taking second-generation antipsychotics. Blood samples were available for EV biomarkers for 19 patients with schizophrenia and 16 controls. Patients with schizophrenia had significantly lower scores on the HVLT, BVMT, and UPSA compared to controls. There were no statistically significant differences in neuronal insulin resistance biomarkers between subject groups.

In patients with schizophrenia, neuronal insulin resistance biomarker scores were associated with higher brain glucose levels and poorer performance on the HVLT, but not the BVMT. Patients with schizophrenia had higher brain glucose levels than controls, and brain glucose levels were associated with poorer BVMT scores. In participants with schizophrenia, several individual neuronal insulin resistance biomarkers were significantly correlated with HVLT but not BVMT scores. In the control group, insulin resistance biomarker scores were not associated with HVLT scores or brain glucose nor were individual insulin resistance markers correlated with memory function.

The findings indicate that poor glucose utilization, reflected by higher brain glucose levels, is evident in patients with schizophrenia. Furthermore, there was evidence of schizophrenia-specific interrelationships between neuronal insulin resistance biomarkers, brain glucose, and memory impairment. Limitations of the study include the relatively small sample size, the uncertain impact of antipsychotic medications on brain insulin resistance in schizophrenia is unclear, the self-reported diabetes status, and the lack of measurements for peripheral metabolic markers.

Findings from this preliminary study suggest that brain insulin resistance may be an underlying cause of memory impairments in schizophrenia and a novel potential treatment target.

Dr. Miller is Associate Professor of Psychiatry, Department of Psychiatry and Health Behavior, Augusta University, Augusta, Georgia. He is the Schizophrenia Section Editor for Psychiatric Times. He reports that he receives research support from Augusta University, the National Institute of Mental Health, the Brain and Behavior Research Foundation, and the Stanley Medical Research Institute.

REFERENCES
NEUROPSYCHIATRIC DISORDERS

Will a Photobiomodulation Trial Turn the Tide Against Alzheimer Disease?

Michael R. Hamblin, PhD

On May 22, 2019, Vielight Inc, a Toronto company, announced that it was commencing the recruitment of participants for a pivotal trial using near infrared light as an intervention for Alzheimer disease (AD). Vielight’s proposed intervention is based on photobiomodulation (PBM) involving the delivery of low-power near infrared light from light emitting diodes (LEDs) to the brain (Figure 1). In light of recent failed trials, why would another trial by a small Canadian company be expected to succeed against the odds? The proposed justification is that PBM works by “helping the brain repair itself,” rather than by targeting a single biological mechanism.

Understanding failed trials

No new drug for treating AD has been approved since 2003, at which time memantine (a blocker of the N-methyl-D-aspartate receptor [NMDA] subfamily glutamate receptor) received FDA approval. There have been several reasons offered to explain the repeated failures of AD drug trials—ranging from targeting the wrong biological mechanisms, to suboptimal methodologies, to the late disease stage of the participants. There is a trend in new drug trials to target populations with preclinical and prodromal disease, and increasingly towards non β-amyloid (Aβ) mechanisms of action in the earlier phases of drug development. There has been negligible discussion on any physical treatment modality, which appears to have been eclipsed by a continued search for prospective drugs despite multiple repeated failures.

Broadly speaking, drug development takes the approach of molecular screening, which may or may not be based on alteration of phenotypes. Over the years, many of these single molecule candidates have been related to Aβ oligomers and/or plaques or tau misfolding. AD has been found to have a much more complex etiology, with multiple risk factors that argue against single molecule targeting. On the other hand, PBM is an intervention that is able to modify multiple pathways, which may be an elegant answer to a complex problem.

The multifactorial and complex risk factors related to AD

Between 60% and 80% of the risk of AD is genetic, and many genes seem to be involved. Other risk factors include a history of head injury, depression, and hypertension. AD is generally characterized by diffuse atrophy of the entire brain, accompanied by extracellular Aβ plaques and intraneuronal neurofibrillary tangles composed of hyperphosphorylated tau protein. AD mechanisms have been widely discussed, but there is still a lack of fundamental understanding with much ongoing debate.

Neuroinflammation and reactive gliosis are also hallmarks of AD. Accumulating evidence suggests that microglia with the M1 phenotype are contributors to inflammation in AD.1 However, the M2 microglial phenotype is non-inflammatory and is also proposed to be able to clear the amyloid plaques by phagocytosis. PBM is capable of switching the microglial phenotype from M1 to M2, which partly explains its well-known anti-inflammatory effects.

Reductions in mitochondrial activity and glucose metabolism are widely seen in AD, including changes in cytochrome c oxidase and morphological changes in mitochondria. PBM is consistently cited to be able to improve mitochondrial activity.1 The multifactorial and complex risk factors related to AD are schematically shown in Figure 2.

Mechanisms of photobiomodulation in the brain

A bewildering array of different mechanisms and pathways have been proposed to account for the benefits of transcranial PBM on the brain. These are schematically shown in Figure 2.

METABOLISM. Improved metabolic function of the mitochondria is one of the most easily recognized effects of PBM, and increased intracellular adenosine triphosphate production (required for cellular energy) is one of the most strongly supported mechanisms of action. Several preclinical studies have shown that the brain adenine triphosphate content was increased in experimental animals subjected to transcranial PBM.

BLOOD FLOW. Disorders of cerebral blood flow have been associated with AD. Researchers have found that transcranial PBM induced significantly increased cytochrome c oxidase concentration and led to a higher oxygenated hemoglobin concentration in the treated site.3

It has been suggested that the release of nitric oxide as result of PBM is responsible for the increased cerebral blood flow.4 Nitric oxide is a major neuronal signaling molecule that, among other functions, possesses the ability to trigger vasodilation.

REDUCTION AND NEUROPROTECTION IN OXIDATIVE STRESS.

Findings suggest that PBM can be utilized for neuroprotection—essentially, to protect cells from damage, to promote their survival and longevity, and reverse apoptotic signaling processes.5 PBM may also protect cells from the harmful effects of toxins, which can be traced to its stimulation of cytochrome c oxidase.5 PBM lowers excitotoxicity effects, thus promoting cell survival and lowering oxidative stress.6

ANTI-INFLAMMATORY EFFECTS.

Many diseases, including AD, can be traced (at least in part) to chronic inflammation. One way that PBM helps to quell inflammation is through the inhibition of the cyclo-oxygenase 2 (COX-2) enzyme. 635 nm light irradiation at low power was able to cause COX-2 inhibition by decreasing intracellular ROS.5 PBM can also modulate cellular levels of free nuclear factor kappa-light-chain-enhancer of activated B cells (NFκB), which contributes to inflammation.7

NEUROGENESIS. Recent research showed that there was a sharp drop in hippocampal neurogenesis in people with AD, and this reduction further increased along with disease progression.12 The first report of neurogenesis being stimulated by transcranial PBM delivered to the brain came from a study in 2006 that treated stroke in rats.10 The number of newly formed neuronal cells as well as migrating cells was significantly elevated in the subventricular zone (SVZ). A similar result was reported by other investigators who treated mice that had suffered TBI using transcranial PBM.13 They found that there was a significant increase in neuroprogenitor cells in the dentate gyrus of the hippocampus and in the SVZ.

SYNAPTOSIS. One manner in which transcranial PBM may promote synaptogenesis could be by up-regulation of brain derived neurotrophic factor (BDNF). BDNF is also

FIGURE 1. The Vielight Neuro RX Gamma in use

[Insert Figure 1 here]
Does your patient need more intensive care?

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### RESEARCH UPDATE

**FIGURE 2. Multiple mechanisms for PBM in brain**

<table>
<thead>
<tr>
<th>Mechanism</th>
<th>Effect</th>
</tr>
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<tr>
<td>Angiogenesis</td>
<td>Increased blood flow</td>
</tr>
<tr>
<td>Reduced Cerebral Flow</td>
<td>Decreased cerebral blood flow</td>
</tr>
<tr>
<td>Synaptogenesis</td>
<td>Improved synapse formation</td>
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<tr>
<td>Neuritogenesis</td>
<td>Increased neuron growth</td>
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There are many mechanisms for transcranial PBM in the brain that have been proposed as potentially beneficial to brain function and that could possibly impact the progression of AD.

The participants were assessed with the Alzheimer Disease Assessment Scale-cognitive (ADAS-cog) and the Mini-Mental State Examination (MMSE) scales. At 12 weeks, cognitive function was significantly improved (MMSE increased by a mean of 2.6, P < 0.003; ADAS-cog decreased by a mean of 7.4, P < 0.023). Moreover, sleep was improved, there were fewer angry outbursts, less anxiety, and wandering. There were no negative adverse effects. Precipitous declines were observed during the 4-week follow-up/no-treatment period. It should be noted that this small trial commenced as a placebo-controlled trial, but the patients randomized to receive placebo dropped out before the conclusion.

A second pilot trial tested the effects of home PBM on cognitive and behavioral function, cerebral perfusion, and resting-state functional connectivity in eight patients with dementia.

PBM treatments were administered at home three times per week with the VIelight Neuro Gamma device (pulsed at 40 Hz). The participants were assessed with the ADAS-cog and the Neuropsychiatric Inventory at baseline and at 6 and 12 weeks, and with arterial spin-labeled perfusion MRI and resting-state functional MRI at baseline and 12 weeks.

After 12 weeks, there were improvements on ADAS-cog (P = 0.007) and Neuropsychiatric Inventory (P = 0.03), increased cerebral perfusion (P < 0.03), and increased connectivity between the posterior cingulate cortex and lateral parietal nodes within the default-mode network in the transcranial PBM group. The lack of blinding was a limitation of this study.

**Conclusion**

PBM can trigger cellular activities that restore cellular metabolism, promote blood flow, neuroprotection, and reduce levels of inflammation and oxidative stress. All of these cellular mechanisms can be summed up as “helping the brain to repair itself.” While PBM will probably not be a permanent cure for AD, it can be proven to be effective in large well-controlled trials, it could make a substantial impact on patients with AD and their caregivers.

If demonstrated to be effective, and with no reports of significant adverse events having been made as yet, the significance for geriatric psychiatrists is great. The potential of a modality that could turn the tide on AD with a convenient, affordable, home-use device would make a big impact. The preliminary clinical evidence from these small studies to date is impressive when compared to the results of controlled studies using AD drugs. The findings support moving forward with larger, double-blind, placebo-controlled trials using the Neuro PXM Gamma (810 nm near infrared at 40 Hz).

The pivotal trial involves 228 participants with moderate to severe cognitive impairment, in a double-blind study at eight sites across North America. The trial incorporates 24 weeks of assessment with the Severe Impairment Battery (SIB) as its primary endpoint. It is expected to take three years to complete. The details of this study have been reviewed by the FDA; these details are published online at ClinicalTrials.gov.

