In the Room With Climate Anxiety

PART 1

>> Janet Lewis, MD

Psychiatrists and other mental-health clinicians are being increasingly called upon to respond to patients’ worries about the destabilization of many aspects of our world. Within a longer series about the psychiatric aspects of climate change, this is the first of two articles dealing specifically with climate anxiety. The majority of Americans are now worried about climate change and a record 21%, one in five Americans, are very worried about climate change. Recent hurricanes, floods, and wildfires have been reminders of climate change. Although no one event can be solely attributed to climate change, the trend to more severe storms, more heat, and overall destabilization of the climate is clear.

Our patients are exposed through the news, and sometimes via personal experience, to an increasing pace of climate disasters and species extinctions and to reports of inadequate response by leadership. Patients who are well informed also know that, because of the long existence of many greenhouse gases in the atmosphere and because of the many (CONTINUED ON PAGE 1)

EDITOR’S NOTE: The mental health effects of climate change are immediate, long ranging, and complex. As a premiere psychiatric publication, we were compelled to provide crucial information on the psychiatric sequelae of climate change, which was the genesis of this exclusive series from the Climate Psychiatry Alliance (CPA). We urge you to follow the series in upcoming issues and online at www.psychiatrictimes.com as we cover climate-change related issues such as ethical implications and denial as well as transformational resilience.

EXCLUSIVE CLIMATE CHANGE COVERAGE

Vietnam, 50 Years Later: Remembering Those Who Served

> Norman “Mike” Camp, MD

Dr Camp is Colonel, Medical Corps, US Army (Ret), and Clinical Professor of Psychiatry, Medical College of Virginia/Virginia Commonwealth University, Richmond, VA.

On November 1st the American Psychiatric Association held a ceremony at the Vietnam Veterans Memorial in Washington, DC, to honor the psychiatrists who served with the US military in Vietnam or offshore waters 50 years ago and to remember Army psychiatrist Dr Peter Livingston, who died in a helicopter crash near Saigon on November 19, 1968. This semi-Centennial commemoration was one of almost 15,000 such government-supported events that have taken place or will take place across America to thank and honor Vietnam veterans for their service on behalf of the US and to thank and honor the families of these veterans (Public Law 110-181 SEC.598, 2008 National Defense Authorization Act).

In addition to calling attention to the APA’s recognition of the individual psychiatrists who served in Vietnam, the following synopsis also recognizes their legacy. It was drawn from my recently published study of the military morale and mental health crisis that arose in Vietnam. The commitment of American ground troops in Southeast Asia in the spring of 1965 (CONTINUED ON PAGE 4)
Climate Anxiety
Continued from Cover

positive feedback loops in the climate system, we are not simply dealing with a “new normal” of increased heat, fires, flooding, and storms. Rather our collective situation is even more serious and urgent, in ways that are difficult to fully take in emotionally. Further adding to this large psychological task of grappling with the reality of climate change is the knowledge that we are all participating in the fossil-fuel–based social, cultural, and economic systems that have brought on and that are worsening this slow-moving disaster.

Understanding the anxiety resulting from this reality

Worry over climate change can be seen as appropriate and is usually not maladaptive. A quantitative and qualitative study done using online surveys showed that people who describe habitual worry about the environment can be functioning quite well. They tend to have pro-environmental attitudes and engage in “pro-environmental behavior.”

However significant distress over climate change is being described. Some of these descriptions are in populations that are being particularly affected. For instance, indigenous peoples have close relationships to the land and some are losing their lands—cherished aspects of their cultural identities—to climate change, producing significant distress.

