Everyone in Puerto Rico (PR) was affected by Hurricane Maria, which made landfall on September 20, 2017 as the largest scale natural disaster in the US during our lifetime. Many months later, Puerto Ricans continue to face unreasonable obstacles that prevent recovery. This article summarizes literature on post-disaster mental health and describes the public health crisis in PR. Special attention is given to highlight higher suicide rates and PTSD that develop in post-disaster areas.

Psychosocial context and obstacles to recovery

A country with a high-income economy, PR experienced financial decline a decade before Hurricane Maria. A recession and high unemployment rates led to a depopulation process. From 2006 to 2016 the population decreased from 3.9 to 3.4 million.\(^1\) Migratory flow during the economic crisis resulted in compromised provision of essential services and a large exodus of medical professionals. Homicide and suicide rates nearly doubled and binge drinking increased. Approximately 50% of adults in PR are binge drinkers compared with the US national average of 17%.\(^2\)

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Currently, 45% of the island residents live in poverty. Hurricane Maria caused an estimated $100 billion in damages. Four months post-impact 32% of the population had no electricity and 14% had no potable water. The official death toll has been questioned, and physicians acknowledge an increase in unreported deaths of vulnerable persons because of inadequate access to medical care.

CASE VIGNETTE

Mr. S is an elderly man from PR who now lives in the continental US. He has sarcoidosis, diabetic retinopathy, and blindness. He is being treated for PTSD and is unable to treat or even assess in the relatively brief 6- to 12-week randomized controlled trials that lead to FDA approvals and marketing. The costs, clinical challenges, and desire to do no more than is needed to show relative safety and efficacy have limited these studies’ duration. Such short durations do not typically allow time for participants to develop any level of significant physiological dependence or to produce a difficult or even detectable withdrawal syndrome. These trials, which usually focus on determining efficacy, often have adequate methodology or statistical power to identify and characterize only very common and relatively severe withdrawal syndromes. Because of these challenges in acquiring the necessary data for educating physicians about any potential withdrawal syndromes, medications come onto the market with many unknowns about their longer-term effects and discontinuation syndromes. Many unidentified problems beyond withdrawal syndromes can take years to become fully appreciated—often requiring an accumulation of published case reports or other observational studies before they become widely known to the medical community.

For instance, although the first benzodiazepine was released onto the market in the US in 1960, it was not until 1988 that health authorities finally acknowledged the true extent and impact of the dependence and addictive potential of these agents. The clear surprise to physicians was that recovery from this hurricane would not take months, but years. This was a rude awakening to the vulnerability of the very institutions that are expected to be able to respond in situations such as these. Hope waxes and wanes.

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hits a month and www.surviving antidepressants.org receives approximately 150,000 hits each month. It is interesting to note that the patient narratives from these websites are generating early clinical data that researchers are using to learn more about unexpectedly difficult withdrawal symptoms and syndromes.

Beyond these forums there is a vivid and expansive community of thousands on YouTube.com, where participants have shared their personal withdrawal experiences. Some participants have created daily videos to chronicle the process: a generic search for the terms “antidepressant withdrawal” or “benzo withdrawal” will bring up 7000 and 14,000 personal video blogs, respectively.

While it might initially seem that these communities and video blogs are simply artifacts of the internet culture, a closer look at the stories told on these forums suggests a different message. The message is that physicians have been unprepared for these withdrawal disorders and are unable to treat or even guide patients through complicated withdrawal from these substances.

How did this happen?

Medication withdrawal is difficult to assess in the relatively brief 6- to 12-week randomized controlled trials that lead to FDA approvals and marketing. The costs, clinical challenges, and desire to do no more than is needed to show relative safety and efficacy have limited these studies’ duration. Such short durations do not typically allow time for participants to develop heroic efforts on behalf of their patients, but many hospitals, ambulatory care centers, dialysis centers, chemotherapy infusion centers, radiation oncology suites, operating rooms, and doctors’ offices remain inaccessible or unable to maintain adequate levels of care.

An excerpt from a journal entry of a resident of PR illustrates the situation in PR post-hurricane [Anonymous, shared with author 2017].

My immediate reaction to the hurricane was to check in with relatives to ensure they were safe. This took several days as communications were down and roads were blocked with fallen trees and debris. We began to learn the severity of damages through scattered news reports. I stayed disconnected from my mother, who lived merely 30 miles away, for several days. She lives alone and I feared for her wellbeing. Eventually we made contact and I was relieved to find out she was uninjured, but I felt guilty that I could not help others who experienced loss. Anxiety grew. I had poor concentration, erratic sleep, distressing dreams and was startled when hearing sirens or gunshots at night. Agitation and anxiety would alternate with apathy, withdrawal, and numbness. Some symptoms improved but I struggled to stay motivated and productive. Debris still line the streets, some towering as high as homes. Homes have shattered or boarded up windows and parts of the roof missing, and traffic lights at intersections are down or dangling on wires. One of the hardest realizations was that recovery from this hurricane would not take months, but years. This was a rude awakening to the vulnerability of the very institutions that are expected to be able to respond in situations such as these. Hope waxes and wanes.

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Economic losses following natural disasters compound physical destruction and health outcomes. A study following typhoons in the Philippines found that household income drops and infant mortality rises the year after a typhoon hits, and economic deaths by far exceed exposure deaths, by a factor of 15.3

New Orleans lost 44% of its population a year after Katrina, and unemployment rose to 33%.4 Will PR be faced with a similar exodus and economic downturn? Experts estimate that by 2019, PR will lose an additional one-half million residents. Physicians and other health professionals are relocating to the continental US in large numbers. William Julio, from the Puerto Rican Psychiatric Society, reports that the number of psychiatrists in the island decreased from 500 to 300 over the last decade.

Suicide following natural disasters

Although suicide rates vary depending on the location and population studied, we see that suicidal behavior increases following natural disasters. In PR there was an average of 19 suicides per month in the 8 months before Maria in 2017, and 25 suicides per month in the immediate 3 months post Maria (Table 1).5 Kessler and colleagues6 noted significant increases in the prevalence of suicidal ideation and suicide plans 6 months post-hurricane Katrina compared with 2 years later. They concluded that follow-up outcomes persist and even intensify because psychosocial stressors associated with the natural disaster continue or intensify as time progresses.

From a psychodynamic standpoint one could formulate that dissociation, reaction formation, and heroic efforts that occur soon after a disaster serve as protective factors against suicide, but these defenses only offer temporary relief as the grim reality of destruction and loss evolve into complex affective states of disillusionment, hopelessness, and helplessness. These complex states of mind correlate with high suicide risk and may explain the protracted post-disaster increase in suicide deaths.

PTSD after natural disasters

The literature on PTSD after natural disasters is extensive. Neria and colleagues7 undertook a comprehensive review of the relationship between man-made compared with natural disasters and PTSD in survivors between 1980 and 2007. Findings from the survey indicate PTSD prevalence among direct victims of disasters of 30% to 40% compared with a prevalence of 5% to 19% in the general population. PTSD determinants include sociodemographic and background factors, stressors, and mental health.

Table 1. Total calls to the Primera Ayuda Psicosocial/Youth Suicide Hotline before and after Hurricane Maria8

<table>
<thead>
<tr>
<th>Period</th>
<th>Persons with suicidal ideation</th>
<th>Persons with suicide attempts</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-month period pre-hurricane</td>
<td>2176</td>
<td>637</td>
</tr>
<tr>
<td>2-month period post-hurricane</td>
<td>2996</td>
<td>973</td>
</tr>
</tbody>
</table>

Table 2. Correlates of PTSD after natural disasters9

- Affective states: guilt, anger, dysphoria, hopelessness, helplessness
- Neuroticism
- Obsessive traits
- External locus of control
- History of prior traumas
- History of prior psychiatric disorders
- Comorbid psychiatric disorders
- Low social support
- Poor interpersonal relationships
- Media exposure
- Degree of exposure to a disaster: low socioeconomic status, having lost a home, unemployment, vulnerable age groups (children, elderly)

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when it was initially presented to physicians as a minor preventable syndrome and simple to treat.4 It would take many more years before the complexity and severity of antidepressant withdrawal began to take shape and the information published in medical journals.

The pharmacodynamics and pharmacokinetics of the medication and an individual’s genetics all play significant roles in the timing, duration, and severity of withdrawal. These multiple factors lead to the observed heterogeneity in withdrawal syndromes. This challenge has spurred publication of increasingly refined diagnostic guidelines to help clinicians recognize these syndromes. It is uncertain how many clinicians are aware of the variety of presentations of withdrawal syndromes and the range of medications that can produce these syndromes. If clinicians are unaware of the complexity of such syndromes, they may misdiagnose these withdrawal syndromes as manifestations of the underlying original mental illness, a new physical condition, or perhaps an adverse effect of a different medication.

Recognition that a patient has incurred an iatrogenic complication is essential in the recovery process. A correct diagnosis will inform the decision of how to manage the withdrawal. Clinicians can engage patients in a discussion about the variety of existing treatment options. They can choose to wait out the withdrawal syndrome, if it is tolerable, reinstate treatment, or try a slower medically supervised withdrawal treatment regimen. They might also opt to use other pharmacotherapies for symptomatic treatment.

The ability to tolerate the dysphoric moods and physical symptoms associated with psychotropic medication withdrawal is undoubtedly linked to a patient’s baseline psychological resilience and the strength of his or her support system. Therapies targeted at bolstering psychological resilience such as cognitive behavioral therapy (CBT) can be useful in helping patients cope with withdrawal. For instance, CBT might be useful in challenging patients’ beliefs that discontinuation symptoms are a sign that they are incapable of coping without the medication. CBT could transform this self-belief to the more accurate understanding that these symptoms are common and often time limited.

A systematic review by Fava highlights 3 main complexities in managing antidepressant withdrawal. First, no clear sociodemographic and clinical characteristics appear to be associated with increased vulnerability to severe withdrawal; second, although gradual tapering of antidepressants is a reasonable clinical strategy, it often will not prevent the onset of severe withdrawal symptoms; and third, antidepressant withdrawal appears to be associated with a variety of other iatrogenic complications such as the onset of hypomania/mania and other persistent mood instabilities.

Similarly, Lader and Kyriacou discuss the difficulty of managing benzodiazepine withdrawal. Three of these difficulties are illustrative:

1. The onset of severe withdrawal symptoms sometimes does not respond to re-initiation of medication.

2. Persistent withdrawal reactions can last years.

3. Unavoidable severe withdrawal symptoms may occur despite slow withdrawal over several months or years.

When the risks of treatments are not identified in the clinical trials that bring them onto market, these risks are not cautioned against in widely circulated medication guidelines. As a result, the prescribing physician will overestimate potential benefits and neglect patients’ vulnerabilities to the adverse effects of treatment. Expert commentaries in psychiatric journals are available to help clinicians correctly weigh the risks and benefits of...
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ground factors, event exposure characteristics, social support factors, and personality traits.

A study of Florida residents exposed to Hurricane Andrew in 1992 found that the prevalence of PTSD increased to 26% and 29% at 6 and 30 months after the disaster.2 A specific finding of this study was that while intrusion and arousal symptoms declined over time, avoidance symptoms increased. Variables found to be predisposing factors in this study included specific populations at risk (e.g., minorities, elderly, children, direct victims, first responders), persons who bear the brunt of the social and economic consequences, and the magnitude of exposure to the event. Particularly, degree of physical injury, immediate risk of life, severity of property destruction, distance from epicenter, people who experienced loss of family members, and people who suffered property loss or were forced to relocate were at higher risk for PTSD. Additional risk factors for PTSD after hurricanes and other natural disasters are listed in Table 2.

Blackouts and power outages post-disaster negatively affect mental health. Studies after Hurricane Sandy, which caused outages lasting up to 2 weeks, found a dose-response relationship between the duration of maximum blackout percentage and the risk of mental health problems.1 Mood disorders, anxiety disorders, substance use disorders, and utilization of psychiatric resources in the New York area increased for months to a year after Hurricane Sandy.

Sub-threshold PTSD, common in post-disaster states, results in significant morbidity. In Louisiana, previously considered a permutation of generalized anxiety disorder (GAD) colloquially became known as “Katrina brain.” Many Katrina survivors with GAD described additional symptoms of irritability, diffuse anger, guilt, and health worries. After the September 11 terrorist attacks, researchers at the New York State Psychiatric Institute studied the morbidity of sub-threshold PTSD among disaster survivors and caregivers.