**Dr Hamblin** is Principal Investigator, Wellman Center for Photomedicine, Massachusetts General Hospital, Associate Professor, Department of Dermatology, Harvard Medical School, Boston, and Affiliated Faculty, Harvard-MIT Division of Health Sciences and Technology, Cambridge, MA. He reports that he receives financial compensation as a Scientific Advisory Board Member and Consultant to Vielight Inc. For the sake of completeness other potential conflicts of interest are Scientific Advisory Boards: TransdermalCap Inc, Cleveland, OH; BeWell Global Inc, Wan Chai, Hong Kong; Hologenix Inc, Santa Monica, CA; UMBT Inc, Poulbo, WA; Vielight, Toronto, Canada; Bright Photomedicine, Sao Paulo, Brazil; Quantum Dynamics LLC, Cambridge, MA; Global Photon Inc, Bee Cave, TX; Medical Coherence, Boston, MA; NeuroThera, Newark DE; JOOVV Inc, Pleasanton CA; IRx Medical, Pleasonton CA; F/X Industries, Inc. Ransey, NJ; UVLRx Therapeutics, Oldsmar, FL; UltraLUX UV Inc, Lansing MI; Illuminheal & PETthema, Shoreline, WA; MB Lasterytherap, Houston, TX; AXR LED, San Clemente, CA; Varuna Biomedical Corp, Incline Village, NV; Nirax Light Therapeutics, Inc, Boston, MA; Consulting: Lexington Int, Boca Raton, FL; USHIO Corp, Japan; Merck KGaA, Darmstadt, Germany; Philips Electronics Nederland B.V. Eindhoven, Netherlands; Johnson & Johnson Inc, Philadelphia, PA; Sanofi-Aventis Deutschland GmbH, Frankfurt am Main, Germany. Stockholdings: Global Photon Inc, Bee Cave, TX; MITonix, Newark, DE.

**REFERENCES**

I have always been intrigued by Dr Allen Frances’ views on psychiatric diagnosis. I was in medical school when DSM-5 was in development, and it was fascinating to see his relentless commentary on issues related to diagnostic inflation and diagnostic validity as an inside critic. His critique also served as a portal for me (and many others) to explore larger philosophical issues in psychiatric diagnosis. This made him an ideal candidate with whom to converse for the launch of this interview series on critical psychiatry.

DR AFTAB: In many ways, you are one of the architects of modern psychiatry, yet you have also emerged as one of its most prominent critics. How do you see your own relationship with the field?

FRANCES: I think psychiatry is among the noblest of professions, but it has drifted astray from best practice. It is heartbreaking to me that 600,000 of our most severely ill patients are either in jail or homeless and that we have done so little to advocate for the community mental health centers and affordable housing that would have freed them from confinement and ended the shameful neglect.

I fear that too many psychiatrists are now reduced to pill pushing, with far too little time to really know their patients well and to apply the rounded biopsychosocial model that is absolutely essential to good care. We also have done far too little to educate the primary care doctors who prescribe 80% of psychiatric meds on the principles of cautious prescribing, proper indications, full consideration of risks, and the value of watchful waiting and tincture of time.

I despair the diagnostic inflation that results from a too loose diagnostic system, aggressive drug company marketing, careless assessment, and insurance company pressure to rush to judgement. Diagnoses should be written in pencil, and underdiagnosis is almost always safer and more accurate than overdiagnosis. And, finally, I object to the National Institute of Mental Health (NIMH) research agenda that is narrowly brain reductionistic; it has achieved great intellectual masterpieces, but so far has not yet helped a single patient.

So, in sum, I have loved being a psychiatrist, but wish we were better organized to end psychiatric suffering.

AFTAB: When it comes to a philosophical understanding of mental disorders, on several occasions you have eloquently expressed that you neither see them as real diseases nor as fanciful myths, but rather something in between, as useful constructs that represent our current best guess on how to sort psychiatric distress. I am reminded a bit of the argument by Thomas Szasz that there are only two possible realities behind mental health conditions: They are either brain diseases or they are problems in living, and there is no in-between. Do you accept this dichotomy between diseases and problems of living?

FRANCES: If so, by calling mental disorders as constructs, are we admitting that we don’t really know which conditions are diseases and which are problems in living?

AFTAB: Might psychiatry be in a better shape now?

FRANCES: The narrow research focus of the RDC made it a completely inadequate guide to clinical practice. Going overboard in the other direction, the diagnostic exuberance of DSM-5 confuses mental disorder with the everyday sadness, anxiety, grief, disappointments, and stress responses that are an inescapable part of the human condition. DSM-5 ambitiously mislabels normal diversity and childhood immaturity as disorder, creating stigma and promoting the excess use of medications.

CONVERSATIONS IN CRITICAL PSYCHIATRY

Allen Frances, MD
Relentless Warrior for Mental Health

EDITOR’S NOTE: Conversations in Critical Psychiatry is an interview series with prominent individuals who have made meaningful criticisms of psychiatry and have offered constructive alternative perspectives to the current status quo. It is Dr Aftab’s hope that these discussions will stimulate a much-needed debate in the psychiatric community.
Relentless Warrior

Continued from page 17

and of mislabeling them. At the moment, mislabeling rules.

AFTAB: You have expressed that the DSM approach has been far too influential, leading to a reification of diagnostic constructs and a checklist approach to diagnosis that the creators of DSM had never intended. Why do we still need DSM? Most other fields of medicine don’t rely on an official manual in this fashion.

FRANCES: DSM is a system of limited, but essential, value. I don’t trust clinicians who know only DSM, but I equally don’t trust clinicians who don’t know it at all or use it carelessly. The DSM evaluation should be just a small part of an initial interview and not done as a rote checklist. Eliciting symptoms in a natural way expresses empathy and understanding for what the patient is experiencing and can be a giant step toward a strong therapeutic relationship. DSM also plays a central role in differential diagnosis (particularly in ruling out medical, medication, and substance causes for symptoms), in differential selection of treatments and in predicting course and prognosis. Reductionistic systems are useless or harmful in clinical practice; see for example NIMH’s Research Domain Criterion and “Understanding Psychosis and Schizophrenia” by the British Psychological Society. ²

AFTAB: You recognize DSM as an imperfect document, yet you also advocate for diagnostic conservatism—that current diagnostic constructs should be maintained unless there is convincing meta-analytic evidence to support a change. When groups of researchers come up with proposals for diagnostic criteria for psychiatric conditions and their supporting evidence falls short of meta-analytic evidence, those proposals are not given much legitimacy, even though the amount of evidence would likely still be far more evidence than Robert Spitzer ever had for DSM III. Does that not seem like an unscientific state of affairs?

FRANCES: With all its flaws and lack of empirical base, I think the field would have been better off sticking with DSM III. Changes since that edition have been consistently exploited to increase diagnostic inflation. If anything in DSM can be misused, it will be misused. We had excellent empirical evidence for including both bipolar II and Asperger’s in DSM IV, but both did more harm than good. Data drawn from for the generation of financial revenue. It seems odd for a manual of such importance to be tied to organizational professional politics.

FRANCES: I have worked with a group studying how guidelines are developed throughout medicine. We recommend that specialty groups never be permitted sole power to determine the diagnostic guidelines for that specialty. There is an inherent financial, intellectual, and emotional conflict of interest that leads every specialty to recommend overdiagnosis. Diagnostic guideline development needs specialists as consultants, but they should never be allowed to call the shots. Contributions from primary care, public health, health economics, and consumers are also important, and methodologists without specialty affiliation should do the review and evaluation of evidence. Moreover, APA has a special conflict of interest because DSMs are such a valuable publishing property—essential for meeting its budget. This makes frequent revision too tempting and results in an unseemly hyping of the product.

AFTAB: You have acknowledged that conditions have become mental disorders by “accretion and practical necessity” and that mental disorder is “what clinicians treat and research researchers research and educators teach and insurance companies pay for.” Does that not imply an unseating relativism in the shape psychiatry has taken? I am reminded of something Robert Kendell, FRC Psych, wrote in 1975: “The fact is that any definition of disease which boils down to ‘what people complain of,’ or ‘what doctors treat,’ or some combination of the two, is almost worse than no definition at all. It is free to expand or contract with changes in social attitudes and therapeutic optimism and is at the mercy of idiosyncratic decisions by doctors or patients.”²

FRANCES: Bob Kendell was the clearest voice in the history of psychiatric diagnosis, and his caution about diagnostic relativism is even more cogent and widely applicable today than when he wrote 45 years ago. Diagnostic inflation exists not just in psychiatry, but in every medical and surgical specialty.

The definitions for just about every disease—hypertension, osteoporosis, diabetes, glaucoma, knee, shoulder, and back disease, prostate, breast, and thyroid cancers—are far too loose and ever getting looser. Half of adults in the US now have hypertension. Modern medicine is making such rapid advances, soon none of us will be well. If I were in control of psychiatric diagnosis now, I would recommend a reduction in diagnostic inflation through a risk/benefit analysis. We need an evaluation of which diagnoses and what diagnostic thresholds do more harm than good.

AFTAB: You have talked about epidemiological studies that exaggerate the prevalence of mental disorders because they also include psychiatric symptoms, which lack clinical significance in their prevalence estimates. DSM relies heavily on “clinical significance” as a necessary criterion, but the concept is never formally defined in the manual. How do you understand “clinical significance”?

FRANCES: Never believe the extremely high rates of mental disorders routinely reported by epidemiological studies in psychiatry—usually labelling about 25% of the general population as mentally ill in the past year, about 50% lifetime. This entire literature has a systematic, but unacknowledged, methodological bias that inherently results in over-reporting. Because epidemiology requires such huge samples—in the tens of thousands—it is prohibitively expensive to conduct clinical interviews. Instead, phone surveys are done by non-clinicians following a highly structured format that allows no clinical judgment whether the symptoms reported cause sufficient

FRANCES: I would consider that diagnostic inflation exists not just in psychiatry, but in every medical and surgical specialty.

Diagnostic inflation exists not just in psychiatry, but in every medical and surgical specialty. . .

Modern medicine is making such rapid advances, soon none of us will be well.

research studies on highly selected patients in the hothouse environment of a university research clinic generalize very poorly to the hustle and bustle of primary care.

AFTAB: What are your thoughts on the role and relevance of Freud and his ideas in contemporary psychiatry?

FRANCES: Freud is punished now for being unduly worshipped during his heyday 100 years ago; he gets far too little credit for presciently anticipating much of modern cognitive theory, neuroscience, and psychotherapy technique. Freud’s emphasis on the power of instinct and unconscious mental functioning successfully applied Darwinian psychology to a wide variety of clinical problems. But psychoanalysis was too important to be left in the hands of the antiquated psychoanalytic institutes that adhere rigidly to old ideas that Freud himself would have surely abandoned as modern science made them obsolete and quaintly silly. It is tragic that many residents now get so little psychotherapy training; it explains why some psychiatrists become mindless pill-pushers.

AFTAB: Is it appropriate in your view that one single organization, the American Psychiatric Association, has total control over DSM? Some would say that the APA uses the book to solidify its authority and

FRANCES: With all its flaws and lack

clinically significant distress and impairment to qualify as a mental disorder. Since there is no sharp boundary between normal distress and mental disorder, not assessing for clinical significance includes among those labelled mentally ill many who are merely distressed. The rates in studies are really only upper limits, not accurate approximations of true rates. They should be, but never are, reported as such. “Clinical significance” is an indefinable but essential construct in applying DSM criteria—so important that we repeated its necessity in each and every criteria set despite the fact that we could not operationalize its application. Many of the most essential terms that we use so glibly in everyday life and practice are equally indefinable, eg, mental disorder, disease, illness, impairment, and dysfunction. Words that are categorical lose precision in defining phenomena that are distributed dimensionally. DSM should be seen only as a tool helpful in guiding clinical judgment, not a replacement for it.