From Australia, where there have been noteworthy droughts, came the first reported climate change delusion: a 17-year-old with delusional guilt about drinking water stopped drinking water.5 In a study of OCD patients in Australia, 28% of the participants in the study had spontaneous descriptions of OCD concerns related to climate change, such as compulsively checking to make sure that the faucets were all the way off or checking lights to make sure electricity was not being wasted.6 A quantitative study of Australians, half of whom lived in urban areas, documented significant distress over climate change, particularly among women, and in those aged younger than 35 years.7

Distress over climate change is described in a cluster of related terms such as “climate anxiety,” “eco-anxiety,” “eco-paralysis,” and “climate grief,” all of which could be considered psychoterratic syndromes. The term “psychoterratic,” coined by the philosopher Glenn Albrecht, refers to mental conditions arising from our relationship with the natural world. One so-called psychoterratic syndrome is solastalgia, another term coined by Albrecht. The word “solastalgia” joins the Latin word for comfort with the Greek word meaning pain. It refers to the distress one experiences when a well-known environment has changed and no longer offers the same solace. It is a kind of nostalgia one can feel while still at home, an experience of loss that can be very difficult to put into words.8

The concept of solastalgia is gaining a research base. A qualitative study of Great Lakes residents, using semi-structured psychoanalytic interviews of the residents, documented in their descriptions of their relationship with their environment an “arrested mourning.” Interestingly, these study subjects were individuals who were not particularly environmentally active.9

Place-based distress has also been documented in Australian family farmers, and in Australian residents of an area changed by mining.10 A quantitative study of emergency room visits in Kentucky suggested a greater risk of depressive and substance use disorders in areas where there was mountain top removal mining, a process that drastically changes the landscape.11 The study controlled for other demographic factors such as socioeconomic status.

Another proposed psychoterratic syndrome is dysthymia, another term coined by Albrecht. The word “dysthymia” joins the Latin words for feeling down and Greek word meaning illness as a result of our being alienated from nature.

There is some support for this concept. There are many documented salutary effects of nature exposure, including effects relevant to psychiatric disorders and treatment, such as effects on attention, rumination, and social bonding. This topic of the mental health benefits of involvement in the natural world will be explored in a future article in this climate series.

A growing psychoanalytic literature is also exploring our relationship to climate change. In addition to other psychoanalysts, Sally Weintrobe, a British psychoanalyst, editor of the book Engaging with Climate Change, has recognized that climate change can be seen as a developmental issue. As Weintrobe describes it, just as in the development of the small child, we are collectively seeking to move from a relationship with nature as a “breast and toilet mother” to a more mature relationship where we recognize that Mother Earth has limits.12

Psychoanalysts are documenting climate distress. Rosemary Randall describes distress over the experience of ecocultural debt. Once someone becomes deeply aware of the fact that, in their ordinary Western life, they are engaged in activities that are negatively affecting the environment, harming both the people of today and future generations, it can be a crisis for the individual. She describes that sometimes this understanding of debt can lead to depression, masochism, or bitterness. She recommends “a sense of proportionality” about one’s guilt, including understanding the social problems that contribute to our situation, and describes how engaging in reparation in response to the sense of ecological debt can potentially reframe one’s identity.13

Psychoanalyst Susan Bodnar describes cases of climate distress in young adults who engage in self-destructive lifestyle behaviors because they feel hopeless about their future lives on what they see as a damaged planet. She recommends the “environmental metaphor” as a helpful therapeutic intervention. This involves linking the patient’s self-neglect and self-destructiveness to the behavior of humanity towards the Earth and emphasizing the importance of not perpetuating this pattern but instead fighting this neglect and abusive-ness. For these patients, she emphasizes the importance of working on respect for limits, boundaries, and space within their own lives. These cases are explained by understanding that the environment functions as an internal object, just as parents or siblings do. Therefore, when the environment is being treated destructively, this can influence personality development in sensitive individuals.14

Working with distressed patients

It is generally agreed that the mental-health effects of climate change, including climate anxiety, require more research. The astute reader will recognize many possible causes of climate-related distress in the above review, including the direct traumatic effects of extreme weather events, economic effects, possible physiological effects of heat, vicarious traumatization, in addition to concern for current and future generations and ecosystems. For research purposes one might wish to parse out the multiple pathways by which climate change affects mental health. However, when we deal with a patient in our office we must accept that the multiple pathways are often overlapping and intersecting.