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using benzodiazepines and antidepressants in the management of depression and anxiety disorders.60,61 Although many people do not have substantial difficulties withdrawing from these medications, it is clear that withdrawal syndromes are not rare. Reports of withdrawal syndromes are becoming increasingly common on patient websites, and the widespread use of these types of medications poses a substantial public health concern.

The ubiquity of social media in the past 10 years and informal online communities have led adolescents to utilize these as the most likely forums in which to seek mental health advice.62 As young patients continue to turn to these sources for mental health guidance, mental health professionals need to familiarize themselves with and interface with these online communities.

An important ethical issue to consider is who should conduct research into drug-related problems that emerge following licensing? Burning pharmaceutical companies to conduct such research before granting them license to sell would certainly slow down the development of many new and helpful medications. Yet, who is responsible for conducting the urgent and resource-heavy research needed to help guide clinicians in managing the variety of unanticipated iatrogenic complications of these medications?

Given the current state of our understanding of complex withdrawal syndromes, increased awareness of these syndromes among providers is of utmost importance. These syndromes need further research, or more patients will continue to turn away from the medical establishment to look for support from other patients on the internet.

Mr. Witt-Doerring is a PGY 3 Psychiatry Resident; Dr. Shorter is Assistant Professor of Psychiatry, and Director, Psychiatry Residency Program; and Dr. Kosten is Professor of Psychiatry, Neuroscience, Pharmacology, Immunology, and Rheumatology, and Vice-Chair, Psychiatry for Research, Baylor College of Medicine, Houston, TX.

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SPECIAL REPORT

INFLAMMATION AND PSYCHIATRY: PART 1

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Andrew H. Miller, MD

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Janine D. Flory, PhD and Rachel Yehuda, PhD

FROM THE GROUP FOR THE ADVANCEMENT OF PSYCHIATRY

College Students Under Stress

Brunhild Kring, MD, Helene Keable, MD, Alexandra Ackerman, MD, Malikah Notman, MD, and David Stern, MD for the GAP, College Student Committee

LETTER TO THE EDITOR

The Prevalence of Schizophrenia in the US

David Pickar, MD

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POETRY OF THE TIMES

Birthday Party

Richard M. Berlin, MD
The Prevalence of Schizophrenia in the US

Dr. Pickar is Adjunct Professor of Psychiatry, Johns Hopkins University School of Medicine, Baltimore, MD. He is also Former Chief, Experimental Therapeutics Branch, Intramural Research Program, NIMH, and Former Director, NIH Clinical Center 4-East Research Ward for Schizophrenia.

The prevalence of schizophrenia in the US is 0.3%. Reality? I thank the Treatment Advocacy Center and Dr. Fuller Torrey and Elizabeth Sinclair for bringing attention to the NIMH’s website, which states just that.

A schizophrenia prevalence of 1% of the US population is a foundation fact that has wide implications.1 Torrey and Sinclair discuss this odd error with characteristic pith and accuracy in the March issue of Psychiatric Times.2 The “disappearance” of 2 million patients with schizophrenia is certainly an effective way to bring home the implications of the NIMH error.

The response of NIMH Director Dr. Joshua A. Gordon1 to Torrey and Sinclair’s piece does little to persuade that the NIMH is on point. Pardon this 21st century cynicism, but was there an interest in reporting a lower prevalence figure for the most serious of mental illnesses? Might a lower prevalence suggest that we have somehow been successful in reducing its occurrence?

The NIMH error is particularly noteworthy in light of recent Congressional efforts to bring attention to persons who suffer with serious mental illness. The Helping Families in Mental Health Crisis Act approved by the House in 2016 and later incorporated into the 21st Century Cures Act in 2017 highlighted the need for renewed, effective attention to this population by Federal agencies. Does NIMH research meet this challenge?

NIMH Intramural Research beds for schizophrenia at St. Elizabeth’s Hospital in Washington, DC and those at the NIH Clinical Center in Bethesda together numbered in the range of 35 to 45 in the 1970s through 1990s. Research into schizophrenia at the NIH Clinical Center today (there are no longer beds at St. Elizabeth’s Hospital) limps along with few inpatients and lacks supporting evidence from “above.” Inpatient research beds represent a national resource for families of patients with schizophrenia. No one has used research beds better than The NCI in its Intramural Research Program.

The NIMH website highlights 2 clinical studies, CATIE and RAISE. CATIE completed in the 1990s, brought home the fact the new generation of antipsychotic drugs is no more effective than older drugs, leaving clozapine, first used in the 1970s and FDA approved in 1989 for patients with treatment resistance as the only antipsychotic drug with enhanced efficacy. RAISE further demonstrates the limitation of current treatment. Unfortunately, the NIMH has never followed up its own leads to improve the treatment of schizophrenia. Dr. Gordon correctly mentions the importance of neurocognitive deficits of schizophrenia, an area pioneered by Intramural NIMH Clinical Scientists. Despite considerable academic and industry efforts, drug development for these deficits has been entirely unsuccessful. A fresh look is in order.

Perhaps just an oversight, the NIMH error about schizophrenia prevalence prompts a closer examination into NIMH’s attention to schizophrenia. I support the suggestion by Torrey and Sinclair for a new study of the prevalence of schizophrenia. It is also time for an independent review of the NIMH’s research efforts into our most serious mental illness.

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

References
What Psychiatrists Need to Know About the Determination of Dispositional Capacity

Naalla Schreiber, MD, James A. Bourgeois, OD, MD, John C. Landry, Mariana Schmajuk, MD, Jennifer M. Erickson, DO, Rebecca Weintraub Brendel, MD, JD, and Mary Ann Cohen, MD

Dr. Schreiber is Attending Psychiatrist, Department of Psychiatry and Behavioral Sciences, Montefiore Medical Center, New York; Dr. Bourgeois is Clinical Professor, Department of Psychiatry, Texas A & M University Health Science Center, College of Medicine, Bryan, TX; John C. Landry is a Senior Undergraduate, Fordham University, New York; Dr. Schmajuk is Clinical Assistant Professor, Psychiatry and Behavioral Sciences, Stanford University School of Medicine, Stanford, CA; Dr. Erickson is Acting Assistant Professor, University of Washington, Seattle, WA; Dr. Brendel is Assistant Professor of Psychiatry, Harvard Medical School, Boston, MA; and Dr. Cohen is Clinical Professor of Psychiatry, Icahn School of Medicine at Mount Sinai, New York.

Psychiatrists are often consulted to determine whether a patient has the capacity to make medical decisions during an inpatient medical hospitalization. Some of the most challenging decisional capacity consultations are requests to determine if a patient has the capacity to participate in discharge planning. For a patient to demonstrate capacity to participate in discharge planning, the patient should have the capacity for self-care, the ability to cope with illness, and be capable of accessing medical care and treatment once he or she has left the hospital. Frequently such psychiatric consultations are requested when a patient is refusing what the medical team defines as a safe discharge.

In this article, we present some of the complexities of what we propose to call “dispositional capacity,” or the capacity to participate in discharge planning. Inherent in a dispositional capacity determination is an assessment of whether the patient will be able to survive safely and independently in the community following a hospital stay and whether he or she can refuse placement in a chronic care or rehabilitation facility. Basically, the primary medical team is asking the psychiatrist to answer the question: “Can this patient go home?”

Dispositional capacity is a subset of decisional capacity determinations that is distinct from the capacity to give informed consent for or to refuse medical procedures. Although all determinations of decisional capacity are complex and require consideration of the medical, ethical, legal, and psychosocial dimensions of care, most decisional capacity consultations are requests to determine if a patient has the capacity to participate in discharge planning. Inherent in a dispositional capacity determination is an assessment of whether the patient will be able to survive safely and independently in the community following a hospital stay and whether he or she can refuse placement in a chronic care or rehabilitation facility. Basically, the primary medical team is asking the psychiatrist to answer the question: “Can this patient go home?”

Dispositional capacity is a subset of decisional capacity determinations that is distinct from the capacity to give informed consent for or to refuse medical procedures. Although all determinations of decisional capacity are complex and require consideration of the medical, ethical, legal, and psychosocial dimensions of care, most decisional capacity determinations pertain to a single decision as a threshold inquiry of whether the patient can give or withhold informed consent.

While the ability of a patient to participate in his or her own discharge plan is inclusive of elements of a procedure-specific decisional capacity assessment, discharge planning requires other unique dimensions for the clinician to consider. Dispositional capacity determination, in contrast to most other decisional capacity determinations, requires some assessment of a patient’s current functional capacity, prediction of a patient’s future behavior, and ability to self-manage after hospitalization. After discharge from the hospital, the patient must have the ability to make decisions conducive to recovery. Dispositional capacity is therefore a unique subset of decisional capacity that requires an element of prediction.

**Review of decisional capacity**

Decisional capacity assessments that clinicians perform every day help protect vulnerable individuals from neglect and exploitation, preserve autonomy and self-determination, and help other clinicians and administrators communicate with each other to address complex bioethical and biomedical questions and dilemmas. Decisional capacity has been extensively described elsewhere. These standard capacity evaluations provide a forum for the multidisciplinary hospital team to engage in thoughtful deliberation about how we care for patients in a manner that upholds the highest ethical values of our profession. Myths and facts about decisional capacity are summarized in Table 1.

Capacity questions and their assessments lie on a gradient depending on what is being asked of the patient and the potential risks of their decision. Medical decision-making falls on a spectrum: some choices require more complex thought processes and thus a more sophisticated demon-

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**Table 1 Decisional capacity: myths and facts**

<table>
<thead>
<tr>
<th>Myth</th>
<th>Fact</th>
</tr>
</thead>
<tbody>
<tr>
<td>A patient is incapable of making decisions until proven otherwise</td>
<td>A patient is assumed to have decision-making capacity unless history or examination suggest otherwise</td>
</tr>
<tr>
<td>A patient with cognitive impairment cannot have decision-making capacity</td>
<td>Patients must be assessed on a case-by-case basis; many patients with mild and moderate cognitive impairment have the capacity to make some or all their decisions</td>
</tr>
<tr>
<td>A patient with a history or evidence of serious mental illness, such as schizophrenia, does not have the capacity to make decisions</td>
<td>The majority of patients with serious mental illness can make their own decisions except when psychopathology directly interferes with the decision-making process</td>
</tr>
<tr>
<td>Decision-making capacity is an “all or none” phenomena; a patient either has capacity, or he does not</td>
<td>Decision-making capacity is task-specific; a patient may have capacity to handle finances but may not have capacity to participate in discharge planning</td>
</tr>
<tr>
<td>Lack of decision-making capacity is a permanent condition; once a patient is determined to lack capacity to make decisions, the patient will never regain capacity</td>
<td>Capacity, except in rare cases, is variable and fluctuating and can improve with time and constructive interventions</td>
</tr>
<tr>
<td>Patients who refuse an intervention or demand to leave against medical advice lack capacity</td>
<td>Each decision is patient and context-specific and warrants an individualized evaluation of capacity</td>
</tr>
</tbody>
</table>
stration of the domains of capacity, including understanding, reasoning, appreciation, and communication of a choice (Figure).

Decisional capacity determinations have medical, psychiatric, functional, and socio-economic components, all of which are involved in the complexity of the patient’s decision-making process. While neurocognitive disorders are the primary drivers of impaired decisional capacity, other psychiatric disorders may also have an adverse impact on decision making. The psychiatrist needs to make a biopsychosocial assessment that includes all elements that may adversely affect decisional capacity. (See Table 2 for examples of how psychiatric disorders can impair decisional capacity).

Understanding dispositional capacity as a distinct concept
On the spectrum of decisional capacity, dispositional capacity appears to be a particularly special circumstance. In the case of decisional capacity, a patient is required to demonstrate adequate cognition as evidenced by an understanding and appreciation of the facts and circumstances and an ability to rationally manipulate information, be capable of intact reality testing relative to the medically relevant information, and sufficient emotional stability to make a consistent choice over time. Dispositional capacity, on the other hand, is more complicated in that it requires the patient to make multiple present and future decisions that are conducive to good health, and it requires that patients demonstrate adequate functional abilities in the physical and occupational performance areas to survive in the community. Thus, dispositional capacity hinges on many more factors than a focal, discrete choice to accept or reject a medical intervention or diagnostic procedure while in the hospital.