**AFTAB**: Are there books that have profoundly influenced how you understand psychiatry that you would like to recommend to other psychiatrists and trainees?

**FRANCES**: Here are some of my favorites:

- *Ulysses* by James Joyce for the fullest literary description of how people think;
- *The Brothers Karamazov* by Fyodor Dostoevsky for the deepest understanding of human motivation and best takedown of expert witness testimony in forensic psychiatry;
- *The Peloponnesian War* by Thucydides for its profound insight that interacting complex contingencies make predicting the future impossible no matter how well we know the past;
- *The Expression of Emotions in Man and Animals* by Charles Darwin for inventing evolutionary psychology and making almost completely obsolete the prior psychological musings that had occupied the world’s greatest philosophers;
- *On the Nature of Things* by Lucretius for its brilliant scientific intuitions and calm acceptance of the small place we humans occupy in this universe.

I also watch lots of movies, travel, and read widely. See lots of patients, and imagine yourself in their life, feelings, and thoughts. The broader and deeper you are as a person, the better you will be as a psychiatrist. The easiest—and most mindless—part of psychiatry is prescribing meds; be good at it, but not limited by it.

“There’s no more terrible pain a man can endure than to see clearly and be able to do nothing.”
—Herodotus, *The Histories*

**AFTAB**: Thank you!

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Eating disorders (ED) are associated with significant comorbid psychopathology and the most extensive medical complications of any psychiatric disorder. Disordered behaviors that present across diagnoses (e.g., restriction, binge eating, compensatory behaviors) are linked with acute medical risks that often require careful medical monitoring and clinical intervention. Yet, individuals with EDs frequently express hesitancy towards recovery and have great difficulty controlling their ED symptoms.

EDs are typically chronic and follow a treatment-refractory trajectory. Existing research indicates that even the most effective evidence-based outpatient treatment yields recovery for only around one-half of patients.1,2 In our clinic, we often encounter patients like “Hayley,” “Georgia,” and “Michael” (see Case Vignettes) for whom outpatient treatment has been unsuccessful. Like many other eating disorder treatment programs, our program seeks to optimize recovery by providing more intensive treatment with stepped levels of care.

Most research explores the efficacy of treatment at the outpatient level; little is known about the comparative value of the higher levels of care for patients with EDs.3 However, these approaches are important alternatives for treatment-refractory EDs because they provide the more intensive treatment and meal support that many severely ill patients need.1,2 Common reasons for needing higher levels of care include substantial weight loss that might be life threatening; difficulty eating enough food to gain weight; severe binge/purge behaviors; incapacitating ED symptoms; comorbid substance abuse; and anxiety, depression, obsessive compulsive disorder, or suicidal intent.

It is not unusual that such behaviors result in medical instability with symptoms of cardiovascular compromise, electrolyte disturbances, or hypoglycemia. It is important to note that some individuals have a lack of insight about their behaviors or are not motivated to engage in treatment. Because of these factors, the mortality rate for anorexia nervosa and bulimia nervosa can be 5% or higher.3,6 Higher levels of care provide a structured and protective environment.
Levels of Care
Continued from page 24

**CASE VIGNETTE**

Georgia, aged 17 years, has bulimia nervosa (BN) with comorbid major depressive disorder, panic attacks, and a history of sexual trauma. She has been engaging in polysubstance abuse, including alcohol, marijuana, prescription painkillers, and cocaine, since the age of 12. She has been hospitalized several times for suicide attempts and accidental drug overdoses. She binge and purges daily and states that she is only able to reduce these behaviors when using substances. Her outpatient therapist feels overwhelmed by all of Georgia’s comorbidities and is not sure how to help her reduce these self-destructive behaviors, so she refers Georgia to a PHP program.

**Description of available higher levels**

Higher levels of care for EDs include various types of programs, with different levels of intensity.

**The treatment goals for EDs are similar and include:**

- Restoring weight;
- Interrupting binge, purge, and restrictive behaviors;
- Managing physical complications;
- Enhancing motivation for recovery;
- Providing psychoeducation regarding regular eating;
- Challenging ED-related cognitions;
- Treating comorbid conditions;
- Supplementing family support; and
- Preventing relapse.

Psychotherapy approaches among higher levels of care are typically informed by cognitive behavioral and dialectical behavioral therapies. Family-based treatment is often incorporated for children and adolescents. Patients might transition between levels of care due to variables such as symptom severity, medical status, motivational status, treatment history, and financial limitations.

There are several different levels of care from which to choose:

**1 Inpatient hospitalization** is the highest level of care available. This setting can be in a medical hospital and is intended for patients with acute medical instability. Alternatively, this may be in a psychiatric hospital if there are severe behavioral symptoms. In either event, subspecialty medical and behavioral consultation are readily available, meals are supervised, and one-to-one monitoring is available.

**2 Residential programs** offer full-time treatment in a non-hospital setting. Patients receive multidisciplinary care that includes nutritional support, medication management, and individual and group therapy.

**3 Partial hospitalization programs** (PHP), or daytreatment, offer treatment in an outpatient setting approximately six to 10 hours a day, between three and seven days per week. Patients typically spend nights and sometimes weekends on their own, allowing them to practice the skills they are learning in social, occupational, and leisure settings outside of treatment.

**4 Intensive outpatient programs** (IOPs) offer treatment approximately three hours a day, from three to five days per week. At both the PHP and IOP levels, patients receive meal support, group therapy, individual therapy, dietary sessions, and medication management.

**Outcomes research**

**Treatment efficacy for higher levels of care.** Randomized controlled trials (RCTs) are necessary to avoid the confounding effects of psychopathology severity and evaluate the comparative efficacy of different levels of care. Since patients with more severe symptoms and greater functional impairment are more likely to present to higher levels of care than those with mild ED pathology (and milder ED pathology is associated with better outcomes), reliable findings are dependent on patients matched with controls based on symptom severity or random assignment to level of care.

Unfortunately, RCTs that compare different levels of care are limited given significant costs and ethical considerations related to randomizing acutely ill patients. As such, literature on higher levels of care treatment efficacy is scarce and consists largely of open trials assessing outcome at discharge. A 2015 review of PHP and residential programs identified that duration of treatment was similar between these levels of care, and all but one study reported improvements in outcomes (ie, body mass index [BMI], number of binge/purge episodes) at discharge.

There have been several, more recent naturalistic studies of higher levels of care treatment that also offer support for the effectiveness of care in most patients. However, less than half of the open trials identified in the review reported follow-up data after discharge. Follow-up completion rates tend to be low; the average rate of follow-up completion was 66% for PHP and 37% for residential. Although most of the studies reported that positive treatment outcomes at discharge were maintained or improved at follow-up, the missing data at follow-up make long-term results difficult to interpret.

**Predictors of recovery**

As previously mentioned, the literature on treatment efficacy at higher levels of care is preliminary and consists largely of open trials. Within the context of these trials, researchers have begun to study the predictors of long-term recovery. However, more is known about predictors of recovery from EDs in general, regardless of type of treatment, and no study has looked at how predictors of successful outcome might differ depending on level of care received.

Vall and Wade conducted a meta-analysis of predictors of treatment outcomes that included a large number of patients treated at a higher level of care. Their findings indicate that patients with higher BMI, fewer binge/purge behaviors, greater motivation to recover, lower depression, lower shape/weight concern, fewer comorbidities, better interpersonal functioning, and fewer familial problems at baseline had better outcomes both at end-of-treatment and follow-up. The most robust predictor of outcome at both end-of-treatment and follow-up was the motivational mechanism of greater early symptom change.

The literature consistently corroborates that early behavioral change predicts later symptom remission. Given that higher levels of care treatment settings typically involve meal supervision and more opportunities to quickly learn skills, these settings may be uniquely well-suited to facilitating early symptom change.

**Determining level of care**

When determining the appropriate level of care, practitioners should consider practice guidelines published by reputable organizations as well as individual variables important in predicting treatment response. The American Psychiatric Association (APA), Royal Australian and New Zealand College of Psychiatrists (RANZCP), and National Institute of Clinical Excellence (NICE) published guidelines for ED treatment that outline factors to consider in making decisions regarding level of care.

The NICE and RANZCP guidelines recommend first seeking outpatient care and suggest transferring to higher levels of care if there is no improvement of symptoms. Alternatively, the APA advises consideration of greater early symptom change.

The literature consists of relatively few randomized controlled trials (RCTs) or other well-controlled studies. This is partly because of the challenges of enrolling patients in these trials, which are often highly motivated and have a strong desire to be treated. These patients may be more amenable to participating in research because they are seeking treatment for their ED and are willing to make the time commitment required for participation. To ensure that these findings can be applied to a broader population, future research should include a diverse sample of patients with EDs.
fore returning to her outpatient team. Georgia stopped using drugs and alcohol within the structure of PHP, participated in weekly family therapy, and learned skills for coping with emotional dysregulation. Michael restored his weight in PHP through repeated food exposures that helped him increase his food volume and variety and decrease his fears surrounding contamination.

For many of the complex, severely ill patients who present to treatment, intensive treatment with stepped levels of care can offer a cost-effective structure that promotes positive behavioral change.

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Anorexia nervosa is the third most common chronic illness among adolescent females. The mortality rate is 12-fold higher than with all other combined causes of death for females aged 15 to 24 years. The disorder is associated with severe emaciation from self-driven food refusal and a perception of being overweight despite very low body weight. Anorexia nervosa shows a complex interplay between neurobiological, psychological, and environmental factors, and it is a chronic disorder with frequent relapses, high treatment costs, and severe disease burden. Little is known about the pathophysiology or biomarkers that characterize anorexia nervosa brain function, treatment effectiveness is limited, and there are no FDA-approved medications.

Brain circuitry

What makes anorexia nervosa so difficult to treat is the seemingly willful food avoidance and self-driven relentless motivation to lose weight. While eating is a very normal behavior for most of us, overcoming the fear of eating and weight gain is extremely difficult for children or adults with anorexia nervosa. Humans have historically evolved to be biologically protected to survive times of food scarcity. The brain circuitry that drives food-seeking has been well defined in basic science found that in the process of eating, anticipation of the receipt or omission of stimuli is associated with changes in the brain reward system, which determines food approach or avoidance. Stress and anxiety may lead to changes in eating and may drive anorexia nervosa behaviors in persons vulnerable to the illness. This model can be used to prepare patients and/or their families for times when there is a high risk of triggering anorexia nervosa behaviors.

FIGURE 1. Brain imaging design to study the Pavlovian learning paradigm during functional magnetic brain imaging.
food restriction, the dopamine system in the brain gets sensitized to stimulate food seeking. We interpreted this elevated activation as a normal response.

This brain activation does not drive eating as it would in healthy individuals. In fact, it can often be observed in individuals with anorexia nervosa that despite weight loss, fear of weight gain worsens and there is no limit as to how low the weight will drop. In our most recent study, we propose a model of how this drive to lose weight may be perpetuated and how the elevated prediction error response fits into this behavior. Our findings indicate that elevated brain response correlated positively with harm avoidance—a measure of trait anxiety—but negatively with weight gain during treatment.