Anxiety about climate change is a bit different than other anxieties we often treat, in that our goal should not be to eliminate what in this case is usually an appropriate anxiety. As therapists, we know the importance of exploring and validating people’s feelings in a process that can help them come into a clearer relationship with reality. This is no less important when patients are distressed about climate.

Many patients experience deep distress as they contemplate the suffering wrought by climate change and the circumstances their children and grandchildren are facing. Such patients re-
quire witnessing in a manner that does not minimize the real basis of their distress. In our work with these patients, witnessing and validating feelings is essential and also insufficient.

Given the threatening nature of climate change and its complexity, paralysis and hopelessness can easily occur. Throughout the literature on climate distress, experts counsel that we should foster active hope, emphasizing engagement. Whereas fear can produce a freezing response, action may overcome freezing via known neurophysiologic pathways.13	Failing to help the climate-distressed patient figure out what actions they can take may reinforce paralysis.

From a psychological point of view, engagement in concert with others should be recommended for two reasons. Relationships help provide containment for potentially overwhelming feelings. The second reason for doing this work with others is the phenomenon of disavowal. In our awareness of climate change and its implications, we are all emerging from various degrees of disavowal, a phenomenon of disavowal. For doing this work with others is the containment for potentially overwhelming feelings. The second reason for doing this work with others is the phenomenon of disavowal.

Moreover, there are many specialized climate related projects within particular areas and professions that psychiatrists or patients can volunteer for or professionally pursue. An upside of the complexity of climate is that there are uses for everyone’s interests or skills. Any climate-anxious patients can be encouraged to engage in a way that feels right and empowering for them.

In part 2 of this discussion of Climate Anxiety, specific psychotherapeutic and countertransference issues in dealing clinically with climate change will be described.

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References
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Let us hear from you!
Risk of Major Malformations Following First-Trimester Quetiapine Exposure

Brian Miller, MD, PhD, MPH

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In 2008, the National Pregnancy Registry for Atypical Antipsychotics (NPRAA) was established at Massachusetts General Hospital to systematically gather post-marketing reproductive safety data for second-generation antipsychotics (SGAs). Presently available data do not suggest that SGAs as a class are major teratogens, nor has a specific pattern of malformations associated with exposure to these agents been identified. Quetiapine is the most commonly prescribed SGA, and therefore an understanding of its reproductive safety profile from rigorously designed cohort studies is critical.1

Cohen and colleagues2 determined the risk of major malformations among infants exposed to quetiapine during pregnancy compared with a group of infants whose mothers had a history of psychiatric morbidity but who did not use a second-generation antipsychotic during pregnancy. Pregnant women aged 18 to 45 years with a history of psychiatric illness were enrolled. Participants were systematically interviewed at enrollment, at 7 months’ gestation, and at 12 weeks’ postpartum, and provided consent to the release of obstetric and pediatric records. Data from interviews and medical records were abstracted using a standardized outcome template. Redacted records of suspected major malformations were sent to a dysmorphologist for final blind adjudication, to rule out chromosomal, single-gene, and minor anomalies.

Baseline demographic and clinical characteristics were compared between quetiapine-exposed and control groups. The exposure of interest was defined as use of quetiapine during the first trimester of pregnancy (<13 weeks gestational age). The comparison group comprised women with psychiatric disorders who did not use SGAs during pregnancy (but may have used other psychotropic medications). The primary outcome measure was the presence of a major malformation—defined as a structural abnormality with surgical, medical, or cosmetic importance—identified within 6 months of birth. The researchers used unconditional logistic regression to estimate the odds for major malformations between groups, controlling for potential confounding factors.