Seen in this light, dispositional capacity to refuse a safe discharge requires a higher bar of understanding and self-awareness by the patient. A patient may have the decisional capacity to give informed consent for an extremity amputation, but may not have dispositional capacity or the capacity to care for himself or herself at home after recovering from the surgery. Conversely, a patient may lack decisional capacity to refuse a risky CNS tumor resection but nonetheless have dispositional capacity to return home with family supports. Each type of decision requires a full psychiatric assessment, and “one size does not fit all.”

Table 2
Examples of psychopathology that interferes with decisions

- A patient with severe depression refuses to consent to a cardiac catheterization for unstable angina because she believes she is unworthy of living and hears God telling her it is time to die
- A patient with advanced dementia repeatedly receives information about his medical problems and medications but cannot remember that medications have been prescribed, their indications, or that he needs to take them
- A patient with chronic paranoid schizophrenia presents to the emergency department with pneumonia but refuses to consider hospitalization because he believes all the doctors and nurses are working for the CIA and they want to admit him to the hospital where he will be tortured for information
- A patient with refractory anorexia nervosa is rapidly deteriorating; she is severely hypotensive and hypokalemic but refuses fluid resuscitation and electrolytes because she fears the medical staff have hidden calories that will make her gain weight
- A patient with avoidant personality disorder who has a fungating breast lesion refuses to allow her physician to examine her breast because she is in denial and insists that there is nothing wrong with her
Dispositional Capacity

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Special elements of dispositional capacity

Dispositional capacity determination requires a multidimensional biopsychosocial approach to the patient. This approach, while important in all capacity determinations, is even more critically salient in determination of dispositional capacity, and includes an appreciation of the biological, psychological, and social obstacles that must be overcome to maintain health, safety, and access to care in the community. A dispositional capacity assessment requires an evaluation of:

- Understanding of the medical illness
- Obstacles to understanding (eg, language, socio-cultural barriers, neurocognitive disorders, substance use disorders, other psychiatric disorders)
- Ability to perform activities of daily living (ADLs) and instrumental activities of daily living (iADLs) or to accept assistance with these needs
- Social factors (family dynamics, housing, economics, and broader social supports)
- Access to and navigation through the health care system

To begin, a clinician must first assess a patient’s understanding of his or her ongoing medical problems and what specific interventions are needed upon discharge (eg, physical or occupational therapy, follow-up medical appointments). Subsequently, the clinician must assess cognitive difficulties that are interfering with the patient’s understanding of the illness and medical care needs.

CASE VIGNETTE #1

Mr. A is an 85-year-old with a past medical history of hypertension, diabetes, and coronary artery disease who presents after a fall in his apartment. It was hours before his daughter found him on the bathroom floor. Upon admission to the hospital, Mr. A was dehydrated with associated rhabdomyolysis, acute kidney injury, and hypernatremia; he was treated with IV hydration. He sustained a hip fracture but refused the recommended hip replacement. The consulting psychiatrist diagnosed delirium, possibly superimposed on a major neurocognitive disorder (dementia), and prescribed PRN haloperidol for agitation. His daughter provided informed consent for the surgery.

After surgery, the orthopedic team recommended discharge to a subacute rehabilitation facility (SAR) to assist with his post-operative recovery. Mr. A was adamant that he be discharged home. The psychiatrist was called in to assess dispositional capacity. Mr. A believed he would be fine at home because he’s a “strong man” and “I can take care of myself.” He seemed unaware of any risks to returning home and couldn’t explain how he would prepare his food or attend to his grooming. He scored poorly on the Montreal Cognitive Assessment with a score of 16. An occupational therapy evaluation demonstrated a failing score on the KELS. The psychiatrist found that Mr. A lacked dispositional capacity; after much encouragement from his daughter, Mr. A agreed to a temporary...
SAR stay to regain his mobility.

Functional assessments to clarify a patient’s limitations with daily activities, including iADLs and ADLs, can further elucidate areas of concern. Collaboration with a team of experts is most relevant in dispositional capacity determinations. Specifically, an occupational therapist can provide a Kohlman Evaluation of Living Skills (KELS) or other similar assessment of self-management abilities that can be selected based on patient-specific characteristics. KELS or similar instruments can provide comprehensive evidence of cognitive skills involved in self-management. Input from physical, occupational, and speech and language therapists can assist the psychiatrist in better understanding the patient’s current level of functioning.

Social workers can arrange access to community programs such as home health aides, visiting nurses, physical and occupational therapy, companions for persons who are visually impaired, transportation to medical appointments, prepared food delivery for meals, and panic buttons, all of which can make home a safer place for elderly patients with cognitive impairment. A patient who is unable to adequately perform iADLs and ADLs may still be safely discharged if a family member, friend, or a home health aide is available to assist with shopping, cleaning, food preparation, and transportation to medical appointments. Social workers can also help identify untapped resources such as family, friends, or members of the patient’s religious faith to help the patient after discharge.

CASE VIGNETTE #2

Ms B is a 90-year-old widow with hypothyroidism, schizophrenia, and mild neurocognitive disorder. She lives in her own home with the support of a home health aide and assistance from 2 sons. She has chronic paranoia and lifelong beliefs that the FBI is spying on her and targeting her children. Ms B’s pharmacy packages risperidone in blister packs and her aid

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Dispositional Capacity

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reminds her to take the medication. She presents to the hospital with her son for abdominal pain and is found to have a perforated duodenal ulcer. Although she believes the FBI has caused the ulcer, she agrees to all recommended treatments and her decisional capacity is not questioned. Her hospital course is complicated by sepsis and delirium. She requires PRN risperidone, in addition to her standing risperidone, which is recommended by the consulting psychiatrist.

When it is time for discharge, the medical team recommends SAR. However, Ms B wants to go home because she believes that the FBI will have better access to her at SAR. The psychiatrist is called in for an assessment of dispositional capacity. Ms B explains her reasoning to the psychiatrist and acknowledges that others might choose differently. She agrees to resume her homecare services, and her sons agree to check on her daily.

Ms B scores in the mildly impaired range on the Montreal Cognitive Assessment with a score of 18. She has prominent delusions but her family and psychiatrist confirm that she is at her baseline; she has no homicidal or suicidal thinking. She is found to have dispositional capacity and is safely discharged home with resumption of her community supports.

Summary

Dispositional capacity is a specific subset of decisional capacity that addresses a patient’s ability to accept or reject a safe discharge plan. Psychiatrists are often called upon to assess dispositional capacity when a patient is refusing the recommended discharge plan, sometimes in concert with decisional capacity for informed consent for a medical procedure, and sometimes solely in the discharge context.

Assessment of dispositional capacity, framed as a distinct subtype of decisional capacity, includes a comprehensive diagnostic psychiatric evaluation as well as targeted evaluations by occupational and physical therapy staff and social workers to provide the optimal interdisciplinary assessment of the patient. This complete appraisal, tailored to the patient’s specific circumstances, addresses the patient’s safety and honors the 4 principles of biomedical ethics, specifically balancing patient autonomy against physician beneficence, nonmaleficence, and justice. Mastery of the dispositional capacity assessment is an essential core skill for consultation-liaison psychiatrists who are crucial members of the health care team.

Acknowledgement—The authors acknowledge the Academy of Consultation-Liaison Psychiatry for helping to bring this article to fruition. The Academy is the professional home for psychiatrists providing collaborative care bridging physical and mental health. Over 1200 members offer psychiatric treatment in general medical hospitals, primary care, and outpatient medical settings for patients with comorbid medical conditions.

Reference


Recommended Reading

In 1897, the French sociologist Émile Durkheim (1858-1917) published *Le suicide: Étude de sociologie* [Suicide: A Study in Sociology]. With it, Durkheim largely succeeded in achieving one of his main goals—to use an empirical analysis of the subject of suicide to launch the field of modern scientific sociology. Reading the book today, one is still impressed by its innovative methods. For example, its epidemiological approach based on international statistical data and its often surprising findings—for one, that suicide rates rose not during social crises, but rather at times when governing norms were breaking down.

While the work has been hailed as a founding text for the social sciences, historians have shown that Durkheim was perhaps less a pioneer than beneficiary of generations of research. As historian Daryl Lee puts it, the book “marks not the beginning but the culmination of nearly a century of intense anxiety and debate over the subject of suicide.”

What for centuries had been considered a matter for clergy, theologians, and philosophers alone to comment on became in the 19th century a problem that increasingly drew the attention of psychiatrists and sociologists. Why did things change?

If we look back to ancient Greece and Rome, philosophers there considered it a matter of debate whether it was morally acceptable to end one’s life. Intellectuals such as Socrates and Cato, both suicide completers, continued to enjoy respectable reputations after their passing. Christian Europe, however, expressed a far less tolerant attitude toward self-inflicted death. For over a thousand years, Christian thinkers shared the aversion to suicide of St. Augustine (354–430), who held the act to be an arrogant refusal to submit to God’s will; it was widely accepted, He and He alone rightfully decided on when an individual’s life should come to an end. As such, suicide was deemed a crime and the bodies of suicide completers were often desecrated and their possessions confiscated.

A shift in thinking began to take place between 1500 and 1800. While intellectuals of the 16th and early-17th centuries continued to pronounce suicide to be a moral abomination, some Enlightenment figures of the 18th century like Voltaire (1694–1778) and David Hume (1711–1776) argued for its legitimacy under certain situations. Historians examining judicial and church records have shown that in between these 2 periods, local authorities throughout Europe were slowly decriminalizing suicide, believing the penalties imposed on the corpses and estates of victims an unjustified burden on family members. Popular at-
Suicide

Continued from page 11

...as a symptom of an altered state of mind. On the latter question, some—like the famed French psychiatrist Jean-Étienne Esquirol (1772–1840)—generally believed it to be “a disorder of the emotions,” a view a later writer in 1857 would criticize as “…a dangerous and serious mistake which can give rise to undesirable moral consequences.”

At the time, the debate within psychiatry represented only one thread of the discussion over suicide. In the early 19th century, there was widespread perception that the incidence of suicide was rising. Whether this was so is difficult to judge. What we do know, however, is that this was exactly the moment when governments began to concertedly collect statistics on suicide as part of a broad effort aimed at developing a more empirically-informed public policy.

While interest in the regularities of birth, marriage, and death rates dated back to the 18th century, during the 1830s the field of what was called “moral statistics” was ever more drawn to deviant acts like crime, alcoholism, and suicide. For moral statisticians, like the Belgian Adolphe Quetelet (1796–1874), the fact that these morally corrupt and seeming irrational actions followed consistent patterns in their incidence, attitudes at the time also appear to have been evolving, as people gradually attributed suicides not to moral failings or the devil, but to deep emotions such as grief. This opened the way in the 1700s for reform-minded thinkers to begin pathologizing suicide as an expression of melancholy.

Clinical observers and researchers began taking up the subject in the early 19th century. In 1807, Danish physician Heinrich Callisen (1740–1824) dubbed it a form of illness and others soon followed suit. This was not due to the emergence of any new clinical evidence, however. Rather, legal and judicial changes in defining criminal responsibility inspired debate within psychiatry over a range of issues: the possibility of “partial” insanities, the existence of emotional and volitional forms of madness, as well as whether suicide should be treated simply as a symptom of an altered state of mind. On the latter question, some—like the famed French psychiatrist Jean-Étienne Esquirol (1772–1840)—generally believed it to be “a disorder of the emotions,” a view a later writer in 1857 would criticize as “…a dangerous and serious mistake which can give rise to undesirable moral consequences.”

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prevalence, and distribution demonstrated that human behavior—like the rest of the natural world—followed certain laws. And these laws, he thought, could be scientifically discovered and analyzed. Here was compelling proof of the need for a social science on par with the physical sciences. Thus, 2 lines of research emerged in 2 emerging fields, one rooted in psychiatry, the other in sociology. The 2 paths certainly diverged from one another: psychiatrists remained most interested in the psychopathology and treatment of individuals. Social scientists were drawn to identifying and influencing collective patterns.

Nevertheless, there were points where the interests of the 2 groups overlapped. Both statistician André-Michel Guerry (1802–1866) and physician Brière de Boismont (1797–1881), for instance, separately took it upon themselves to classify and analyze the motivations of those committing suicide. Pouring over the letters, notes, and writings of thousands of victims, they sought out trends that might be common among those attempting to kill themselves.