Harm avoidance was positively correlated with drive for thinness and body dissatisfaction. We propose that when a person who develops anorexia nervosa starts to lose weight, the dopamine system quickly gets faster or more strongly involved, i.e., sensitized. Weight loss leads to low blood sugar and changes in hormonal and neuropeptide levels, which signal to the hypothalamus that the organism should eat. However, this biological motivation and drive to eat disagrees with conscious motivation to not eat and lose weight, which leads to high levels of anxiety. To avoid weight gain and driven by extreme anxiety, the person with anorexia eats even less, which further reduces weight and triggers more biological drive to eat and further increases anxiety. Thus, setting off a vicious cycle that is difficult to break (Figure 2).

Benefits of understanding the mechanism

Clinically, this has been a useful model to discuss the neurobiology of anorexia nervosa with patients or families. I draw and develop this model in a monthly seminar with parents of children with anorexia nervosa, which helps them understand the typically very difficult to comprehend ongoing drive for food restriction. Understanding a certain mechanism does not cure the illness, but it provides opportunities to support treatment. In psychotherapy it helps to go from something inexplicable to understanding the connection between an anxious temperament with a predisposition to worry and eating problems. This is also relevant for patients who have recovered but who may be at risk for relapse.

Every year in August, around the time when school starts, I see several patients with symptom relapse in my outpatient clinic. This is due to heightened stress over grades that triggers eating problems and food restrictions. The subsequent weight loss may then set in motion the vicious biological cycle as previously described.

As do other biological studies including genetic research, such a model serves another important purpose. If anorexia nervosa is caused by genetic and epigenetic factors, then the basic rules that determine the way that genes are turned on or off. We are starting to identify those genes that predispose individuals to at-risk behaviors such as eating disorders.

Harm avoidance and perfectionism are the severe eating disorder core behaviors while the original anorexia nervosa motivation is sustained. Weight loss briefly alleviates anxiety and reduces food restriction. Lowering gut hormones and dopamine that stimulate food-seeking, elevate anxiety, and subsequently elevate AN core behaviors. Anorexia triggers a food control circuitry from the ventral striatum to the hypothalamus that depends on dopamine D1 receptors, which have been involved in the control of food restriction. Anorexia core behaviors elevated in the brain circuit due to the potential loss of control and weight gain, and this becomes a self-reinforcing cycle. Dopamine food restriction and weight loss perpetuates the cycle.5

References

Understanding and Treating Avoidant Restrictive Food Intake Disorder in Children and Adolescents

Voadvert restrictive food intake disorder, or ARFID, is a newly introduced eating disorder in DSM-5. ARFID is characterized by a persistent failure to meet appropriate nutritional and/or energy needs, which can result in at least one of the following: significant weight loss or nutritional deficiency, dependence on enteral feeding or nutritional supplements, and/or a marked interference in psychosocial functioning. ARFID cannot be explained by a lack of food availability, cultural practices, body image concerns, or concurrent medical or mental conditions.

Given that the disorder was introduced in 2013, it remains unclear how prevalent ARFID is in the general population. Early research suggests that compared with anorexia nervosa patients, those with ARFID are typically younger, more likely to be male, more likely to have an anxiety diagnosis, and have a longer duration of illness.

Clinical presentation
ARFID can present in a variety of ways, making it difficult to describe a typical case.

DSM-5 suggests 3 primary reasons why those with ARFID avoid food
- Fear of negative consequences of eating
- Low appetite or disinterest in food
- Avoidance of food based on sensory characteristics

Our review of 48 children and adolescents (mean age 13.6 years) who presented to a hospital-based eating disorders clinic with ARFID revealed that 13% of cases had a mixed presentation of two or even three of these subtypes.

Most patients with ARFID will avoid food for one or more of the following reasons:

1. **Fear of negative consequences of eating.** Although patients in this category restrict food because they are afraid to eat, they do not have body image concerns and are not afraid of weight gain. The fear of eating may be direct (eg, the patient feels nauseous or experiences abdominal pain when eating so the patient restricts to avoid these symptoms) or indirect (eg, the patient worries that he might vomit or have an allergic reaction if he eats). Other presentations in this cohort may include younger patients who have learned about “bad foods” and avoid these foods out of a fear of being unhealthy. (Although there is debate about whether these patients should be considered as having a form of AN, so further research is required.)

2. **Low appetite or disinterest in food.** Parents often describe children in this second ARFID category as being “grazers” or “eating like a bird.” Their histories are characterized by longstanding low appetite, early satiety, and indifference to food. While they may present at any stage of childhood or adolescence, puberty often triggers weight and growth concerns. In these cases, patients’ appetites do not increase sufficiently to meet the increased energy needs of puberty, resulting in a fall off their growth curve. Other examples include children and youth who are active in sports and cannot keep pace with their high energy needs because of low appetite, which is often combined with the stress of busy schedules and lack of family meals (especially for those who eat slowly).

3. **Avoidance of food based on sensory characteristics.** Patients in this category struggle primarily with food variety; they are often extremely selective (picky) regarding the food that they consume.

AFRID cannot be explained by lack of food availability, cultural practices, body image concerns, or concurrent medical or mental conditions.

Their histories of food refusal usually date back to an early age. They often have sensory hypersensitivity that results in profound rigidity involving food (eg, can only eat foods of a certain color or texture). In many cases, the rigidity extends to the manner in which food is served (eg, different foods on a plate cannot touch; the hotdog must be cut up in equal pieces) and to details related to preparation (eg, pasta must be boiled...
for exactly 11 minutes). These patients often will only accept the same limited number of foods prepared in the exact same manner and served in the exact same way. These extremely rigid picky eaters are challenging to treat, and treatment will almost always require a multidisciplinary team approach. Often, caregivers are exhausted from years of trying to meet the needs of these children. Although picky eating is common in children, and in most cases improves with age without the need for any intervention, this is not the case for children with this subtype of ARFID. Maybe not surprisingly, early research suggests that children with autism spectrum disorder are more likely to be in this category of ARFID.

It is important that health care professionals not simply dismiss parental concerns around feeding based on weight gain and growth at a rate deemed acceptable. Our early study illustrates that when patients and families with such presentations are treated with an intensive intervention, the child’s weight and growth velocity can supersede that observed before the intervention, and that this weight gain can be associated with improved physical and mental well-being. It is also important to recognize that these children may not be simply picky eaters but may have feeding difficulties that severely affect their functioning. For example, one 12-year-old girl would only eat baby food, while one boy with autism would only eat Cheerios and fish crackers.

### Treatment

In children and adolescents, insufficient nutrition that results in weight loss or poor growth is associated with significant medical and psychological complications, and as such should be treated aggressively. This is especially true for a young person who has fallen off his or her growth curve. Using pediatric growth curves and working with families and health care providers to determine a child’s optimal growth velocity can be an essential step in the assessment and treatment of patients with ARFID.

Limited published evidence exists to guide clinicians in the treatment of ARFID, although trials are presently underway in the US and abroad. Strandjord and colleagues undertook an open label trial and concluded that modified family-based therapy was helpful for adolescents with anorexia nervosa or with ARFID, although few adolescent ARFID patients took part in the family-based therapy sessions, thus limiting the study’s conclusions. Family-based therapy, the gold-standard treatment for adolescent anorexia nervosa, seems well-suited to the treatment of a proportion of underweight youngsters with ARFID, given that family-based therapy focuses on lifting blame, raising the family’s anxiety about the dangers of low weight and malnutrition in young people, and empowering parents to take charge of nutrition and to focus on the goal of weight gain.

All six patients were treated with the atypical antipsychotic medication olanzapine for its anti-anxiety properties plus appetite stimulation; four of the patients subsequently transitioned from olanzapine to an SSRI (such as fluoxetine) as they approached their treatment goal weight, and two remained on a low dose of olanzapine at bedtime in addition to an SSRI. These last two patients, who had a combination of chronic low appetite, picky eating, severe anxiety, and acute stressors, also required the appetite stimulant cyproheptadine in addition to olanzapine to help them reach their healthy weight.

The medications were all used off-label because of the lack of evidence for their role in the treatment of ARFID. Currently there is only one case series that explores the utility of olanzapine for treating ARFID. In the Brewerton and D’Agostino’s study, it was demonstrated that the use of low-dose adjunctive olanzapine may have improved patients’ appetites and weight gain and helped reduce symptoms of anxiety and depression for nine of the patients.

Some patients with anorexia nervosa may present with low weight, but deny body image concerns. In such cases the diagnosis is unclear, and we recommend proceeding with treatment focused on weight gain as described above. Moreover, the development of eating disorder-specific and ARFID-specific measures and diagnostic instruments should be considered. In cases of anorexia nervosa, the fear of weight gain typically becomes apparent during the course of treatment. In our eating disorders clinic, approximately 8% of 77 patients who presented initially with ARFID subsequently received a diagnosis of anorexia nervosa.

### Conclusion

Additional research is needed to better understand which treatments or combinations of treatments are most effective for ARFID. There is a lack of evidence to guide clinicians, and in many cases, consultation with a feeding or eating disorder specialist is helpful. Moving forward, it will be important for researchers to conduct treatment outcome studies that investigate the effectiveness of various therapies and medications, alone and in combination, for the various subtypes of ARFID in both children and adults. Helping underweight patients reach their treatment goal weight is often an essential first step in addressing their physical and mental well-being.

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The Martial Personality and the Decline of Communal Values

Ronald W. Pies, MD

Writing in 2016, The New York Times columnist David Brooks described the perilous state of communal values in this country:

The great challenge of our moment is the crisis of isolation and fragmentation, the need to rebind the fabric of a society that has been torn by selfishness, cynicism, distrust, and autonomy. At some point there will have to be a new vocabulary and a restored anthropology, emphasizing love, friendship, faithfulness, solidarity, and neighborliness that pushes people toward connection rather than distrust.

In my estimation, the problem of societal disintegration in the US has only worsened in the past three years. While many social, political, economic, and psychological forces are probably at work here, I have been struck by the growing prominence—and, in some circles, acceptance—of what I call the Martial Personality (MP). More precisely, this should be called the Aresian Personality—named for Ares, the Greek god of war—as I will explain presently.

In all likelihood, the MP has been around since our paleolithic ancestors first fought one another over mastodon meat. But in recent years, this personality type seems to have proliferated and flourished. Before exploring the archetypal foundations of the MP, I need to stress that I am not describing a new category of mental illness, such as might be included in the next edition of DSM. Rather, I am describing a constellation of personality traits that may or may not veer into frank, clinical psychopathology; and which, paradoxically, may be adaptive in certain contexts—think bullfighting, politics, and Wall Street.

I also want to head off the criticism that I am describing any specific public figures, though I suspect many readers will have one or two in mind. But if you need a fictional character to prefigure my development of the MP, think corporate raider Gordon (“Greed is good”) Gekko in the movie, Wall Street. As one reviewer described him, “Gekko isn’t in his line of work only for the money . . . he is in it to crush his opponents.” That is not a bad capsule summary of the MP.

Just to be clear: I believe this personality type may be seen in people on both ends of the political spectrum and probably in the middle as well. And although the Martial archetype is strongly male-centered, I do not believe the MP is limited to men. Indeed, readers may well recognize the MP type in some of their male or female co-workers, supervisors, or even former lovers (long gone, I hope!). In short, the MP is an equal opportunity archetype.