Between 2008 and 2017, 888 women were enrolled in the registry, of whom 357 had evaluable data and first-trimester SGA exposure; 152 of these women used quetiapine during the first trimester, resulting in 155 live births (3 sets of twins). A total of 205 control women with evaluable data had 210 live births (5 sets of twins). Medical records were reviewed for 88% of participants. Mean age was 33, and mean baseline BMI was 26. Women exposed to quetiapine were more likely to have a diagnosis of bipolar disorder, and unexposed women were more likely to have a diagnosis of either depression or anxiety. Some women in the exposed group (83%) used quetiapine throughout pregnancy.

The primary outcome was the prevalence of major malformations. One percent among infants with first trimester quetiapine exposure and 1.4% among infants not exposed to SGAs. Two major malformations were reported among infants with quetiapine exposure: transposition of the great arteries and pulmonary stenosis. The prevalence of major malformations was 1.3% among infants with quetiapine exposure, whereas those with no exposure had an odds ratio of 1.36 (95% confidence interval 0.90-2.00). Maternal BMI did not differ between groups, controlling for potential confounding factors.

The bottom line
Findings from the study suggest that quetiapine is not a major teratogen. However, the results can rule out only an approximately 5-fold increased risk of major malformations (comparable to that seen with medications such as valproate). They note that risk of malformations must be considered in the con-
was purportedly done to aid our ally, South Vietnam, in defending itself from an armed takeover by its communist neighbor, North Vietnam. But the war turned out to be far more challenging and costly than anticipated and resulted in a strategic defeat, if not a tactical one. The eight years of fighting in Vietnam involved almost 2.6 million American servicemen and women and produced 47,400 combat deaths and over 350,000 additional wounded in action. In fact, US casualty numbers for Vietnam eclipsed those for World War I (321,000) and were double those for the Korean War (158,000). Compared with the more recent wars in Iraq and Afghan-istan, the Vietnam War produced roughly 7.5 times as many US military deaths from all causes as occurred in these two theaters combined.

An estimated 200 psychiatrists, including two women, served in Viet- nam with the Army, Navy, and Air Force between 1964 and 1973. Among the roughly 135 who served with the Army (66% of the troops in Vietnam), two-thirds were drafted civilians—citizen soldiers—while the remainder received their psychiatric training in military residency programs. Most psychiatrists served a single 12- to 13-month deployment. Dr Peter B. Livingston was the only fatality, and he is remembered on the Vietnam Veterans Memorial Wall.

The mental health challenges that arose in Vietnam over the course of the war were in many respects both prodi-gious and unprecedented. During the first half of the war, the deployed psy-chiatrists treated, or supervised treat- ment of, a wide but manageable array of psychiatric conditions, but they saw surprisingly small numbers of combat exhaustion cases (i.e., combat stress reaction cases), compared with the numbers from earlier wars.

Cases that did arise were effectively treated, at least by military standards, by specialized and non-specialized psychi-tratic personnel applying the traditional military forward treatment doctrine (i.e., brief, simple treatments such as safety, rest, wound care, and physical replen-ishment; peer support; and opportuni-ties for emotional catharsis, all applied as close to the soldier’s unit as practical and accompanied by expectations of rapid recovery of duty, even combat function). In many instances these treat-ments were augmented with psychotro-pic medications.

In time, and resonant with the growing anti-war movement, civilian psychiatronists began to question whether the soldiers so treated were at greater risk in subsequent combat or were more vulner-able to developing delayed psychiatric conditions as veterans. Whereas these doubts were new in the modern history of military psychiatry, the concerns were never systematically addressed.

As the war lengthened, mounting ev-idence suggested that the enemy’s guer-rilla strategy and tactics, the bloody, ambiguous, and often discouraging na-ture of the fighting, and the rising oppo-sition to the war at home, were causing increasing numbers of low-grade psy-chological and psychosomatic reactions as well as behavior disorders such as heavy drug use (typically marijuana at that point) and excessive combat ag-gression. Some deployed psychiatrists came to think that these symptoms and behaviors were collectively expressive of “partial trauma” or “strain trauma” (emotionally taxing events—singular or recurring—that were not of sufficient intensity at the time to make them dis-abling, but that were nonetheless psychi-ATRICAL). It is especially noteworthy that from the outset, military psychiatrists went to Vietnam supplied with medications not previously used on the battlefield: neuroleptics, anxiolytics, and the tricy-clic antidepressants. In contrast to the sedatives that were used sparingly in earlier wars because they could pro-duce sustained CNS depression and interfere with military performance, these new medications were widely prescribed and thought to produce sal-uatory results. In this respect, the record reveals a great deal of imprudence in the use of these medications under unique war-time conditions.