But what continued to worry many analysts in both camps, however, was what seemed to be the shockingly high suicide rate in contemporary society. Thomas Mau- saryk in his 1881 study of the topic put it bluntly: suicide was “the sickness of our time.” It appeared to be not just an epidemic in, but also endemic to the modern world. What was one to make of this?

The growing influence of Darwinian evolutionary theory moved some to search for answers there. The physician and writer Max Norder (1849–1923) argued that the rising suicide rate reflected a more general pattern of “degeneration,” an evolutionary regression of the human race caused by society’s neglect of the moral and hygienic health of civilized peoples.

Others, however, wondered whether the evolutionary connections between humans and other animals meant that suicide could be found in other species. Scottish alienist William Lauder Lindsay (1829–1880) believed so. A critic of the use of mechanical restraints and an advocate for psychotherapy in asylums, Lindsay argued that evidence showed that animals did commit suicide just like humans, not as “the simple product of malady, but of malady aggravated by mismanagement.” In other words, it was due to neglect and abuse. The famous British psychiatrist Henry Maudsley (1835–1918) begged to differ. He categorically dismissed the notion of animal suicide. Non-humans, he contended, lacked the capacity to deliberately seek their own deaths, and he criticized Lindsay for sacrificing scientific assessment in the service of a “spirit of romance.”

Others saw less value in evolutionary arguments, opting instead to focus on recent historical changes. Durkheim entered the debate, emphasizing the impact modern secular and consumer values had on unmooring individuals from their familiar moral anchors. He was hardly the first to argue along these lines. Almost 2 decades earlier, the Italian physician Enrico Morselli (1852–1929) published Suicide: An Essay on Comparative Moral Statistics (1879), in which he related contemporary suicides to the rise in the unsatisfied desires and unregulated self-gratification characteristic of modern life.

By century’s end, many researchers concluded that suicide represented not so much an illness as a symptom—a response by some to the challenges posted by living in the modern world.

Dr Eghigian is Associate Professor of Modern History and Former Director of the Science, Technology, and Society Program at Penn State University; he is also Section Editor for Psychiatric Times’ History of Psychiatry.

References

found increased suicide rates of sub-threshold PTSD, even after controlling for MDD.10

Conclusion

With little economic relief in sight in the foreseeable future, approximately a million Puerto Ricans are expected to present with PTSD in the next 2 years and hundreds will die by suicide as a result of the hurricane. We hope that this article will serve to clarify protracted disaster-related psychopathology, especially within the context of psychosocial and economic stressors. In addition we hope heighten awareness among members of the World Psychiatric Association and American Psychiatric Association, at institutional-systemic and national-local levels, to offer assistance to those affected by this humanitarian crisis.

Dr Alfonso is Associate Professor of Psychiatry, Columbia University Medical Center, and Chair, Psychotherapy Section of the World Psychiatric Association.

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

References


Drug Withdrawal

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References

INFLAMMATION AND PSYCHIATRY, PART 1

INTRODUCTION:
The Inflammation Connection

Charles Raison, MD

When I attended medical school in the mid-1980s, no one imagined that the immune system had anything to do with the brain. When I became a researcher in 2000, we were convinced that inflammation would only be relevant to patients with medical illnesses that might account for their immune activation. Now, in 2018 I find myself amazed that inflammation is frequently named as the root cause of all mental illness.

This 2-part Special Report devotes itself to the new inflammatory world that we—as mental health clinicians and researchers—find ourselves in, and it does an admirable job of showing how most of our prior and current preconceptions about the role of immunity and mental illness have—and are—wrong.

In retrospect, my years in medical school seem like the dark ages. We now know the immune system and the brain function together as part of one larger system with causal influences that move in both directions. Brain states that produce mental illness also tend to activate inflammation and that this activation would be found to predict the later development of psychopathology.1 Far from being specific to any one mental illness, or a sub-population within a mental illness, inflammation turned out to be a common denominator and likely risk factor for every manner of psychiatric disturbance, from schizophrenia to obsessive compulsive disorder, from mania to depression.2

On the other hand, our hopes that major depression might turn out to be an inflammatory condition that could be uniformly treated with anti-inflammatory medications turned out to be as wrong as all the other assumptions prevalent in the field and in my own brain. It is increasingly clear that inflammation is not the cause of depression: it is at best one cause of depression. We now know, in fact, that depression patients with elevated depression have different patterns of brain functioning than do patients who are just as depressed but have low levels of inflammation. And the story gets trickier, because several studies suggest that further lowering inflammation in these non-inflamed patients makes things worse, not better.

What does it all mean? Fortunately, the articles in this Special Report do an outstanding job of glossing our best current understandings, which are:

- First, that inflammatory processes induce changes in brain/body functioning that can contribute to the development of a wide range of psychiatric conditions. Inflammation is an equal opportunity risk factor, with specific disease pathogenesis depending on factors such as when in the life cycle the inflammatory event(s) occur and/or genetic predisposition of individuals.
- Second, that a wide range of environmental adversities, many of which—like stress—we don’t tend to think of as immunological, can be pro-inflammatory and likely increase the risk of mental illness through this mechanism.
- Finally, that even though inflammation may be a cause of a given mental illness in a given individual, psychiatric disorders are not inflammatory conditions. There are plenty of other ways of getting depressed, or manic, or psychotic.

Our recent celebration of all things inflammatory will not allow an escape from the truth—that psychiatric treatment will never be “one size fits all.” How anti-inflammatory strategies will fit into our larger armamentarium is one of the most exciting questions facing the field of psychopharmacology.

Here’s to hoping that when the next Psychiatric Times Special Report on inflammation comes out, we will have the answers.

Epub ahead of print: www.psychiatrictimes.com

SPECIAL REPORT

Charles Raison, MD

ALSO IN THIS SPECIAL REPORT

16 Five Things to Know About Inflammation and Depression
Andrew H. Miller, MD

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Inflammation in Psychiatry: Where There’s Smoke There’s Fire
Roger S. McIntyre, MD and Carola Rong, MD

Why Are Depressed Patients Inflamed? A New Path to Personalized Treatment in Psychiatry
Carmine M. Pariante, MD, PhD
Five Things to Know About Inflammation and Depression

Dr. Andrew H. Miller, MD

Dr. Miller is William P. Timmie Professor of Psychiatry and Behavioral Sciences, Emory University School of Medicine, Atlanta, GA.

Understanding the immunologic basis of disease has revolutionized the treatment of cancer and autoimmune and inflammatory disorders, benefitting millions of people with breakthrough immunotherapies. We now suspect that immunologic processes may also play a pivotal role in the development and maintenance of psychiatric disorders, opening an entire new avenue for novel strategies to prevent and treat psychiatric disease.

The immunologic processes connected to depression have received the most attention. A vast amount of data supports the hypothesis that the immune system in general and inflammation in particular, represent a pathway to pathology in a significant number of depressed patients. Although the relationship between inflammation and depression may at first glance appear straightforward, this relationship is much richer and more nuanced than is often believed. In hopes of embracing the complexity involved, 5 essential points that represent our current understanding of the field are presented.

**Depression is not an inflammatory disorder**

Probably the most important lessons that we have learned about inflammation and depression are that depression is not an inflammatory disorder and not every patient with depression has increased inflammation. Although a multitude of studies have demonstrated increased mean concentrations of a variety of inflammatory markers in depressed patients compared with controls—including reproducible increases in the inflammatory cytokines tumor necrosis factor (TNF), interleukin (IL)-1β, IL-6 and the acute phase protein C-reactive protein (CRP)—there is considerable variability within the depressed population. Indeed, despite the question being asked repeatedly, we do not know the percentage patients in whom inflammation plays a role.

The difficulty in addressing this question is that the answer depends on the patient population being considered. The more inflammatory risk factors a patient has, the more likely he or she will have inflammation. There are a multitude of factors associated with increased inflammation (Table 1) including treatment resistance. For example, 45% of patients enrolled in a study on treatment resistant depression had a CRP > 3 mg/L, which is considered high inflammation.1

Another pivotal point is that increased inflammation not only occurs in depression but also in multiple other psychiatric diseases including bipolar disorder, anxiety disorders, personality disorders, and schizophrenia. These data suggest that inflammation is transdiagnostic in nature, occurring in subpopulations of patients within a number of psychiatric disorders.

**Inflammation has specific effects on the brain and behavior**

As we gain more insight into how inflammation affects the brain, it is becoming increasingly clear that there is a surprising specificity on the impact of inflammation on behavior. Such specificity is apparent in the neurocircuits and neurotransmitter systems that appear to be most affected by inflammation both in the context of the administration of inflammatory stimuli or in association with inflammatory markers in patients with depression or other psychiatric disorders (Figure). For example, administration of the inflammatory cytokine interferon (IFN)-α to patients or administration of typhoid vaccination or endotoxin to healthy volunteers has shown that inflammation affects subcortical and cortical brain circuits associated with motivation and motor activity as well as cortical brain regions associated with arousal, anxiety, and alarm.2-4

Similar results have been found in patients with depression where increases in peripheral blood concentrations of the CRP were correlated with decreases in connectivity within motivation and reward circuits involving the ventral striatum and ventromedial prefrontal cortex (vmPFC), that in turn were associated with anhedonia.5-6 Greater inflammatory responses to stress as reflected by salivary concentrations of soluble TNF receptor 2 have also been correlated with activation of threat assessment circuits in the brain involving the dorsal anterior cingulate cortex (dACC) and insula.5 This latter effect of inflammation on threat and fear-related neurocircuity
may explain the emerging literature on the association of inflammatory markers with suicidal ideation and suicide attempts. Indeed, threat sensitivity has been shown to independently predict suicide risk, and data suggest that increased inflammatory markers may be preferentially associated with depressed patients who have attempted suicide.

In terms of the neurotransmitter systems involved, inflammation reduces the availability of monoamines by increasing the expression and function of the presynaptic uptake pumps (transporters) for serotonin, dopamine, and norepinephrine and by reducing monoamine synthesis and release by decreasing enzymatic co-factors such as tetrahydrobiopterin. Cytokine-induced decreases in basal ganglia dopamine release have been observed in humans and directly correlated with reduced motivation in laboratory animals. Inflammation also decreases relevant monoamine precursors by activating the enzyme indoleamine 2,3 dioxygenase, which breaks down tryptophan, the primary precursor for 5-HT, into kynurenine. Activated microglia can convert kynurenine into quinolinic acid, which can lead to excessive glutamate, an excitatory amino acid neurotransmitter. Excessive glutamate can lead to decreased brain-derived neurotrophic factor (BDNF) and excitotoxicity. Increased CRP has been directly correlated with increased glutamate in the basal ganglia of patients with depression. Finally, based on the inhibitory effects of inflammation on monoamine metabolism and BDNF, it is not surprising that inflammation is associated with a poor response to conventional antidepressants, whose efficacy relies in part on increasing monoamine availability and inducing BDNF and neurogenesis.

The immunology of inflammation in depression is only beginning to be understood. Our understanding of the immunology underlying inflammation in depression is limited to a small number of human studies in addition to animal studies. Thus, the relative contribution of innate and adaptive immune responses is unknown. One might suspect from the inflammatory mediators that are increased in the blood of depressed patients (eg, TNF, IL-1β and IL-6) that the primary drivers of inflammation in depression involve monocytes and activation of the innate immune response. Consistent with this notion is a recent report of increased perivascular monocytes/macrophages and monocyte chemotactrant protein (MCP)-1, a protein that attracts monocytes to the tissues in postmortem brain samples of presumably depressed suicide victims.

Findings from animal studies also suggest that stress-induced increases in catecholamines stimulate the release of monocytes from the bone marrow. Once in the blood, these monocytes encounter danger- or microbial-associated molecular patterns derived from stress-induced alterations in metabolism or microbial products from the gut that in turn activate inflammatory signaling pathways such as nuclear factor κB (NF-κB) leading to TNF and IL-6 as well as the inflammasome, which leads to decreased monoamine availability and inducing BDNF and neurogenesis.