So how might MP present in modern-day guise—perhaps in a psychotherapist’s office? A brief composite sketch may be helpful at this point.

CASE VIGNETTE

“Mr Ares” is a 28-year-old single male who is self-employed as a day trader. He is referred for psychotherapy by the woman he has been dating off and on for the past two years, and who—as the patient expresses it—“... said she’d kick me to the curb if I didn’t get some f—ing help.” Although he denies he has any emotional or psychological problems “except dealing with all the wimps...”
Zeus further characterizes Ares as “wicked and fickle.” And this, from Ares’s father! Ironically, Ares—though often showing great bravado—rarely emerges victorious in battle; he is easily bested by the cool-headed warrior goddess Athena, who calls Ares a “vain fool.” Mythology scholar Mark Cartwright describes Ares as “… perhaps the most unpopular of all the Olympian gods because of his quick temper, aggressiveness, and unquenchable thirst for conflict.”

According to the Dictionary of Greek and Roman Biography and Mythology, Ares was “not so much the god of war as of its tumult, confusion, and horrors.” Ares “loves war for its own sake” and has no qualms about which side of the battle he supports; in fact, “sometimes assists the one and sometimes the other side, just as his inclination may dictate.” And Ares sometimes behaves less like a god and more like a cowardly, petulant child, as when Athena guides the spear of a Greek warrior like a god and more like a cowardly, petulant child, as when Athena guides the spear of a Greek warrior.

The martial personality and related conditions
Readers familiar with character pathology will quickly recognize certain pathological traits in both Mr Ares and his mythic counterpart. Narcissistic and sociopathic traits stand out, along with impulsivity, sadism, and aggressive behaviors. It would be fascinating to sit old Ares down and do a complete psychiatric evaluation, but a discussion of the differential diagnosis would take us far afield. (That said, I suspect Ares might meet DSM-5 criteria for narcissistic personality disorder, among others.)

Despite substantial overlap with several conditions or disorders, I believe that a distinguishing feature of the MP is the individual’s sheer delight in causing harm, discomfort, or chaos: something akin to schadenfreude (from the German, Schaden [damage, harm, discomfort, or chaos: something akin to malicious joy in the misfortunes of others], among others.)

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MOOD DISORDERS

Mania and Hypomania: Latest Thinking on Duration of Episodes and Other Features

David N. Osser, MD

An international task force of experts in the diagnosis and treatment of bipolar disorder was recently convened to address concerns about DSM-5 criteria, particularly the definitions of manic episodes. This initiative was funded by the National Health and Medical Research Council of Australia; 64 individuals from 14 countries spanning five continents responded to a questionnaire probing different aspects of the criteria. The findings are pertinent for clinicians struggling to make the bipolar I and II diagnoses, which have been found to be both underdiagnosed and overdiagnosed in different studies. The consequences for patient outcomes with these missed diagnoses can be severe.

The DSM’s duration criteria is an area of concern. Currently, it includes seven days for mania and four days for hypomania. Patients with only brief episodes who meet phenotypic criteria are excluded from the diagnosis, and a lot of time is spent with patients struggling to find if they have had the syndrome for four or more days. Some task force members felt that any duration of this syndromal criteria should be sufficient. However, most responders (75%) thought that ultra-short episodes have many possible explanations, and some limit should be imposed. Of those nominating a finite period, the modal recommendation was two days for both mania and hypomania.

Thus, for patients who have a sufficient number of symptoms to meet criteria, it may be that [hypo]mania durations of as little as two days could be a reasonable basis for concluding that the diagnosis is probably bipolar disorder and treatments should be chosen accordingly.

The group also came up with a new proposed definition for hypomania and mania:

A distinct period of either an abnormally elevated and expansive mood, or an irritable and quick-tempered mood, characterized by increased activity and cognition such that the individual feels unusually energized, hyper, or wired. Such changes are perceived at the time or on later reflection as excessive and an unambiguous change in functioning from the individual’s usual state.

The consensus was that this characterized the disorder better than the current DSM definition.

In differentiating bipolar I from bipolar II, the majority voted to continue to require marked disturbance in functioning at work or socially for bipolar I (mania). However, the requirement that hospitalization would automatically qualify the patient for bipolar I was strongly opposed. This requirement was considered arbitrary and too dependent on local health services practices, insurance, or other external factors. However, if the patient was hospitalized, that certainly could be an indicator of severity and likely mania. The group thought psychosis should be retained as a criterion indicating mania.

The group has studies underway to test these proposed changes and others to see how well they describe a consecutive series of patients in clinical practice. They are also looking at 78 possible symptoms of mania to see if any are better than the seven in DSM-5.? 

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EXCLUSIVE COVERAGE

The End of Human Civilization

» Beth Mark, MD

A person’s a person, no matter how small
—Theodore Seuss Geisel

It’s not that I did not believe in climate change—I could sense the subtle changes in the seasonal norms, and I forced myself to read the increasing number of articles offering scientific proof of it—but it was an unsettling, nagging insight that I could generally pack away. I would recycle my plastics, make some donations, and get on with my busy day. My defensive structure was shaken four years ago when my son sent me a link to an article with the title “When the End of Human Civilization Is Your Day Job,” which described how climate scientists were struggling emotionally with the burden of facing the facts and trying to communicate them to the public.

The article forced upon me the realization that, in the face of impending catastrophe, I had not only resorted to repression (trivializing the magnitude of the problem and thereby diminishing the intensity of my fear and anger). I had engaged in retribution, manifesting a remarkably childlike consciousness with respect to authority.

Of the generation whose formative experiences included the Vietnam War and Watergate, I generally thought of myself as an adult who had a healthy skepticism about the competence and morality of those in power. The fear of climate change had evoked my childish trust that the adults in charge would “take care of things.” To my surprise, I realized that I (or some part of me) still retained the belief that scientists impersonally discern the facts and those in charge make the appropriate policy changes to keep us safe, and that’s just the way things work. Yet, the scientists featured in the article were distraught about what they were finding. Even more intense was their agitated expression of repressed anger, manifesting a remarkably adult-like consciousness with respect to climate change—I became interested in how actual (ie, chronological) children and adolescents are responding to climate change. As it turns out, there is little research in this area.

Scientific and psychological challenges

One of the central insights of those in the field of climate change is that the scientific and psychological challenges confronting the climate crisis cannot be severed from politics, economics, ethics, and even religion. In part, this is because our treatment of each other and our treatment of Mother Earth reflect the same ethos. The allocation of money and attention with respect to research on children’s emotions and attitudes toward climate change reflect colonialism and racism. Eighty percent of the world’s children live in the developing world, ie, those countries that did the least to create the climate crisis while suffering the most from it. Lake writes:

Prejudice

Childism, prejudice against children, is evident in the amount of research in this area on children—whether from the developing or developed world. Children are uniquely vulnerable, both physiologically and psychologically, to the direct and indirect effects of climate change. For example, children not only have greater biological sensitivity, they literally interact with their environment—as a percentage of their body weight, with the air, food, and water—more than adults.

Children are uniquely at risk for environmental contamination while playing on the ground and putting their hands, dirt, and other objects in their mouths. Extreme weather events—occurring more frequently in the context of global warming—disproportionately disrupts childhood, a period of relatively more limited adaptive capacities (eg, children are less able to digest the psychological and physiological traumas of migration). Despite all of this, there is very little research on children’s emotions and attitudes. In contrast, there is a relatively robust body of literature examining adults’ emotions and attitudes with respect to environmental issues in the US.

As another manifestation of childism, there is a top-down quality to the research insofar as it is concerned with how adults can help children cope with their emotions and how adults can facilitate children’s “pro-environmental behavior” (ie, reducing one’s carbon footprint). I wonder if our current emphasis on getting children to reduce their carbon footprint reflects the condescending belief that, until children grow up and gain more sophisticated skills and power, this is the only way they can contribute to mitigating the climate crisis.

Of course, I believe that adults have the responsibility to help children regulate their emotions. And, while reducing one’s carbon footprint is a laudable goal, it is not for the reason I had thought while I was busy recycling my plastic. The mate...
rivial benefits of recycling is no longer terribly meaningful; many believe the goal of sustainability is no longer feasible.1

Nevertheless, children’s participation in efforts to recycle can acquire the character of a needed, vital ritual. It becomes a mindfulness practice that re-orient our relationship with the environment from one of exploitation to one of mutual care. Recycling mindfully can also open up opportunities for children to become curious about what we use, where it goes, and how much do we really need. Rather than a top-down lesson to be “learned,” a more mutual, naturally occurring conversation between parent and child can take place.

A radical and urgent perspective
Children, less wed to existing political “realities” and economic structures than adults, may provide the more radical and urgent perspective that is needed in times of crisis. It is the children who are listening to climate change scientists. They believe in the fact of human generated global warming more than adults.2 Students are suing their governments, organizing marches and school strikes around the world, and creating student-led environmental activism groups. Children are sounding the alarm and calling for more fundamental changes in our ways of being.

Children, it would seem, are angry and feel betrayed. They are increasingly putting these feelings and their unique perspective to adaptive use—pushing us out of our complacency. As adults, we too can make unique contributions, including sharing our wisdom and defining core values, and a capacity to regulate our own and our children’s emotions in the face of crisis.

A dialogue needs to be opened. As the older generation, we need to not only listen to children and youths, but we must also acknowledge that we have failed in our fundamental duty to create a safe home on planet Earth for them. Such acknowledgment might open the way for each generation to hear the other and might best permit us all to move forward doing everything we can; not because we have a childlike belief in a happy ending, but because it is the right and only thing to do.

“Children, less wed to existing political ‘realities’ and economic structures than adults, may provide the more radical and urgent perspective that is needed in times of crisis.”

Dr Mark is a staff psychiatrist at the Counseling and Psychological Services of the University of Pennsylvania, and a student in the Masters of Environmental Studies Program at the University of Pennsylvania. She reports no conflicts of interest concerning the subject matter of this article.

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Treater, Disability Assessor, or Forensic Expert
A Trap in Disability Claims

Imagine: Your patient has complained about a disagreement with his boss, who he thinks is criticizing him unfairly. You have prescribed an antidepressant and have been helping the patient communicate better with the boss, but the hostility between the two has escalated, and the boss terminated him. At his request, you supported his application for Social Security Disability Insurance (SSDI). His application was denied, and he is suing SSDI for the denial and his former employer for discrimination based on the Americans With Disabilities Act (ADA). He wants you to provide a forensic expert psychiatric opinion that he is disabled, and that the denial of benefits has psychologically damaged him permanently. You feel caught in a bind, and you are. By stepping out of the treater role, either into the role of disability evaluator or forensic expert, you assume risks inherent in this role combination.

This article highlights some of these major risks. The take-home point is that treaters should avoid role duality if at all possible, preserving the role as treater and referring disability and forensic evaluations to a colleague trained in this area. The following principles apply to psychiatrists who are asked either to support a patient’s disability application or offer forensic expert opinions if litigation ultimately ensues because disability is denied.

Advocacy role

The treater is an advocate for the patient’s mental health. The treater absorbs what the patient says without question and makes treatment decisions accordingly, viewing suspected distortions or exaggerations only as part of a complicated clinical picture. If the treater suspects malingering, treatment is terminated.