Psychiatric matters became expon-entially more difficult in the second half of the war following the enemy’s Tet Offensives in the winter of 1968 and the consequent social upheaval in the US. Opposition to the war at home rapidly accelerated to become highly charged and confrontational. Although (CONTINUED ON PAGE 26)
The so-called “problem” film emerged during the 1930s during the Great Depression. It rejected Hollywood’s traditional addiction to neat happy endings. Films like I Am a Prisoner in a Chain Gang (1939) and The Grapes of Wrath (1940) addressed the era’s poverty and economic injustice. Studio moguls were initially doubtful about “message” movies’ commercial viability. Who wanted dispirited audiences to exit the theater more bombarded out then when they came in? The problem genre proved unexpectedly popular. Warner Brothers, under the charismatic dictatorship of Darryl Zanuck, notably figured in producing inexpensive, gritty hit message pictures. Eventually other studios cashed in on the trend. Who came in? The problem genre’s promise of a satirical resolution of the real world’s unhappiness prevailed. (To be fair, no further action needed to be taken in the real world. [54x599]For the studio mandate that good always prevailed.)

BlackKkKlansman

Deep into BlackKkKlansman, Lee has continued to underplay the Klan’s menace. The prevailing tone has been jocular/satiric (eg. Duke’s wacky truths about identifying “hidden” blacks by their speech nuances).

The Klan klatch resembles a bumbling preadolescent clubhouse, with arcane symbols, secret words, arcane regalia. Despite flaunting a murderous arsenal, the doofus bunch doesn’t bring off a single cross burning because of utter incompetence and the undercover unit’s tip-offs. When Duke visits Colorado Springs to induct new members, Lee again unpacking the old Hollywood mentality of Duke’s new, supposedly user-friendly “nationalist” Klan. The ceremony is a sinister mirror of a church mass robed in priestly vestments, Duke openly advocates extinguishing the impure legions of blacks, Jews, and Catholics threatening God-given white Christian rule. A celebratory screening of DW Griffith’s The Birth of a Nation follows, its mockery and mayhem giddily cheered on by the yahoo initiates and their families.

In a simultaneous student meeting elsewhere, an aged activist describes the gruesome torture and lynching of a friend during his boyhood. Intercutting between Klan and student meeting recapitulates many of Griffith’s seminal contributions to cinematic rhetoric. Lee clearly uses the device here as an anti-tribute.

Shortly afterwards Ron pulls off Patrice’s last-second rescue from a bungled Klan bombing, which causes the chapter’s exposure and dissolution. Back at headquarters, Ron receives a high-five from all. Too boot, the arch-sleazy racist cop is entrapped in sexual misconduct by the team, and jailed. The rejoicing is extinguished by the chief summarily ordering the record of the team’s triumph expunged.