<table>
<thead>
<tr>
<th>Table 1. Factors associated with increased inflammation</th>
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<tr>
<td>Obesity</td>
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<td>Sedentary lifestyle</td>
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<td>Disordered sleep</td>
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<td>Childhood maltreatment</td>
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<td>Emotional and physical trauma</td>
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<td>Medical illnesses (eg, cardiovascular disease, diabetes, cancer, autoimmune and inflammatory disorders)</td>
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<tr>
<td>Bacterial or viral infection (including exposure to a high pathogen load [eg, unsanitary living conditions, poor dentition, poor hygiene])</td>
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<tr>
<td>Medical treatments (eg, surgery, radiation, chemotherapy)</td>
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<td>Antidepressant treatment resistance</td>
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INFLAMMATION AND PSYCHIATRY

SPECIAL REPORT

April 2018

Inflammation and Depression

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the production of IL-1. TNF in turn has been shown to activate microglia to produce MCP-1, attracting monocytes to the brain notably in areas that regulate fear and anxiety including the amygdala. Recent data indicate that chronic social stress in laboratory animals can also lead to permeability in the blood – brain barrier that allows peripheral inflammatory signals including IL-6 to enter the brain in regions relevant to motivation and reward. Consistent with these laboratory animal data, peripheral blood immune cells from depressed patients have shown evidence of activation of both nuclear factor κB and the inflammasome.

Despite evidence that monocytes and the innate immune response play a pivotal role in effects of inflammation on the brain, there is growing evidence to suggest that T cells and the adaptive immune response may also be involved. Decreased anti-inflammatory T regulatory cells and increased hyperinflammatory Th17 cells have been described in depressed patients and animal models of depression. Moreover, T cells and their production of IL-4 have been associated with resilience to stress and depression in laboratory animal models. These data are especially intriguing given recent characterization of the lymphatic system within CNS that allows the T cells to patrol the brain. Whether inflammatory responses are primarily driven by innate immune responses and monocytes versus the adaptive immune response and T cells will have profound implications for immunotherapeutic targeting of the immune system to treat depression.

Inflammation is related to treatment response

A major advantage of a pathophysiological process that is believed to largely emanate from the periphery and spread to the brain is the opportunity to use blood tests to identify specific individuals for treatment targeting and ultimately precision care. Indeed, inflammatory markers alone or in combination have been shown to predict treatment response to conventional antidepressants and psychotherapy as well as advanced treatment strategies such as ketamine and anti-cytokine immunotherapy. Unfortunately, these studies are post hoc in nature, and no study has yet to prospectively assign patients with one or more level of inflammatory marker to a given treatment and predict response. The greatest challenge is to determine which inflammatory marker(s) exhibits the greatest predictive value, while also being readily available for clinical application. Findings suggest that individuals with a CRP >1mg/L, which is the cut off for moderate inflammation, were less likely to respond to SSRIs. High CRP was also shown to predict response to the anti-inflammatory drug infliximab, an inhibitor of TNF. Given the relative availability of CRP in clinics and hospitals throughout the US and elsewhere, it may be that until other data are available, clinicians can use CRP as a general yardstick for inflammatory load.

There has been recent interest in identifying inflammation directly in the brain of depressed patients using positron emission tomography to identify activated microglia reflected by upregulation of the translocator protein (TSPO). Although there has been an assumption that increased TSPO binding signals neuroinflammation, the TSPO ligand is not able to distinguish microglia that are actively involved in adaptive and neuroregulatory functions from microglia that are inflammatory. Therefore, these ligands are not ready for prime time, and results from the published literature using TSPO ligands should be interpreted with caution.

Therapeutic implications are imminent

Clearly, there is much to be learned about the relationship between depression and inflammation. Nevertheless, the most exciting aspects of this work are the clear therapeutic implications ranging from blocking inflammation to targeting the downstream effects of inflammation on neurotransmitter systems and neurocircuits to implementing lifestyle interventions that reduce inflammation (Table 2). Several clinical trials are underway using immunotherapies that target TNF and IL-6. In each instance, a precise medicine approach is being taken: individuals with increased inflammation of CRP >3 mg/L are being treated. Whether targeting these cytokines versus targeting T cell-derived cytokines such as IL-17 is more efficacious and for whom remains to be determined. In addition, studies have suggested that both monocyte, which blocks microglial activation, and inhibitors of the inflammatory mediator cyclooxygenase (COX)-2 have antidepressant efficacy. However, more data are needed, given that precision targeting of patient populations with high inflammation has not been incorporated into the clinical trial design of these studies. Based on the impact of inflammation on dopaminergic and glutamatergic pathways, drugs that enhance dopamine signaling or block glutamate receptors may be especially relevant for patients with depressive symptoms and increased inflammation.

References


In addition to psychosocial problems, there is a growing realization that PTSD may also lead to or exacerbate chronic medical health conditions. Several large cohort studies demonstrate a prospective association between PTSD symptoms and cardio-metabolic disorders, such as myocardial infarction, stroke, type 2 diabetes mellitus, and coronary heart disease. The impact of sex and gender on this association also warrants further examination as many of the large prospective studies have been conducted using same-sex cohorts.

More recently, PTSD has been linked with autoimmune disorders and neurodegenerative diseases. O’Donovan and colleagues reported that patients with PTSD had a greater risk for thyroiditis, inflammatory bowel disease, rheumatoid arthritis, multiple sclerosis, and lupus erythematosus. Findings from this retrospective cohort of more than 600,000 Iraq and Afghanistan veterans were not associated with age, race, or gender. The temporal association between PTSD and autoimmune disorders has not been studied extensively. However, results from one longitudinal cohort study of women showed that the onset of trauma exposure and PTSD symptoms preceded the development of lupus erythematosus. The public health significance of understanding why and how trauma exposure/PTSD are linked to medical illness is enormous. Recent results from gene expression studies offer some intriguing research possibilities for investigation.

Is PTSD a Systemic Disorder?

SIGNIFICANCE FOR THE PRACTICING PSYCHIATRIST

It is important to understand how and why trauma affects medical illness and whether successful treatment for PTSD is associated with improvements in physical health. Alternatively, behavioral health treatments that address physical health conditions may also contribute to improvements in PTSD symptoms.

- There is a growing realization that PTSD may lead to or exacerbate chronic medical health conditions.
- An unanswered question is whether reductions in PTSD symptoms following treatment also lead to changes in immune system functioning.
- The association between PTSD and medical illness appears to differ by race and ethnicity, with black and Latino adults with PTSD at greater risk relative to whites.

Is PTSD symptom severity associated with metabolic and inflammatory markers?

Genome-wide transcription studies of trauma exposure and PTSD have identified specific genes, as well as causal pathways that implicate dysregulation of the immune system. Breen and colleagues undertook a mega-analysis using the results from 5 PTSD transcriptome studies. They

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PTSD

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observed that PTSD was associated with differential expression in genes that regulate innate immunity, cytokine production, and type I interferon signaling. The study included more than 225 cases and 300 controls, which allowed for sub-analyses by gender and trauma type.

Lower expression of cytokine-related genes was observed in men exposed to interpersonal trauma relative to women exposed to interpersonal trauma or men exposed to combat. Further work is needed to explore whether gene expression differences associated with gender and trauma type, which may carry over to observed group differences in the expression of chronic medical illness.

These genome-wide studies complement an established body of research on PTSD biomarkers that have focused extensively on the stress response, including dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis. Stress exposure initiates downstream release of endogenous glucocorticoids (GCs), which bind to GC receptors on target metabolic and immune system tissue (eg, adipose tissue, skeletal muscle, pancreas). Following stress exposure, increases in GC activity lead to immunosuppression, increases in metabolic activity, and negative feedback of the HPA axis to establish homeostasis. The link between PTSD and chronic illness may stem from increased C-reactive protein, an inflammatory marker of cardiovascular disease risk and the development of PTSD in trauma-exposed Marines. Similarly, higher IL-6 levels measured within 24 hours of a motor vehicle accident predicted PTSD symptoms in children and adolescents.

While some inflammatory activity may relate to psychotropic medication use, comorbid depression, or even trauma exposure itself, there is little doubt that PTSD is associated with immune system functioning. For example, see Lindqvist and colleagues who report no group differences in some of these measures in combat-exposed veterans with and without PTSD; this suggests that trauma exposure by itself may lead to increased inflammatory activity.

Does behavior mediate the relationship between PTSD and chronic health problems? It is important to understand whether the inflammatory signature associated with PTSD reflects an extension of trauma-related pathophysiology, or whether it is an inevitable outcome of the behaviors that are associated with PTSD (eg, tobacco use, physical inactivity, imprudent dietary choices, disrupted sleep). If the inflammatory signal is an extension of trauma-related consequences that associate with, or possibly even lead to, other medical illnesses, this would suggest that PTSD is part of a larger systemic illness linked to psychological trauma.

Evidence-based psychotherapies for PTSD address psychological benefits for patients with PTSD.

One study examined changes in inflammatory markers following treatment of PTSD with paroxetine. Findings from this open trial do not show a decline in IL-6 despite a decline in PTSD symptoms. In contrast, SSRI treatment of depression is associated with a decline in cytokines. Sertraline and transcranial direct current treatment of depression were associated with declines in 6 of 7 cytokines in a randomized clinical trial.

Some of the novel PTSD pharmacotherapy approaches currently under investigation may also have the added benefit of targeting the immune system. One of the exciting developments in pharmacotherapy involves the use of glucocorticoid-related drugs to either prevent the development of PTSD, augment the gains of psychotherapy, or treat symptoms of chronic PTSD. Glucocorticoids are primarily used in a variety of medical ailments because of their anti-inflammatory properties.

Ketamine, an NMDA-receptor antagonist, is under investigation for PTSD. Findings indicate that it influences cytokine production in animal models. Although controversial in some settings as a treatment option, cannabinoids have immunosuppressive properties. The anti-inflammatory properties of these agents may augment the potentially beneficial effects on psychological symptoms. An intriguing possibility is whether these and other medications for PTSD exert direct benefits on symptoms as a result of their influence on the immune system. If so, it is critical to consider the broader implications of the inflammatory signature of PTSD and its psychiatric and medical comorbidities.

Future directions

The link between PTSD and chronic illness has been established but the potential role of immune system markers in mediating this association is only beginning to be examined. As new psychotherapeutic and pharmacological treatments are developed, there is an opportunity to examine the relationships between inflammatory markers and symptoms as they change over time.

Future research should examine how and whether psychotherapy affects inflammatory markers, and also to determine the extent to which inflammation is reduced by medications that alleviate PTSD symptoms. It is possible that the growing interest in alternative therapies for PTSD such as meditation, yoga, acupuncture, and other interventions that increase physical activity or alter dietary intake may
provide benefits through their anti-inflammatory effects.

It is also important to examine whether the association between PTSD and immune markers is part of a broader association between mental illness and poor health or whether there is specificity between trauma exposure and particular markers and disease outcomes. Moreover, it is important to identify the contributions of trauma type, sex, race, and ethnicity to these associations.

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

References

Find More About PTSD and Suicide

10 Factors to Consider When Assessing PTSD
Ralph J. Koek, MD
http://www.psychiatrictimes.com/ptsd/10-factors-consider-when-assessing-ptsd

Treatment-Resistant PTSD
Ralph J. Koek, MD
http://www.psychiatrictimes.com/ptsd/treatment-resistant-ptsd

Challenges and Opportunities of Caring for Refugees
Arash Javanbakht, MD, and Cynthia L. Arfken, PhD

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http://www.psychiatrictimes.com/ptsd/dog-says-thank-you

The Wrong Way on a Long and Winding Road: Suicide in the US
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College Students Under Stress

Brunhild Kring, MD, for the GAP College Student Committee

Dr. Kring is Associate Director, Psychiatry Services, Counseling and Wellness Services, New York University, NY.

Providing psychiatric care for college students is different from treating other grown-ups. These emerging adults are in the midst of a tremendous emotional growth spurt and a leap of neurocognitive maturation. During this bewilderling life transition, they often cannot articulate straightforwardly what bothers them. They appear mercurial: at times, they may speak in hyperbole and sound very dramatic. At other times, they shroud what ails them in secrecy because of embarrassment, fear, and hopelessness. Eventually, school stress and academic performance problems propel students to seek assistance. Mental health clinicians attending to this population need to keep an open mind and consider a host of differential diagnoses.

CASE VIGNETTE

"Jerry" is a 19-year-old sophomore at a liberal arts college in the Northeast who wants to transfer to a prestigious business school. Two months into the fall semester and 1 week before midterm exams, Jerry reluctantly comes to the counseling service of his college. His dean accompanies him after receiving several alerts from professors about flagging academic performance. Jerry unenthusiastically agrees to meet with a psychiatrist. He appears tired and says that he feels unmotivated. He is upset with his parents. As an only child, he feels pressured to succeed in business, but is hopeless about ever measuring up to their ambitions for him. He admits to relying on alcohol and marijuana daily for sleep initiation and anxiety management. When asked what would be most helpful to him, Jerry seems surprised by the question: "Everyone tells me that I have an attention problem; my roommate gave me Adderall, and it worked!"