In the role of disability assessor or forensic consultant/expert, the psychiatrist is not an advocate for the litigant, instead he or she strives for honesty and impartiality in the assessment. Especially as expert, any signs of advocacy for the litigant leaves the expert open to a challenge of bias from the opposing side and may result in the expert’s being discredited by the fact-finder.

A possible exception exists in the case of a patient with acute and unambiguous impairment and debilitation (eg, florid psychosis, delirium, mania, profound neuro-vegetative depression) in which an appropriately qualified forensic expert cannot be obtained, the treater has not conducted the disability functional assessment, and the patient has been denied disability benefits. Since the psychiatric conditions listed create functional impairment and therefore are generally considered to be disabling, at least temporarily, the treater may be obliged to render an expert opinion in court.

Confidentiality

Ethics require that information divulged in treatment sessions remains confidential. If the treater has also agreed to be the patient’s disability assessor or forensic expert, an ethical bind results, particularly in the latter role. In practicing within ethical guidelines the disabled patient must defend opinions on both diagnosis and causality of the diagnosis in deposition or at trial, since valid legal claims of emotional injury are translated into psychiatric diagnoses caused by the disputed circumstances.

The disability examiner should review collateral information, especially work records, but additionally must understand the mental functions required by the job and explain how any psychiatric diagnoses impair the person’s ability to carry out the job tasks. Psychological testing may be useful.

The expert must also defend the diagnostic opinions by reviewing multiple cross-sectional sources of information including mental health, medical, employment, legal, and other pertinent records. Objective psychological testing is important in order to check for consistency with the diagnostic hypotheses. In either role, a complete mental status examination is essential.

In addition to the psychiatric diagnoses, the disability examiner must discuss any collateral factors that may underlie the request for disability, such as family problems and severe financial problems, as with the IRS and creditors. Some diagnoses, such as PTSD, are easily malingered by review of symptoms posted online. Treaters involved with the Veteran’s Administration clinics and hospitals in which PTSD checklists are administered routinely face a unique responsibility to minimize inappropriate use of the system by these patients.

Limited inquiry

Although treaters may initially obtain information about the patient’s medical, mental
their country’s borders, inevitably flooding into nearby, then distant nations, such as the world has never seen..."

I’ve recalled his words many times since then, as one catastrophic migration, frequently spurred by impending genocide, has followed another. I remembered them again after viewing director Christian Pitzold’s haunting Transit (2019). In German and English, it is based on Anna Seghél’s masterful 1942 novel available from New York Review Classics (https://www.nyrb.com/collections/classics).

Seghél’s story is set in the 1940s; in Paris, then Marseille. Thousands fleeing the Nazi invasion descended upon the gritty port city, known as much for its vigorous criminal element as its bouillabaisse. The refugees came from elsewhere in France and other already occupied European countries.

They ranged across the social spectrum in class, race, and economic status. (Many were Jews.) Their common goal was escape, mainly by sea, to any country willing to take them. The alternative was an arduous, dangerous return through occupied territory, then a trek over the mountains to neutral Switzerland, or through Franco’s Spain to neutral Portugal.

Few were able to leave quickly. The majority found themselves hopelessly stranded, embroiled in a dispirited search for visas and permits. The dizzying array of crucial documents escalated daily. Meanwhile, the uprooted multitude became the prey of hostile, frequently corrupt bureaucrats as well as a legion of con artists.

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With legal passage increasingly scarce, the displaced were compelled to seek illegal means of getting out, shady captains of “rustbuckets,” many of which never intended to sail. When their cash and jewels were depleted, the destitute turned to begging, petty thievery, prostitution — and suicide.

Pitzold’s cinematic translation preserves Seghél’s essential plot, principal characters, and the debased

against the treater?

These are some of the important reasons why, barring certain exceptions, treaters who are asked by their patients to function as a disability assessor or forensic expert should strongly consider declining and remaining in the treatment role alone, referring the patient to an appropriately trained colleague. If asked to testify for the patient, the treater may testify as a fact, but not an expert witness. A possible exception exists when a patient who exhibits signs of acute and unambiguous impairment and debilitation has been denied disability benefits, and a qualified disability examiner or forensic expert cannot be obtained. Such conditions may temporarily require the treater’s assuming a dual role, but the treater should document the reasons for role duality and the limitations this imposes on the treatment process of treatment and disability or forensic assessment, clearly explaining these limitations to the patient, insurer, and the courts.

**Conclusions**

The treater who also assumes the dual role as either a disability examiner or forensic consulting expert faces ethical risks because of the inherent binds in the dual role, including advocacy, confidentiality, integrity of the medical record, diagnosis, causality, limited inquiry, and financial reimbursement. Dual roles leave the treater opining on the patient’s disability claim open to question by the disability insurer, who may then request an independent assessment.

If the treater is also the forensic expert, he or she will be open to attack by opposing attorney at deposition and trial, and the treater/examiner’s credibility, impartiality, and motives for functioning in this dual role may be questioned and memorialized in the public legal record. Worse, if the treater/forensic expert testifies at trial while the patient watches a withering cross-examination by opposing counsel, the patient’s legal case may be compromised and lost. How will the patient/litigant respond to the treater’s loss of credibility? Will the patient terminate treatment and retaliate legally against the treater?

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Complementary and Alternative Treatments for ADHD: What the Evidence Suggests

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Recent surveys suggest that 7% to 8% of children and 4% to 5% of adults meet ADHD criteria.1,2 The rate at which ADHD is diagnosed and treated has increased dramatically since the syndrome was recognized by DSM as a specific disorder in the 1970s. It is estimated that fewer than 20% of adults with ADHD have had a correct diagnosis and have thus incurred significant social and occupational risk. Almost half of those who have ADHD never graduate from high school and fewer than 5% complete a 4-year university degree program.1 A diagnosis of ADHD has been associated with 35 days of lost work on average per year, which suggests US$19 billion in lost productivity and 120 million lost work days annually.3

**Limitations of conventional treatment**

Because stimulants are usually classified as scheduled or restricted medications (depending on the country), prescriptions are often limited to a small supply, which results in treatment interruptions and transient worsening of when refills are not obtained on timely basis. Adverse effects of stimulants include insomnia, decreased appetite, abdominal pain as well as occasional stimulant-induced psychosis; chronic use can increase the risk for slow growth. Moreover, stimulants and other pharmacologic treatments for adult ADHD may be only half as effective as they are in children.

Controlled-release stimulants, bupropion, and the SSRI antidepressants are being increasingly used in the adult ADHD population, however...
these medications may not be as efficacious as stimulants. Although atomoxetine is FDA-approved for the treatment of childhood ADHD, there are growing concerns about its adverse effects, including hypertension, tachycardia, nausea and vomiting, liver toxicity, and possibly increased risk of suicide.

**CAM therapies are widely used to treat ADHD**

Growing concerns about inappropriate prescribing or over-prescribing of stimulant medications and the incomplete understanding of risks associated with their long-term use have led to increasing acceptance of complementary or alternative medicine (CAM) therapies. CAM therapies in children with ADHD are used largely out of parental concerns over prescription drug safety. CAM therapies, including vitamins/minerals, dietary changes, and expressive therapies, are used although parents rarely disclose this to the child’s doctor. Although there is limited evidence to support most CAM therapies for treating ADHD, it is highly regarded by many patients’ parents.

**Dietary modification**

Early studies suggested that artificial food colors were associated with ADHD; however, a meta-analysis of studies spanning a 35-year period failed to confirm this relationship.\(^1\) One such diet, the oligoantigenic diet (OAD), is a highly restrictive multiple elimination diet that excludes food colors and additives, in addition to dairy products, sugar, wheat, corn, citrus, eggs, soy, yeast, nuts, and chocolate. The diet permits a limited number of hypoallergenic foods like lamb, chicken, potatoes, rice, bananas, apples, cabbages, broccoli, brussels sprouts, carrots, peas, pear, and cucumber, as well as salt, pepper, calcium, and some vitamins. Reductions in hyperactivity were seen in children who were on the OAD regimen when specific food items were eliminated from the diet.\(^4\) Behavioral symptoms improved during the elimination and placebo phases and recurred when children were subsequently challenged with the eliminated food item.

Roughly one-third of hyperactive children may benefit from some form of an elimination diet.\(^5\) Although these findings are promising, they cannot be used to develop general ADHD treatment protocols because of study design flaws, including heterogeneity of patient populations, absence of standardized outcome measures, high dropout rates and, in some studies, non-blinded researchers.

The American Academy of Pediatrics does not endorse elimination diets because of inconsistent efficacy findings as well as concerns that highly restrictive diets do not provide balanced nutrition. Parents who are considering restrictive diets should consult with a qualified nutritionist. Highly restrictive diets should not be continued for longer than two weeks in the absence of noticeable improvements in ADHD symptoms.

**EEG biofeedback**

Many individuals with ADHD have abnormal patterns of brain electrical activity, including un-
Acupuncture

A 2010 meta-analysis of acupuncture for ADHD revealed three studies that met inclusion criteria for sufficient methodological rigor and sample size. Positive results were seen with electroacupuncture given concurrently to behavioral therapy. A meta-analysis of two other studies of somatic acupuncture or auricular acupuncture combined with drug therapy showed significant differential effects of combined treatment. The findings, however, were inconclusive because of the small study size, its short duration (less than one month), the absence of blinding, and the absence of an intention-to-treat analysis.

Meditation and yoga

In a systematic review of studies on meditation and mind-body practices (eg, yoga, Tai chi, Qi gong) to treat ADHD, only four studies (83 participants total) met inclusion criteria for methodological rigor and sample size. Two studies evaluated mantra meditation and two studies compared yoga with conventional drugs, relaxation training, non-specific exercise, or treatment as usual. However, design problems resulted in a high risk of bias in all studies and identified only one study that met criteria for formal analysis. In that small study (n = 15) the teacher rating ADHD scale failed to show significant outcome differences between the meditation group and the drug therapy group.

In a small pilot study (n = 19), children in a yoga group experienced greater improvement in symptoms over time compared with children who exercised. Children who continued on stimulants while practicing yoga experienced the greatest improvements. Two small controlled studies suggest that yoga and regular massage therapy may reduce the severity of ADHD symptoms.

Summary and clinical recommendations

When stimulants fail to result in significant reductions in symptom severity or when adverse effects, toxicities, or comorbid substance abuse preclude their use, EEG biofeedback and select evidence-based CAM treatments may be considered. Restrictive diets are reasonable interventions in cases where impulsivity and distractibility may be related to sugar intake or food allergies. Parents of children with ADHD should first consult their child’s pediatrician before initiating a strict dietary regimen, and ideally with a qualified nutritionist who can provide them with expert guidance should be consulted.

When therapeutic doses of stimulants cannot be achieved with acceptable tolerance, the adjunctive use of EFAs and select herbas including Ginkgo biloba, Panax quinquefolium, Pinus pinaster, and Bacopa monnieri may improve response. The adjunctive use of acetyl-L-carnitine, zinc, and iron may be beneficial in some cases; however, these treatments are not substantially supported by strong evidence findings. Regular yoga and massage therapy may help improve attention and hyperactivity in some cases. When a person diagnosed with ADHD fails to respond to pharmacological and CAM treatments it is prudent to rule out confounding psychiatric disorders, including learning disorders, depressed mood, and anxiety disorders, which are frequently comorbid with the syndrome and may interfere with treatment outcomes.