Haunting memories of the elder activist’s scarring tale echo in one’s mind as Lee delivers the devastating deconstruction of the problem genre’s disingenuous conclusion he’s been cannily preparing the viewer for. Patrice and Ron meet at her apartment. As they debate their relationship—now she knows he’s a cop—there’s an ominous rap at the door. In a magisterial Hitchcockian tracking shot the pair seems to float uncannily forward, as the background eerily recedes. The rejoicing is extinguished by the pair seems to float uncannily forward, as the background eerily recedes. The team’s triumph expunged. Patrice’s last-second rescue from a bungled Klan bombing, which causes the chapter’s exposure and dissolution. Back at headquarters, Ron receives a high-five from all. Too boot, the arch-sleazy racist cop is entrapped in sexual misconduct by the team, and jailed. The rejoicing is extinguished by the chief summarily ordering the record of the team’s triumph expunged. Haunting memories of the elder activist’s scarring tale echo in one’s mind as Lee delivers the devastating deconstruction of the problem genre’s disingenuous conclusion he’s been cannily preparing the viewer for. Patrice and Ron meet at her apartment. As they debate their relationship—now she knows he’s a cop—there’s an ominous rap at the door. In a magisterial Hitchcockian tracking shot the pair seems to float uncannily forward, as the background eerily recedes. The two move toward a tiny pinprick of light in the window. Lee’s camera swoops down revealing a giant burning cross, circled by an obscenely capering coven of klansmen. History is knocking at the door!

Lee instantly cut jumps to actual TV coverage of the fatal confrontation at Charlottesville between white supremacist acitists and protestors. The sequence utterly confounds every assertion of “good people” on both sides. While this scene comprises a fraction of BlackKkKlansman, one realizes with a start that all that’s come before was a

Safely ensconced in our seats, rapt in Lee’s front story, we’ve been lulled into feeling safely distant from the racism raging in a deeply divided America.

BlacKkKlansman

Still Birth of a Nation
necessary prelude to the director’s jarring wake-up call.

*BlacKkKlansman* ends in utter silence: an inverted American flag fills the screen, the distress call is emphasized as the flag’s luminous color fades to stark, lingering black and white. The conclusion is a derisive response to Lee’s establishing sequence: the famous scene from *Gone With the Wind* (1939) in which the camera pans across a multitude of wounded Confederate soldiers, and rises to a fitfully stirring “Stars-and-Bars.” *Gone With the Wind*—Zanuck’s Griffithian triumph—never depicts a whit of slavery’s intolerable suffering. Safely ensconced in our seats, rapt in Lee’s front story, we’ve been lulled into feeling safely distant from the racism raging in a deeply divided America. Lee has dashed the comfortable illusion of social progress, given back to us the keys of responsibility for honorable action to stem the swelling tide of racism, as well as the host of articulated evils destroying our country’s social fabric.

Although, *BlacKkKlansman* is threaded with references to the distorted glosses on racial injustice that have pervaded American cinema since its inception Lee chiefly targets the problem film’s facile comfort. Lee’s withering denunciation embraces Griffith’s repugnant summons to violence, implicit commendation of slavery in *Gone With the Wind*, as well as the pseudo-positive depictions of the sixties blaxploitation genre—at one point even Ron and Patrice argue whether the phallic stereotypes of *Shaft* (1971) or *Super Fly* (1972) offer African-Americans more empowerment.

In 1919, *The Birth of Nation* was the first feature ever shown at the White House. Woodrow Wilson called it “history written with lightning,” inaugurating a resurgence of a nearly defunct Klan. A century later, Lee answers Wilson’s detestable accolade—illuminating with actinic brilliance enduring racism’s repugnant emblem of national disgrace.

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**YOU ARE INVITED**

**Portraits of a Psychiatrist’s Life**

With the help of the editors at *Psychiatric Times* and Editorial Board member H. Steven Mofﬁc, MD, we invite you to write an article about anything, from a day in your life to a transformative experience, for a series of articles about psychiatry and self-disclosure, “Portraits of a Psychiatrist’s Life.” It is meant to give a sense of the conﬂict, complement, and/or overlap between personal and professional lives and how one can seep into the other.

The article should convey a lesson learned or offer readers ideas to consider in their own lives and daily struggles and possible growth. Although the articles aren’t clinical per se, authors should feel free to use references and/or an additional-reading list. The goal is to help psychiatrists, so any additional information and resources could prove useful. Of course, we always need to be careful about conﬁdentiality. Obviously, authors are aware these will be published after review, but if you are contributing stories that include patient information, the patient’s identity should be obscured.