The psychiatric conditions most frequently observed among college students are anxiety, depression, ADHD, substance abuse, and bipolar disorder. Eating disorders carry a high risk for medical comorbidity. Stress and anxiety may worsen during exam periods. Moreover, most psychiatric disorders have their onset during late adolescence and young adulthood. Students in crisis may present with suicidality during late adolescence and young adulthood. Most psychiatric disorders have their onset in childhood and persist into adulthood.1

Studies estimate that about half of cases with childhood onset of ADHD persist into adulthood.2 However, because of the well-known rates of version and abuse, psychiatrists in college health services are wary of prescribing stimulants without a thorough diagnostic work-up.3 An in-depth psychiatric interview, screening with the Adult ADHD Self-Report Scale, and a referral for neuropsychological testing are recommended by a fair number of counseling services before any prescriptions for stimulants are issued. Ideally, the psychiatric work-up should include a basic medical exam, EKG, and routine lab testing. Students are also made aware of the university’s academic support resources.

Students who have come to rely on alcohol and marijuana during adolescence for alleviating anxiety, depression, self-esteem issues, camouflaging interpersonal conflict, and for fun are loath to give this up. They feel culturally emboldened to take advantage of the “medicinal” effects of the various marijuana strains. “I only smoke Blue Dreams,” Jerry announces, referring to a variety of marijuana high in cannabidiol content with purported anxiolytic properties.

How best to treat comorbid mood, anxiety, and substance use disorders has been the subject of a longstanding debate. A review of recent evidence-based studies recommends the integrated treatment of co-occurring mood and substance use disorders to achieve a superior outcome.4 The FDA has approved medications to address alcohol, opiate, and nicotine dependence, but the treatment for excessive marijuana use consists of psychosocial interventions. Yet, psychiatrists should keep in mind that academic performance problems are a multifactorial phenomenon. They may be related to poor study habits, or academic under-preparedness. This can create a loss of confidence and narcissistic injury among competitive peers or result in oppositional behavior towards authority figures. There can be a lack of motivation because the student’s major was not his or her first choice. Students may be disappointed about not being accepted by their dream school and therefore not apply themselves.

CLINICAL HIGHLIGHTS

- Explore school stress in the context of the academic calendar
- Be aware of the normative crises of psychological development in young adults
- Assist the student with improving self-management skills: sleep, exercise, diet, relationships
- Evaluate the student's reliance on alcohol and drugs for symptom relief
- Consider onset of major psychiatric disorders in the differential diagnosis and treat accordingly
- Promote engagement in talk therapy and other nonpharmacological modes of treatment
- Engage parents for collateral information and support, if helpful and with the student’s permission

References


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Lifeline for Pregnant and Postpartum Women Who Are Drowning in Plain Sight

Nancy Byatt, DO, MS, MBA
Dr. Byatt is Associate Professor of Psychiatry, Obstetrics and Gynecology, and Quantitative Health Sciences at the University of Massachusetts Medical School in Worcester, MA.

One in 7 women suffers from a mood disorder during pregnancy or in the first year postpartum.1 It is imperative that we, as psychiatric providers, guide each woman to make thoughtful decisions that take into account the effects of the illness and the treatment on her and her baby. Depression, anxiety, and other psychiatric illnesses that occur during pregnancy and the postpartum period have deleterious effects on mom, her child, and her family.

CASE VIGNETTE #1

"Sonja," a 26-year-old with a history of postpartum depression and panic disorder reports that she experienced severe postpartum depression and panic disorder within a month of giving birth to her 2-year-old son. The symptoms resolved shortly after she began taking 20-mg escitalopram daily. Three months ago, Sonja and her husband decided that they wanted to have another baby. Her psychiatrist told her that she had to discontinue the escitalopram before attempting to conceive. She followed his recommendations and the depression symptoms and daily panic attacks soon returned. Without the escitalopram, she is completely immobilized and unable to function. She recently saw her psychiatrist, reported the symptoms and her inability to function and requested that he restart the escitalopram. He responded, "You will not take the escitalopram if you care about your baby." She left the psychiatrist's office feeling guilty and inadequate, and that she had no choice but to suffer for the sake of the baby she hoped to conceive.

Sadly, this is just one example of countless similar incidents that occur daily. As this case illustrates, we miss the opportunity to have a trans-generational impact by optimizing maternal mental health, which in turn affects infant and child health. It is a complete fallacy that a woman needs to ignore her mental health or suffer for her baby. Having a baby is extraordinarily challenging. The best thing a woman can do for herself and her baby is get the treatment that she needs and deserves. There are many safe and effective treatment options for pregnant women.

Risks to mother and child

Although there can be adverse effects of psychotropics on the fetus, there is often not enough information to make decisions about the risks to mother and child.

LEARNING OBJECTIVES

To understand the risk differential of pharmacotherapy compared with no treatment during pregnancy and help women make treatment decisions before, during, and after pregnancy.

TARGET AUDIENCE

This continuing medical education activity is intended for psychiatrists, psychologists, primary care physicians, physician assistants, nurse practitioners, and other health care professionals who seek to improve their care for patients with mental health disorders.

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ACTIVITY GOAL

To understand the risk differential of pharmacotherapy compared with no treatment during pregnancy and help women make treatment decisions before, during, and after pregnancy.

LEARNING OBJECTIVES

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

• Rationalize the need for continued treatment for psychiatric illness during pregnancy
• Explain the risks involved when switching medications during pregnancy and how it affects the fetus
• Discuss the best options for treating psychiatric illness in pregnant women

TARGET AUDIENCE

This continuing medical education activity is intended for psychiatrists, psychologists, primary care physicians, physician assistants, nurse practitioners, and other health care professionals who seek to improve their care for patients with mental health disorders.

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the mother and fetus, there are inherent risks of the illness itself. If medications are discontinued in pregnancy, there is a high risk of illness relapse. The duration of and number of depressive episodes pre-pregnancy are the greatest predictors of the same for during pregnancy. Other risk factors include personal or family history of postpartum depression, history of mood changes related to hormonal contraception, and premenstrual dysphoric disorder. Medications should not be automatically discontinued due to pregnancy. It is critical to ask: “What would happen if my patient does not take her medication? How might her illness affect her ability to take of herself and her baby??”

The FDA’s A, B, C, D, and X categories for medicines used in pregnancy are extremely limited and misleading. For example, the risks of untreated illness are not included. Realizing this, the FDA developed a new approach to replace the risk categories and better support evidence-based decisions.2

The new system, the Pregnancy and Lactation Labeling Rule, uses a narrative model that includes 3 sections on the prescription label for pregnancy-related information: (1) Pregnancy; (2) Lactation; and, (3) Females and males of reproductive potential. Each section summarizes risks to the fetus, illness-related considerations, and available safety data.

Because approximately 50% of pregnancies are unplanned, it is imperative to consider and discuss the possibility of pregnancy with all women of reproductive age. This should include discussing and documenting birth control and the current use of all medications and their risks—especially important with highly teratogenic medications, such as valproic acid. Being aware of interactions between hormonal contraceptives and mood stabilizers is crucial and also needs to be discussed. Some hormonal contraceptives decrease levels of anti-convulsant medications, such as lamotrigine. Conversely, oxcarbazepine and topiramate can decrease the efficacy of hormonal contraceptives. Any discussions and documentation of preconception planning should also include recommendations for prenatal vitamins and folic acid.

**Depression**

Depression during pregnancy is associated with poor health care use, increased use of substances, and poor maternal health care. It is also associated with poor birth outcomes, including low birth weight in preterm delivery. Children of women with maternal depression have also been found to be at increased risk of cognitive delays or behavioral problems.3,4 Moreover, maternal suicide is a leading cause of death among postpartum women.5 It is critical to educate women about the various options for treating depression during pregnancy. It is also essential that non-pharmacologic treatments and lifestyle changes be included in treatment planning (Table). Evidence-based psychotherapy, such as cognitive behavioral therapy and interpersonal psychotherapy, should be considered as first-line therapy when possible. However, many women will need a combination of psychotherapy and pharmacotherapy to achieve full symptom remission. Pharmacotherapy may be the only treatment option for women who do not have access to psychotherapy or who do not see the value of psychotherapy.

**CASE VIGNETTE #2**

“Melissa” is a 32-year-old with a history of severe depression who has 2 children. She is now 14 weeks pregnant. She is currently asymptomatic and taking 300-mg bupropion XL. She notes that she had been severely depressed to the extent that it has affected her functioning and her ability to parent. Once she started taking bupropion, the symptoms resolved. During a visit with her psychiatrist, she reported that she had googled bupropion because she was concerned about the risks of taking it during pregnancy. As a result of her Google search, she believes that she should stop the bupropion and start sertraline. She notes that the information she found online indicated that sertraline is safer and the best option.

How should her psychiatrist counsel her? Melissa’s fetus has already been exposed to bupropion. If bupropion is continued, the fetus will likely experience only a single exposure. While bupropion has less available reproductive safety data than the SSRIs and has been associated with a possible increased risk of congenital heart defects, it is important to consider the risk of switching medications during pregnancy.

If her psychiatrist were to discontinue the bupropion and start sertraline, there is a risk of 3 exposures: her fetus is 14 weeks gestational age and has already been exposed to bupropion; switching would expose the fetus to a second medication (sertraline); and, sertraline may not be as effective as bupropion. Melissa could relapse and expose the fetus to illness. In general, pregnancy is a good time to switch medications.

To avoid exposure to untreated or undertreated illness and more than one medication, it is best to continue medications with known efficacy. Moreover, the risks of untreated illness need to be considered because the risks of exposure to illness are often as or more important than the risks of exposure to the medication.

There may be a small risk of birth defects when taking antidepressants during pregnancy—the data for paroxetine are most concerning. These findings, however, are inconsistent and the absolute risk of birth defects is small; most meta-analyses have been reassuring.

Antidepressant use during pregnancy has been associated with transient neonatal symptoms. This is a self-limited syndrome that can occur in up to 30% of newborns exposed to antidepressants during pregnancy. It can present as irritability, tachypnea, and/or tremulousness. The syndrome is time-limited and resolves within days; in rare cases it can last 1 to 2 weeks. Discontinuing SSRI s in the third trimester has not been shown to decrease the risk of transient neonatal symptoms.6

Although the data are inconsistent, antidepressant use in pregnancy has also been associated with a small increase of risk (baseline rate of 1–2/1000 births) for persistent pulmonary hypertension (PPHN) in the newborn. While there may be a small increased risk (3–4/1000 with antidepressant use during pregnancy), the absolute risk of PPHN appears to be small and more modest than suggested by initial studies.7

Antidepressant use during pregnancy has also been associated with preterm labor and low birth weight; changes in IQ or language development have also been seen. However, depression itself has been associated with an increased risk of preterm birth and low birth weight as well as with changes in IQ or language development.8

Some studies suggest that the risk of autistic spectrum disorders in the offspring of women with psychiatric illness may be higher with exposure to antidepressants during pregnancy. However, other studies suggest that lack of antidepressant exposure increases the risk of autistic spectrum disorders.

Overall, results from available studies do not suggest long-term neurobehavioral effects on children.

**Bipolar Disorder and Psychosis**

The perinatal period is the time of highest risk for first onset or recurrence of bipolar disorder episodes. Bipolar disorder among perinatal women is associated with self-injury, substance use, disruption of mother-child bonding, suicide, and infanticide. Psychotic illnesses have been associated with increased risk of pregnancy complications, including cesarean deliveries, intensive care unit admissions, and higher neonatal morbidity. Moreover, bipolar disorder is the most potent, best-established risk factor for postpartum psychosis.

Lithium is considered the treatment of choice for patients with type 1 bipolar disorder who are pregnant or are of child-bearing age. Preconception levels can be used to guide the therapeutic range of lithium during pregnancy.

Lithium use during pregnancy has been associated with preterm labor, polyhydramnios, polyuria/polydipsia, and lithium toxicity. In addition, ba-
bics of mothers who are on lithium during pregnancy may be large for gesta-
tional age at birth, have cardiac and neural tube defects, neonatal adaptation
symptoms, and changes in long-term neurodevelopment. More recent studies
suggest that the risk of major cardiovascular anomalies, such as Ebstein’s
anomaly, is less than previously thought.