REFERENCES

Already in Hell

Continued from page 38

and mercilessly exploit the stateless but only if they can prove their commitment to leave the city.

The film’s opening sequences deftly establish the refugees’ devastating dislocation. The film is filled with vivid, evanescent encounters.

Georg’s are notably intense and ephemeral. He drags a wounded partisan into a boxcar, then finds him dead upon arriving in the city next morning. He grows close to a fetching North African boy and his deaf-mute mother. The pair then vanishes into the mountains after the youngster angrily rejects Georg when he learns about the intended escape. To paraphrase Goethe’s Faust: all is transitory.

Transit knowingly evokes the classic 1940s and 1950s film noir tropes. Many of these were written and directed by European refugees like Fritz Lang and Billy Wilder, who were strongly influenced by post-World War I German expressionist art, which often contained unsettling urban themes. Emigré filmmakers translated the angst ridden, dispossessed milieu of the doomed European city to Hollywood (eg, The Big Heat, 1953; Double Indemnity, 1944).

The noir genre was typified by labyrinthian plots involving a criminal venture, set in the seamy underbelly of big city nights. Characters often came from working class, low class, or otherwise compromised social backgrounds.

In a common noir subgenre, a pair of star-crossed lovers, one or both seduced into crime, pursue redemption downhill, mean urban streets. A capricious, ultimately imponderable destiny dictate the destruction of their dreams—and usually their lives (eg, Criss Cross, 1949).

Transit insinuates that most of the refugees’ fate will be as fatally sealed, but in the actinic sunlight of Marseille rather than the tarnished nocturnes of Los Angeles or Manhattan. A femme fatale, who caught lov-

Rogowski makes Georg’s default silent isolation achingly palpable. Being so unexpected, his observations about Marseille’s traumatized, unanchored milieu are rendered more incisive—and his rare breakthrough of endearing tenderness even more poignant.

In the film’s most heartbreaking scene he wipes away a single tear, while crooning a sweet lullaby to the North African boy about the twilight return of beasts and parents alike to the solace of home.

I have noted the analogizing of Transit between the totalitarianism engaging Seghal’s era and our troubled time. Pitzhold’s enigmatic project demands strenuous work from the viewer to grasp this searing equivalence, and it brilliantly succeeds. One comes away enlightened and discomfited.

Transit implicitly references the social critics who illuminat-
ed the disrepair and absurdity of the human condition during and after World War II. One chiefly thinks of the great existentialists: notably Camus of The Stranger and Sartre of No Exit. But, it is the ghost of Franz Kafka, paragon of agonized alienation, who hovers over the concluding appraisal of our suffering unmoored world in Transit. Kafka’s presence is unmistakable in the parable of Weidel’s last story, which Georg relates with quiet irony to a cynical American embassy official who would rather see thousands die in Marseille’s squalor than grant them liberty.

A scene occurs at the end of the film: a man who has just died must register himself into hell. What he has done to deserve his fate is as inexplicable as the bureaucratic registration process—he finds himself standing before a large door and waits years without being admitted. (It is all pure Kafka.) Finally, he asks a passerby how to gain entry. The Kafkaesque reply:

“But, sir, this here is hell.”

Dr. Greenberg practices psychiatry in Manhattan, New York. He continues to publish frequently on film, media, and popular culture. For many years, his cinema column appeared in Psychiatric Times. He has appeared frequently on national and international network and cable television programs including Good Morning America, Today, CBS Evening and Sunday News. Please address communications to Dr. Greenberg at HRSG@S@AOL.COM.
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- Flexible work schedules. Private practice permitted.
- Tele-psychiatry positions available at our VTC Suites, including Long Island.
- 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
NATIONWIDE

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 Psychiatrists for Telemedicine and Onsite positions in the following states CA, TX, NV, AZ, FL, OR, and Many other states. Full time and Part Time positions are available.
We offer competitive salaries and excellent benefits!

Immediate Need for BC Psychiatrist FL
Medical license – Onsite
VERO BEACH, FL
SIGN ON BONUS- RELOCATION PROVIDED, OUTSTANDING SALARIES AND BENEFITS

Immediate Need for BC Psychiatrist with CA license for several outpatient and inpatient sites
Contact Sandra Williams at 818-814-7790 or email me your current CV to swilliams@alignedth.com
To be considered for these great opportunities.

California

Vituity
At the heart of better care.

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
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Human Resources
Phone: 916-628-7654
Fax 916-930-6100
Hisham.solimanmd@gmail.com

Outpatient Psychiatry Opportunity
San Joaquin County Behavioral Health Services is seeking to fill Outpatient Adult [General, and Sub-Specialty Psychiatry (Child Psychiatry, Geriatric, Forensic, Addiction and Psychosomatic Medicine) positions in a multidisciplinary, recovery-oriented clinical setting. Services are provided either on-site or using a hybrid model of on-site and tele-psychiatry practice. The positions offer a very competitive salary with a guaranteed base, plus incentive opportunities, board certified Psychiatrists have the potential to easily earn over 300K+ a year; comprehensive health insurance; up to three retirement and pension programs; 35 days of vacation and CME time that increase with tenure. Signing and moving bonuses are also available.
Interested J-1 and H-1B candidates are welcome to apply.
Contact Khurram Durrani, MD at: kdurrani@sjcbhs.org; Fax CV to 209-468-2399. EOE.

ADHS
ARIZONA STATE HOSPITAL

Psychiatrist Position—Arizona State Hospital
Phoenix, AZ

The Arizona State Hospital has an opening for an adult BE/BC psychiatrist for full time inpatient duties. The duties revolve around managing 18-23 inpatients, who have been admitted for long term treatment. The psychiatrist can expect to do 1-2 admissions per month on average. Call is from home, and the hospital does not routinely do after hours or weekend admissions. Call is electively shared among the psychiatry group, and if the psychiatrist does not wish to routinely participate in the call system, they can expect to be assigned on average 1-2 times per month. Call is compensated as a separate stipend. The hospital functions on a “co-attending” model, with primary care practitioners providing routine medical care. Benefits are excellent, and include:
• Yearly compensation 215K BE, 220K BC
• Health Insurance $115 per pay period for family PPO plan ($47 for individual)
• Long Term Disability included
• Enrollment in the defined benefits retirement plan, the Arizona State Retirement System, which guarantees a retirement income after vestiture
• 21 days of annual leave, 12 days of sick leave, and 10 paid holidays

For more information, contact Steven Dingle, M.S., MD, Chief Medical Officer at steven.dingle@azdhs.gov or 602-220-6007.
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DEPARTMENT OF STATE HOSPITALS
• Atascadero State Hospital $275-$280 per hour
• Colony State Hospital $275-$280 per hour
• Napa State Hospital $275-$280 per hour
• Patton State Hospital $275-$280 per hour

( Part time & full time positions available )
Payment Plan: Monthly/Delayed

*Free Direct Deposit*

Ref. bonus/signing Bonus will be $1.5k/$2.5k starting September 2019
(certain rules applies)

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Email: pinnacleservices@pinnaclehealthservicesinc.com
Website: http://www.pinnaclehealthservicesinc.com

Telecare Corporation

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

EEO M/F/V/Disability

FLORIDA

PSYCHIATRY AND BEHAVIORAL SCIENCES

The University of Miami Miller School of Medicine Department of Psychiatry and Behavioral Sciences is in an exciting phase of growth and recruiting full-time child and adolescent psychiatrists, specifically at the assistant or associate professor rank.

Faculty rank and compensation are commensurate with experience. The University of Miami also provides a moving bonus and faculty stipend. The UM Department of Psychiatry is ranked 29th in the nation in NIH Funding and there are extraordinary opportunities to participate in research, resident education and medical school teaching. Position Requirements:

• M.D./D.O. with Board Eligibility or Board Certification in Child and Adolescent Psychiatry
• Active State of Florida Medical License

To be considered for a position, please send a copy of your CV to Barbara J. Coffey, M.D., Professor and Chief of Child and Adolescent Psychiatry, UM Department of Psychiatry and Behavioral Sciences at psychiatry@med.miami.edu

UMass Memorial Health Care and the University of Massachusetts Medical School currently have openings within the Department of Psychiatry.

The Department of Psychiatry is a national leader in public sector psychiatry, child and adolescent psychiatry, neuropsychiatry, psychosocial rehabilitation, women's mental health, and addiction psychiatry. We integrate our clinical, research, teaching and community partnership activities to help individuals and families transform their lives through recovery from mental illness and addiction. We are particularly interested in having Faculty join our Department who are motivated for a career in clinical research. We are the largest provider of psychiatric services in central Massachusetts, with over 400 faculty members and 12 hospitals and community mental health centers.

Our residency program trains 7 residents per year, including general psychiatry and specialty tracks for combined adult and child psychiatry and combined neurology. We offer fellowships in Child and Adolescent Psychiatry, Addiction Psychiatry, Forensic Psychiatry, Neuropsychiatry, and Adult Developmental Disabilities. Interested candidates should send their curriculum vitae addressed to Dr. Sheldon Benjamin, MD

Commonwealth of MA Positions

| Facility/Medical Director (Cap Cod and Islands Mental Health Center, Pocasset, MA): Provides administrative and clinical oversight for the DHH-operated and contracted state hospital and community support programs. |
| Full-Time Inpatient Psychiatrists, Worcester Recovery Center and Hospital, Worcester, MA: Be part of a person-centered, recovery oriented multidisciplinary team that strives to help individuals lead healthy lives and return safely to the community. |
| Part-Time/Full-Time Psychiatrist (Cap Cod and Islands Mental Health Center, Pocasset, MA): Work closely with two advance practice psychiatric nurses, a consulting internist, and a multidisciplinary team. |
| For additional information, please contact: Marie Hobart, MD, Vice Chair, Public Sector Psychiatry marie.hobart@umassmed.edu |

Interested applicants should apply directly at www.academicjobsonline.org/一点儿

As the leading employer in the Worcester area, we seek talent and ideas from individuals of varied backgrounds and viewpoints.

- Atascadero State Hospital
- Colinga State Hospital
- Napa State Hospital
- 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 and H-1B candidates are welcome to apply.

Telecare Corporation

BE or BC psychiatrist needed. Following locations have immediate openings:

• Modesto/Ceres, CA: Schedule: 40hrs per week Pay Rate: $291,00 - $364,000
• San Jose, CA: Schedule: 32 hours per week Pay Rate: $140 - $158/hour (Employee); $183 - $210/hour (Contractor)
• San Jose, CA: Schedule: 8-20 hours per week Pay Rate: $140 - $158/hour (Employee); $183 - $210/hour (Contractor)
• Belmont, CA: Schedule: 24 hours per week Pay Rate: $140 - $158/hour (Employee); $183 - $205/hour (Contractor)

• 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 Psyc orecruiting@telecarecorp.com

Florida

The University of Miami Miller School of Medicine Department of Psychiatry and Behavioral Sciences is in an exciting phase of growth and recruiting full-time child and adolescent psychiatrists, specifically at the assistant or associate professor rank.

Faculty rank and compensation are commensurate with experience. The University of Miami also provides a moving bonus and faculty stipend. The UM Department of Psychiatry is ranked 29th in the nation in NIH Funding and there are extraordinary opportunities to participate in research, resident education and medical school teaching. Position Requirements:

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• Active State of Florida Medical License

To be considered for a position, please send a copy of your CV to Barbara J. Coffey, M.D., Professor and Chief of Child and Adolescent Psychiatry, UM Department of Psychiatry and Behavioral Sciences at psychiatry@med.miami.edu

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Find What You're Looking For Now
Log on to: www.PsychiatricTimes.com/classifieds
Shore University Medical Center our vision for Behavioral Health is Bright.

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.

Hackensack Meridian Health is a leading not-for-profit health care network in New Jersey offering a complete range of medical services, innovative research, and life-enhancing care aiming to serve as a national model for changing and simplifying health care delivery through partnerships with innovative companies and focusing on quality and safety.

Through a partnership between Hackensack Meridian Health and Seton Hall University, the School of Medicine will re-define graduate medical education, research, and clinical practice; reverse the critical physician shortage in both the New York/New Jersey metropolitan area and the nation; and stimulate economic development in northern New Jersey.

The School of Medicine will be the anchor in the development of a comprehensive health sciences campus that will also include research facilities and biotechnology endeavors—all in service of educating tomorrow’s doctors, discovering novel therapies, and facilitating compassionate and effective healthcare that will meet the ever-changing needs of tomorrow’s patients.

The School of Medicine will be the cornerstone of a dynamic venue for the exchange of ideas, the development of healthcare and research thought leaders and practitioners, and the discovery of novel therapies to meet the medical challenges of the future. “Ocean Medical Center’s psychiatry program will be a community-based program,” said Ramon Solhkhah, M.D., program director for psychiatry as well as founding Chair of Psychiatry & Behavioral Health at the Hackensack Meridian School of Medicine at Seton Hall University. “Our new residency program will improve clinical care and ultimately encourage future health care leaders to build practices in the Jersey Shore area.”

Hackensack Meridian Health is seeking a Residency Training Program Director to lead a unique community-engaged psychiatry residency program.

Located in the heart of one of the largest and fastest growing counties in the state, Ocean Medical Center has become a vital part of the community since its opening in 1984.

Ocean Medical Center has been ranked as the top rated hospital for quality in Ocean County, and among the best in the state of New Jersey. We have been rated as the top hospital in the county for the treatment of heart attack, congestive heart failure, and surgical care improvement. In fact, Ocean Medical Center was named one of the safest hospitals in the state of New Jersey by Forbes Magazine.

Requirements: Candidates must have an MD or DO degree; Completion of an ACGME Accredited Psychiatry residency. Current board certification by the American Board of Psychiatry and Neurology. Three years of experience as a member of a teaching faculty or as an educational administrative leader; and have a strong track record of scholarship.

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:

- Medical Director of Adult Inpatient Unit Riverview (Red Bank, NJ)
- Carrier Clinic - Inpatient Attending
  - o Child/Adolescent–Carrier Clinic (Belle Mead, NJ)
  - o Adult/Geriatric–Carrier Clinic (Belle Mead, NJ)
- Residency Training Program Director – Ocean Medical Center, (Brick, NJ)
- Pediatric Psychiatry Collaborative
- Consultation Liaison Psychiatrists:
  - o Hackensack University Medical Center (Hackensack, NJ)
  - oRARitan Bay Medical Center (Perth Amboy, NJ)
- Staff Psychiatrist for Adult Inpatient Unit:
  - o Riverview Medical Center (Red Bank, NJ)
  - o Hackensack University Medical Center (Hackensack, NJ)
- Outpatient Childs Adolescent Psychiatrist: Hackensack University Medical Center (Hackensack, NJ)
- Geriatric Psychiatry: Hackensack University Medical Center (Hackensack, NJ)

Renee.Theobald@hackensackmeridian.org or call: 732 751-3597

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

Department of Psychiatry

CLASSIFIEDS

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

Univ. of Miami, Dept. of Psychiatry Sylvester Comprehensive Cancer Center

EXCEPTIONAL PSYCHIATRY OPPORTUNITY

Consultation-Liaison Psychiatrist

The Department of Psychiatry at the University of Miami and The Sylvester Comprehensive Cancer Center announces a search for an academic psychiatrist with interest and experience in psychosomatic medicine and psycho-oncology. Applicants can anticipate working collaboratively with fellow psycho-oncology providers including five psychologists, a psychiatrist and a team of oncology social workers.

JOB DESCRIPTION

Providing psychiatric consultation-liaison services in either inpatient, outpatient or both oncology settings across the oncology enterprise. Participation as a member of the Department of Psychiatry and Behavioral Sciences. Participating in teaching activity for advanced trainees to ensure the highest level of educational excellence.

QUALIFICATIONS OF THE PSYCHIATRIST

- Board certification in Psychiatry.
- Board eligibility/certification in C-L Psychiatry would be preferred but experience will be considered.

COMPENSATION & BENEFITS

This dynamic position commands an extremely competitive salary enhanced by an attractive benefits package, including but not limited to:

- Competitive compensation including bonus programs, vacation
- Comprehensive benefits include: health/dental/vision, paid malpractice, 403(b) plan

The University of Miami (UM) Miller School of Medicine is an academic medical center with extensive clinical facilities including the Sylvester Comprehensive Cancer Center (Sylvester). All Sylvester physicians are on the faculty of the Miller School of Medicine, South Florida’s only academic medical center.

CV’s and letter of interest can be directed to Maria Rueda-Lara, MD
email: mrueda2@med.miami.edu

Hackensack Meridian Health
HACKENSACK MERIDIAN SCHOOL OF MEDICINE
AT SETON HALL UNIVERSITY

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.

CLASSIFIEDS

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

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CV’s and letter of interest can be directed to Maria Rueda-Lara, MD
email: mrueda2@med.miami.edu
Please visit www.CHAproviders.org to learn about opportunities at CHA, a well-respected, nationally recognized health alliance and specialty outpatient care practices.

CHA offers comprehensive mental health services for all ages and in many languages. Opportunities are available both inpatient and outpatient in our Adult, Child/Adolescent, Psychiatry Access Service (PAS), and Primary Care Integration.

CHA offers a collaborative practice environment with an innovative clinical model. As a teaching affiliate of Harvard Medical School, academic appointments are available commensurate with medical school criteria.

Ideal candidates will possess excellent clinical/communication skills and a strong commitment to and passion for our multicultural, underserved patient population.

Please visit www.CHAproviders.org to learn more and apply. CV and cover letter may be sent directly to ProviderRecruitment@challiance.org.

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

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**MISSOURI**

Compass Health Network is a large non-profit health system delivering Behavioral Health services in multiple settings, both inpatient and outpatient in forty-nine Missouri counties. We have immediate openings for full and part-time Psychiatrists in multiple locations in Missouri. Candidates must have MD or DO degree, be ABPN board-certified or eligible in Psychiatry and possess or obtain a Missouri license. We offer a competitive compensation and benefit plan.

Apply online at [www.compasshealthnetwork.org](http://www.compasshealthnetwork.org) or send your CV to [cgrigg@compasshn.org](mailto:cgrigg@compasshn.org). Candidates with J-1 or H1-b visa status are welcome to apply. EOE

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**Massachusetts**

Psychiatry Opportunities - Cambridge Health Alliance (CHA)

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.

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**North Carolina**

Compass Health, Inc. in Clinton, MO, seeks psychiatrist to provide psychiatric services to patients in Cass County, Henry County, and other locations throughout central MO as assigned. M.D., or prof. equiv. degree, BC/BE in Psychiatry and MO Medical License required. Send C.V. to: Ms. Cathy Grigg at cgrigg@pbhc.org. Fax: 417-532-6606. EOE.
is specialty trained. Schedule consists of 16 hour shifts, approximately 10 shifts per month.

Adult Outpatient Opportunity
• BE/CBC 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 transparent for either or both inpatient and outpatient services. Clinic hours are Monday - Friday with limited call

Child Outpatient Opportunity
• BE/CBC 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(k) match and 457(h), Health, Dental, and other desirable benefits.

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

BRAND NEW ADULT INPATIENT PSYCHIATRIC UNIT OPENING NEAR RALEIGH - Be in on the beginning of a new 20-bed unit helping to mold and develop the program in Loung NC – 30 minutes from Raleigh. Offering employment with benefits. We have already helped the hospital open a 13-bed Geriatric Psychiatry Unit. Please contact Terry Good, Horizon Health, at 904-684-5661; terry.good@horizonhealth.com; Fax: 1-904-684-5663.

OKLAHOMA

Medical Director
St. Mary’s Regional Medical Center, located in Enid, OK, is now hiring a Psychiatrist to provide inpatient and outpatient services. Enjoy providing much-needed services in an attractive Midwestern location. Work while benefitting from the support of a progressive administrative team that values a strong work/life balance.

Opportunity Highlights
• Hospital-employed position
• Position includes treatment of adult patients in a 15-bed inpatient wing as well as a busy outpatient practice
• Program is fully staffed and includes a receptionist, LPN and clinic manager. There is also an NP to assist the physician
• Position includes a Medical Directorship, with 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 transparent for either or both inpatient and outpatient services. Clinic hours are Monday - Friday with limited call

Just 90 miles from Oklahoma City, Enid offers many of the advantages of larger cities without the associated high cost of living. One of Good Morning America’s “Five Hot Real Estate Markets”, Enid offers the best of Midwestern living – fine dining, shopping, historical sites, and recreational activities in abundance. If you’re looking for exception- al quality of life, consider Enid. You’ll see why we’re known as the “Bright Star of the Great Plains”.

For more information, contact: Mark Blakney, Phone: 971-420.7473, or email: mark.blakney@horizonhealth.com

OKLAHOMA

John J Hopper MD PLLC is a well-established Family Psychiatry private practice located in Rockport, Texas. Join this highly successful team with 1000+ active files. We have a patient draw area of 11 counties of 660,000 and have been serving this area for over 19 years. Our office offers a fully staffed professional therapeutic team of experienced medical office and billing management.

Our practice is 100% outpatient and can offer a partnership track. We provide services to children, adolescents, adults and geriatrics. Rockport is a beautiful coastal community only 30 min, away from three psychiatric hospitals. You can expect a strong growth rate in this vibrant area with additional psychiatrists.

Contact Pat Hopper at (361)729-4263 or submit C.V for further information, contact: Mark Hopper MD, Phone: 971-420.7473, or email: mark.blakney@horizonhealth.com

WASHINGTON

PHYSICIAN - Psychiatrist - **Sign-On Bonus** The Mann-Grandsaff Veterans Affairs Medical Center in Spokane Washington, is seeking full-time physicians to serve our Nations Veterans. Seeking board certified or board eligible in Psychiatry. Inpatient and outpatient opportunities. Relocation may be available to physicians who currently reside more than 50 miles from our facility. Benefits include malpractice coverage, and generous paid vacation, sick, and CME package. For detailed qualification requirements and to apply, refer to announcement CBAD-1032852-18-CWZ posted on www.USajobs.gov For further information, please contact the VA Medical Center, Human Resources, 4815 N. Assembly, Spokane, WA 99205 (509)434-7389. An Equal Opportunity Employment Opportunity.

Classifieds 49