Women who take lithium during pregnancy should be monitored carefully
by an obstetrician who is experienced in high-risk pregnancies. A 3D echo-
cardiogram is needed at 16 to 18 weeks gestational age. Lithium should be
continued during labor and delivery. To prevent lithium toxicity, patients
should be well hydrated during labor and immediately post-partum. Postpart-
um, infant levels of lithium, thyroid-stimulating hormone, and renal function
need to be checked. Consider decreasing the dosage to that of pre-pregnancy
in the postpartum period.

Lamotrigine is often considered a first-line medication for women with
type 2 bipolar disorder who are pregnant or are of child bearing age. Precon-
ception lamotrigine levels can be used to guide dosing throughout pregnancy
with the goal of maintaining the therapeutic preconception level. Postpartum,
lamotrigine dose should be decreased to the preconception level.

While early reports suggested an increased risk of cleft lip and palate with
first trimester exposure, more recent data are reassuring—lamotrigine has not
been associated with an increased risk of neurodevelopmental disorders.
However, the following limitations need to be considered before prescribing
lamotrigine:

- It can increase cycling at higher dosages
- It needs to be titrated slowly, thus is not ideal for acute treatment
- It needs to be taken consistently because of the need to re-titrated slowly
  if not taken consistently

Antipsychotics are often indicated for the treatment of mood disorders
with or without psychotic features or primary psychotic illnesses. It is impor-
tant to use antipsychotics that are currently or have previously been effective,
while taking into account the relative risk of the medication.

No single malformation has been consistently reported with antipsycho-
tics, although some data suggest a possible association with septal defects. In
addition, antipsychotic use during pregnancy has been associated with pre-
term labor, low and high birth weight, increased risk of postnatal adaptation
syndrome, and increased neonatal intensive care unit stays.

There are more data for typical than for atypical antipsychotics. Typical
antipsychotics have been associated with a small increase in risk for transient
abnormal muscle movement; however, limited long-term data are reassuring.
Compared with high-potency agents, low-potency agents have been more
strongly associated with teratogenic effects. Atypical antipsychotics have
been associated with gestational diabetes and obesity; but the limited data
from studies that followed women for up to 12 months are reassuring.9

Conclusion
Anticonvulsants such as carbamazepine and oxcarbazepine have been associ-
ated with neural tube defects and cognitive deficits among offspring and
should be avoided. Valproic acid is highly teratogenic and should be avoided
by pregnant women. Supplementation with folic acid is required for women
continuing pregnancy and the postpartum period to assess for symptom recurrence
and use anticonvulsants during pregnancy.

Changes in absorption, distribution, metabolism, and elimination that
occur in pregnancy can lower psychotropic drug levels and possibly treatment
effects, particularly in mood stabilizers, during the perinatal period. Vigilant
monitoring of clinical symptoms is needed for all classes of medications
during pregnancy and the postpartum period to assess for symptom recurrence
and the need for dose adjustments. Mood stabilizers also require therapeutic
drug monitoring in combination with clinical monitoring.

When considering treatment options for pregnant women, there’s no such
thing as no exposure: there is no risk-free choice. We need to work with our
patients to assess the risks of untreated psychiatric illness and the risks and
benefits of medication treatment. A detailed and individualized discussion of
the risks, benefits, alternatives to medication treatment, and the risks of un-
treated psychiatric illness is needed. Careful consideration and discussion of
risks of treatment and under-treatment or no treatment can help can decrease
the risk of decompensation during pregnancy or the postpartum period. And,
it will mitigate negative effects on birth, infant, and child outcomes associ-
ated with untreated psychiatric illness.

References
2. Ramoz LL, Patel-Shini NM. Recent changes in pregnancy and lactation labeling: retirement of risk catego-
3. Forman DR, O’Hara MW, Stuart S, et al. Effective treatment for postpartum depression is not sufficient to
4. Deave T, Heron J, Evans J, Emmond A. The impact of maternal depression in pregnancy on early-child develop-
ment. BJOG. 2008;115:1043-1051.
6. Byatt N, Deligianniids KM, Freeman MP. Antidepressant use in pregnancy: a critical review focused on risks
8. Nulman I, Koren G, Rovet J, et al. Neurodevelopment of children following prenatal exposure to venlafaxine,
selective serotonin reuptake inhibitors, or untreated maternal depression. Am J Psychiatry. 2012;169:1165-
1174.
data from the Massachusetts General Hospital National Pregnancy Registry for Atypical Antipsychotics. Am J

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Our packages vary from a minimum of $300,000 per year plus $10,000 in bonuses and a benefit package valued at approximately $90,000, up to $500,000, for the industrious physician. Our generous benefit package includes almost 7 weeks paid time off per year. If you are creative and think outside the box, if you value diversity and cultural competency, if you like innovative programs that are patient driven, using a rehabilitative, rather than illness model, if you have the opportunity to work with patients, to get the best results, then TBH is the company for you. To learn more about the specific job openings and salary and benefit packages, check out our Website at:

www.tbhcare.com or Email your letter of interest and CV to our company President, Gary A. Hayes, Ph.D. at:
Drhayes3@tbhcare.com
TBH is an equal opportunity employer

www.scvmc.org
www.sccmhd.org

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

Santa Clara Valley Health and Hospital System, a public healthcare system in the heart of Silicon Valley, is seeking BE/BC psychiatrists & PGY-III/IVs for a variety of clinical settings, including emergency psychiatric services, inpatient psychiatric services, outpatient behavioral health clinics, and custody health programs. Opportunities for additional moonlighting also exist within our healthcare system.

As the largest public health care system in northern California, we offer comprehensive healthcare resources to a large and diverse patient population. Psychiatrists are part of a robust team of staff that work in collaboration with other medical specialties to provide integrated health care to patients.

Psychiatrists are eligible for numerous benefits including 7 weeks of annual leave, 1 week of educational leave, 12 holidays, $4500 educational funds, health benefits, life insurance and CalPERS retirement plan. If you are interested in working in a dynamic and collegial work environment, please submit a CV and letter of interest directly to:
Dr. Tiffany Ho,
Behavioral Health Medical Director:
tiffany.ho@hhs.sccgov.org
(408) 885-5767
The County of Santa Clara is an Equal Opportunity Employer

TLC Telecare Physician Services Organization

BE or BC psychiatrist needed. Following locations have immediate openings:
• Camarillo, CA: 16-20hrs per week, Pay Rate: $182 - $205 per hour (Contractor)
• Fontana, CA: Schedule: 9hrs per week. Pay Rate: $205 per hour (Contractor)
• Santa Ana, CA: Schedule: 40hrs per week. Pay Rate: $208 per hour (Contractor)
• Woodburn/Portland, OR: Schedule: 10hrs per week. Pay Rate: $180 - $205 per hour (Contractor)

Benefits include:
• Competitive salary
• Benefits eligible
• Medical, dental and vision benefits
• Private practice permitted
• Retiree healthcare
• Psychiatrist-led treatment teams
• Patient-centric, treatment first environment
• Relocation assistance is available

To find out more, please contact Kristensmith@co.imperial.ca.us
For additional listings, please visit: www.telecarecorp.com/physician-jobs/
Please email your resume to Drhayes3@tbhcare.com
EOE M/F/V/Disability

The J-1 Visa Opportunity in California

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

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

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

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

J-1 applicants welcome.

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

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

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

CONNECTICUT

Psychiatrist to work FT or PT for Behavioral Health Consultants, LLC, a private outpatient clinical and consulting practice. The successful candidate would join a staff of 13 non-medical clinicians offering services across a wide range of diagnostic categories. BHC is part of an ACO in the South Central CT region and is located near New Haven. Please contact Arnold Holzman, Ph.D. 203-288-3554, ext 12 or aholzman@bhcservices.com. EOE

ILLINOIS

Meridian Behavioral Healthcare, Inc. is a CARF accredited community mental healthcare facility located in the heart of Florida. Currently, we have full time position Staff Psychiatrist position available with an excellent salary and benefits package. Looking for someone who can work with a flexible schedule – preferably Adult and Child, with the mixture of inpatient and outpatient to be discussed. Meridian has been a part of the lives of thousands since 1972: providing a safety net for those in crisis. Since then, Meridian has expanded to 16 sites across Central Florida, touching over 22,000 lives through over 325,000 direct care visits a year. Gainesville is home to the University of Florida and serves as the cultural, educational, and commercial center for the north central Florida region. For more information, contact: Logan Anglin, Vice President – Staffing/Recruiting. PBMNET@aol.com or email confidential C.V. to logan_anglin@mbhci.org

MBH is an Equal Opportunity Employer and a Drug-Free Workplace.

Neurostar TMS-CHAIR Complete Therapy System for sale located in Florida. Never Used. Priced to sell. Please contact Tina Zelenko at PBMNET@aol.com for inquiries.

Coliseum Center for Behavioral Health is seeking a Board Certified Psychiatrist to join our team!

• Employed, inpatient only position offering a competitive compensation package that includes a comprehensive benefit package.

• Monday through Friday position patient census split amongst all providers

• Weekend Call 1:4 weekday call 1:5

• Current staff includes 2 NP’s and 3 Psych-Hospitalists

• This is a Hospitalist position with expectations of teaching participation.

The unit consists of 42 inpatient beds - 32 Adult and 10 Gero-Psych Inpatient programming consists of an Adult unit, Geriatric unit, STAR (Stress, Trauma, Addiction, Recovery) unit specializing in the treatment of PTSD and a new, busy ECT service. Coliseum Center for Behavioral Health in Macon, Georgia provides mental health services to assist adults with psychiatric disorders in a safe, nurturing environment. For over 30 years, our mental health specialists and psychiatrists have provided individualized treatment plans for our patients, giving them the best chances of a full recovery and stability.

Macon, GA is only an hour drive from Atlanta! It is the 5th largest city in Georgia, situated in the heart of the state, and is the perfect sized city offering many amenities of a larger city with a small town feel. Here you can experience the change of seasons, enjoy outdoor activities year-round and enjoy beautiful lakes and numerous parks. Macon also boasts great shopping with major department stores, as well as, unique boutiques. Macon is a great place for music lovers as the city hosts many concerts throughout the year. Macon is located off of I-75 and I-16, making it easily accessible for travel.

Please contact: Melissa Sampson (904) 702-6627 melissa.sampson@icacarehealth.com

 Bermudian TMS-CHAIR Complete Therapy System for sale located in Florida. Never Used. Priced to sell. Please contact Tina Zelenko at PBMNET@aol.com for inquiries.

Assistant/Associate Professor of Clinical Psychiatry

The Department of Psychiatry and Behavioral Medicine at the University of Illinois College of Medicine at Peoria is recruiting full-time faculty positions at the rank of Assistant or Associate Professor to join our expanding department. Two Clinician-Educator (CE) positions and one Psychiatry Residency Program Director (PD) position are open. Competitive applicants to the CE positions should value providing and teaching high-quality patient care and supporting the scholarship efforts of residents and medical students. The PD position is a planned changeover in leadership and available to applicants with experience and interest in educational administration and quality teaching. Highly competitive salary and benefits are commensurate with rank. Responsibilities for the CE position include leading an interdisciplinary general psychiatry adult inpatient teaching unit composed of residents, medical students, nursing, social work and support staff. The PD position includes directing our 16-resident, ACGME-approved training program, promoting a culture of excellence, resident recruitment, teaching and resident evaluation. Other duties for both positions include contributing to the interest of the applicant and include opportunities in adult and child outpatient clinics, partial hospitalization program, elec- troconvulsive therapy (ECT), transcranial magnetic stimulation (TMS), community outreach, college student mental health, geri- atric and forensic psychiatry, among others.

Faculty members have protected time to pursue professional interests including clinical or educational program development or research. Our department values a positive, collegial culture and supports the growth, development and advancement of its membership. The department has high faculty and resident satisfaction and low turnover.

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

To inquire confidentially about a position, please contact Dr. Timothy Bruce, Search Chair, at (309) 495-1647 or tbruce@uicomp.uc.edu. Minimum requirements: graduation from an ACGME-approved psychiatry residency training program, board certification or board eligibility in general psychiatry and eligibility for an unrestricted Illinois medical license. UIC is an EOE/AAMF/Disabled/Veteran employer.

For fullest consideration, please apply by April 5, 2018 at the following link: https://jobs.uic.edu/job-board/job-details?jobId=76315

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

Advanced Psychiatry of Elgin is a family-focused practice in a highly desirable suburb, 20-25 minutes from Chicago. We strive to provide the highest quality of care to help patients make positive changes in their lives. We value, respect, and embrace the uniqueness and diversity of all individuals. We are currently looking for a board-certified psychiatrist to join our highly trained staff. This position works in an outpatient practice and must be able to provide patients with emotional tools and methods for recovery.

Duties and requirements:

• Provide services to children and adults with compassion and empathy

• Must be comfortable evaluating, diagnosing, and treating all age groups to determine treatment and recovery plans

• Independent contractor who can counsel patients and listen to their reactions to treatment

• Part time position of 15 hours/week

Please fax resume to 847-783-0730 or email to officemanager@advancedpsychiatryofelgin.com

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THE JOINT COMMISSION

The Joint Commission is an independent, nonprofit organization that is dedicated to improving patient safety and quality of care through the development of standards and measures, and providing accreditation and certification services for health care organizations.

200 Chicago Avenue
Schaumburg, IL 60173
1-800-905-5514
www.jointcommission.org

IN INDIANA

Meridian Health Services Corp. seeks Psychiatrist In Muncie, IN, Indianapolis, IN, and West Lafayette IN to provide both inpatient and outpatient psychiatric care for mainly adult patients. Requires MD or foreign equiv.; current & valid IN Physician License by 7/1/18; compl. of 4 yr. residency in Psychiatry by 7/1/18; & Bd. Certified or Bd. Eligible in Psychiatry by 7/1/18. Must have current auth. to be emp’d in U.S. w/out emp. sponsorsh. Email resumes to Tammy Hargrave, Meridian Health Services Corp., Tammy.Hargrave@meridianhs.org. Refer to Job #00014.

IN MASSACHUSETTS

Psychiatrists Opportunities in MA Cambridge Health Alliance (CHA), a well-respected, nationally recognized and award-winning public healthcare system is seeking full-time/part-time Psychiatrists in our Inpatient and Outpatient services. CHA is a teaching affiliate of both Harvard Medical School (HMS) and Tufts University School of Medicine. Our system is comprised of three hospital campuses and an integrated network of both primary and specialty outpatient care practices in Cambridge, Somerville and Boston’s Metro North Region.

Practice Highlights

• CHA offers a wide variety of inpatient and outpatient Psychiatry services for all ages, including the Psychiatric Emergency Service within the CHA Cambridge Hospital emergency department.
• We are proud to offer a collaborative practice environment with an innovative clinical model. This allows our providers to focus on patient care and contribute to community health and primary care innovation projects.
• Fully integrated electronic medical record (EPIC) is utilized.
• Applicants should share CHA’s passion for providing the highest quality care to our underserved and diverse patient population.
• CHA is a teaching affiliate of Harvard Medical School (HMS) and academic appointments are available commensurate with medical school criteria.
• CHA offers competitive compensation and a comprehensive benefits package including health and dental insurance, 403b retirement accounts with matching, generous PTO, CME allotment (time and dollars) and much more.
• If you are interested in making a difference, please contact us!

How to Apply

Qualified candidates may submit CV to Fatema Khorakiwala, Provider Recruiter at fhkhorakiwala@challiance.org or visit our website www.CHAproviders.org. CHA Provider Recruitment Department can be reached by phone at (617) 665-3555 or by fax at (617) 665-3553.

CHA is an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability status, protected veteran status, or any other characteristic protected by law.

NEW JERSEY

Two Openings: BAYONNE- CONSULTATION LIAISON POSITION and JERSEY CITY-OUTPATIENT POSITION - Full-time employment with benefits through Carepoint Health.

Please call for details. Terry Good, 804-684-5661; terry.good@horizonhealth.com; Fax: 1-804-684-5663. EOE

If you are interested in making a difference, please contact us!

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Learn more about Hackensack Meridian Behavioral Health Services at: https://www.hackensackmeridianhealth.org/services/behavioral-health/

Highlights:

Pediatric Psychiatry – Outpatient Consultation Position

Full Time * Multiple locations

Hackensack Meridian Health is seeking a Board Certified/Board Eligible Child and Adolescent Psychiatrist to join this growing team. With 4 hospitals in the top 10 ranking in New Jersey, this is an outstanding opportunity to join the area’s largest healthcare network.

This opportunity is an outpatient consultation position working with the Pediatric Psychiatry Collaborative Hub Teams (social worker, case manager, data analyst), to provide consultation to Pediatarians and also directly to families and children. The ideal candidate will work collaboratively with Pediatrians in our statewide collaborative hubs to provide comprehensive patient care.

Learn more about Hackensack Meridian Behavioral Health Services at: https://www.hackensackmeridianhealth.org/services/behavioral-health/

Highlights:

401(k) plan with employer match

Paid malpractice insurance

CME reimbursement and additional paid days off

Flexible spending accounts for healthcare and dependent care

Same sex domestic partner benefits

For more details, please contact me at 844-477-4240 or email CV to jane@mhmcareers.com

MMH In-House Provider Recruiter

For details and a list of all our openings please check out our website:

http://www.mmh.com/services/careers/index.html

Two Openings: BAYONNE- CONSULTATION LIAISON POSITION and JERSEY CITY-OUTPATIENT POSITION - Full-time employment with benefits through Carepoint Health.

Please call for details. Terry Good, 804-684-5661; terry.good@horizonhealth.com; Fax: 1-804-684-5663. EOE

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Same sex domestic partner benefits

For more details, please contact me at 844-477-4240 or email CV to jane@mhmcareers.com

MMH In-House Provider Recruiter

For details and a list of all our openings please check out our website:

http://www.mmh.com/services/careers/index.html

Two Openings: BAYONNE- CONSULTATION LIAISON POSITION and JERSEY CITY-OUTPATIENT POSITION - Full-time employment with benefits through Carepoint Health.

Please call for details. Terry Good, 804-684-5661; terry.good@horizonhealth.com; Fax: 1-804-684-5663. EOE

If you are interested in making a difference, please contact us!

How to Apply

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Highlights:
PSYCHIATRY OPPORTUNITIES
New Jersey

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.

As the area's premier provider, Hackensack Meridian Behavioral Health Services has provided comprehensive mental health and substance abuse services to the residents of Monmouth, Ocean, and Middlesex Counties for over forty years. Hackensack Meridian Health is dedicated to providing outstanding Behavioral Health Services to all members of our communities.

Hackensack Meridian Health is the 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.

HACKENSACK MERIDIAN HEALTH www.hackensackmeridianhealth.org
An Equal Opportunity Employer M/F/D/V

NEW YORK

PSYCHIATRISTS & PSYCH NURSE PRACTITIONERS
CONSULTATION SERVICES IN LONG TERM CARE (NH, SNF)

NEW YORK CITY & WESTCHESTER COUNTY

Part Time / Full Time / Per diem

Excellent salaries, flexibility, autonomy, no call, comprehensive benefits.
J-1 & H-1B Visa Waiver

Send CV to recruitment@medcarepc.com
Fax: (718) 239-0032
www.medcarepc.com

OSWEGO, NY – Great Work/Life Balance
College Town on Lake Ontario – 20 Minutes from the Northern Suburbs of Syracuse – Outdoor enthusiasts’ paradise: numerous lakes; skiing options close by; 40 minutes from the Thousand Islands; festivals and concerts every weekend throughout the summer. Seeking an additional Psychiatrist to work on a 28-bed adult inpatient psychiatric unit in the Oswego Hospital. Work with a great group of people in a very supportive hospital. Offering salaried position with benefits.

Please contact Terry B. Good, Horizon Health, at 804-684-5661, Fax#: 1-804-684-5663; Email: terry.good@horizonhealth.com.
EOE
Chairperson, Department of Behavioral Health and Psychiatry: Staten Island University Hospital

Staten Island University Hospital (SIUH), the Staten Island medical center of Northwell Health, is seeking a new Department of Psychiatry Chairperson. This exciting position offers the opportunity to lead and continue to develop an academically oriented behavioral health center of excellence on Staten Island. The Department serves diverse patient populations on its adult inpatient units, New York State Office of Mental Health (OMH) and New York State Office of Alcoholism and Substance Abuse Services (OASAS)-licensed outpatient clinics serving adults, consultation liaison services to SIUH’s 800+ medical-surgical inpatients at SIUH North and South sites, and emergency psychiatry program.

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

Through collaboration with Northwell’s Behavioral Health Service Line, the SIUH Department of Psychiatry is able to interact with many innovative system-wide activities including emergency tele-psychiatry; a CMS-funded practice transformation network; the behavioral health performance improvement coordinating group, pharmacy and therapeutics committee, and incident review committee; the digital behavioral health workshops, collaborative care models; and an ambulatory provider network, IPA, and behavioral health group practice. Interested candidates must have or be eligible for a NYS medical license; be ABPN board-certified in Psychiatry; possess consummate leadership skills, program development experience, financial acumen, and a strategic vision to help shape the future direction of a dynamic multi-faceted department; possess an academic portfolio in clinical service delivery, education, or research; be motivated to engage developing value-based payment models, and other health care reform initiatives; drive optimal quality, patient satisfaction, and staff engagement indices; and thoughtfully interact with both SIUH and Northwell Health clinical and administrative leaders.

Salary – competitive for the New York market

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

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

NORTHWESTERN UNIVERSITY

Chair, Department of Psychiatry and Behavioral Sciences: Northwestern University Feinberg School of Medicine

Northwestern University, one of the nation’s leading universities, is seeking a Chair of Medicine. The successful candidate will have a vision for the future of the Department of Psychiatry and Behavioral Sciences. The Chair will be awarded the rank of Professor of Medicine and will lead the Department in a new strategic direction.

Requirements:
- Leadership experience in academic medicine
- Vision and strategic planning
- Demonstrated commitment to clinical excellence

To apply, please submit a letter of interest, CV, and list of references to the Search Committee Chair, Dr. John J. Stein at jstein@northwestern.edu.

NORTHERN WESTCheSTER HOSPITAL

Chairperson, Department of Behavioral Health and Psychiatry: Northern Westchester Hospital

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

Northern Westchester Hospital’s Department of Behavioral Health provides comprehensive psychiatric care in a private, patient-centered environment. Services include:
- Inpatient psychiatric hospitalization for adults age 18 and over on a dedicated unit of the hospital
- Emergency Department coverage 24-hours a day provided by board certified psychiatrists
- Consultation on the medical and surgical units of the hospital provided by psychiatric and social work staff

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

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

NORTH CAROLINA

CAPE FEAR VALLEY HEALTH

Chairperson, Department of Psychiatry and Behavioral Sciences: Cape Fear Valley Health

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 professionals, and other mental health professionals, Cape Fear Valley Behavioral Health Care provides a team approach to mental wellness. Behavioral Health Care is accredited by The Joint Commission and licensed by the State of North Carolina.

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

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

Adult Outpatient Opportunity
- BE/BC provider with training/experience in a variety of mental health treatment conditions as well as Chemical Dependency and Substance Abuse.
- Candidate with experience in treatment of Bipolar Disorder, Borderline Personality Disorder, and Mood Disorders is preferred. Additionally, ECT training and experience is highly desirable. Well established adult team is flexible and transparent for either both inpatient and outpatient services. Clinic hours are Monday - Friday with limited call.

Child Outpatient Opportunity
- BE/BC Child & Adolescent providers.
- The current structure is for 90% outpatient Monday through Friday work schedule.

We offer best in class compensation plus generous benefits including Paid Malpractice, CME Time and Allowance, Accrued Paid Time Off, 401(b) and Health, Dental, and other desirable benefits.

Please contact Suzy Cobb, Physician Recruiter for more details at (910) 615-1899 or scobb2@capefearvalley.com.

PSYCHIATRIST NEEDED FOR 24/7 CRISIS SERVICE IN DARBY – Day and night shifts available (8am to 5pm or 5pm to 8am) at the Mercy Fitzgerald Hospital. Please contact Terry B. Good, Horizon Health, at 804-684-5661.

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

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

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

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

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

For consideration, send your CV to: Jennia Spangler Physician Recruiter Phone: 717-531-4271

Email: jspsangler2@pennstatehealth.psu.edu

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

WISCONSIN

PSYCHIATRIST

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

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

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

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

An Equal Opportunity Employer