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INTRODUCTION:
Gender-Specific Issues Relative to Mental Illness

Anita Riecher-Rössler, MD

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Florence Thibaut, MD, PhD

Researchers and clinicians have recently become more interested in sex and gender differences in mental disorders. The reasons for this are manifold. On the one hand, sex and gender differences belong to the most stable findings in psychiatry and it is hoped that explaining them would provide interesting clues regarding the etiology of certain disorders. On the other hand, psychiatrists and psychotherapists increasingly understand that we can only deliver optimal psychiatric therapy and care if we take these differences into account.

This Special Report offers articles on gender specific issues relevant to mental disorders. Mary Seeman, MD, focuses on clinical implications of gender differences in schizophrenia. In fact, many sex and gender differences in schizophrenic psychoses have been reported, but few have been soundly replicated. A stable finding is the later age of onset in women compared with men.

A better understanding of the different etiologies and pathogenetic pathways of schizophrenic psychoses in women and men on sex (biological) and gender (psychosocial) factors is needed to better tailor treatments and improve outcomes.

Michelle Mielke, PhD, provides a very informative review on sex and gender differences in Alzheimer dementia. She concludes that the study of these differences is still in its infancy compared with other areas of medicine such as cardiology. She explains that in cardiology a better understanding of sex and gender differences has led to improved treatment and care for both women and men, and the same should happen regarding dementia.

Bronwyn Graham, PhD, offers insight into gender vulnerabilities for anxiety disorders and the influence of sex hormones. She states that our understanding of the role of sex hormones in anxiety in women, while increasing, is still in its infancy, and if sex bias in anxiety research is not addressed, our understanding and treatment of anxiety will remain less rigorous for women. She also suggests ways that clinicians can already integrate existing knowledge into their daily practice.

In her article, Florence Thibaut, MD, PhD, discusses gender differences in addiction and their clinical implications. Findings from recent epidemiological studies indicate an alarming increase in the prevalence of dependence in adult women. Women’s consumption of psychoactive substances during pregnancy can be associated with serious consequences for the child. However, female outpatients are still underrepresented in specialized treatment settings. Providing services adapted to the needs of women, especially for those of childbearing age, is of emergent importance.

All the authors stress that mental health research often ignores sex and gender differences as well as the different risk factors and protective factors for both women and men. This is unfortunate, because not to investigate potentially different causal pathways and treatment responses of both genders not only undermines scientific validity of research, but also results in a failure to deliver gender sensitive treatments.

It is therefore high time for a shift in practice and research. Sex and gender aspects must be addressed more rigorously in research, psychiatric training, and clinical practice. This includes more research on gender differences in illness behavior, coping, help-seeking, and compliance as well as psychopharmacology, hormonal therapies, or gender sensitive psychotherapy.

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Dr Riecher-Rössler reports no conflicts of interest concerning the subject matter of this Special Report.

References
Clinical Implications of Gender Differences in Schizophrenia

Mary V. Seeman, MDCM, DSc

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I did most of my psychiatric residency in the early 1960s on an all-women’s ward in New York City dedicated to research in schizophrenia. There were 30 beds and each patient stayed in the hospital for a long time, so I got to know the women well. I would describe them collectively as well-groomed, chatty, friendly, moody, and smart. It was consequently a shock when in 1975 in Toronto, Canada, I was put in charge of a schizophrenia outpatient clinic and discovered that the patients were mostly young men who were, by contrast to the women I had known, emotionally distant, apathetic, disheveled, and angry. Had my perception of people changed over the years, or, I wondered, does schizophrenia affect men and women differently?

Demographic differences

I wondered why there were so many more men than women in my new clinic. Part of the answer was because the incidence of schizophrenia is higher in men than in women, especially in young adulthood. Nevertheless, the prevalence appears to be similar, perhaps because more men than women with schizophrenia succumb to suicide and accidental death. The men in my clinic were mostly young adults, whereas the women in the clinic tended toward middle age. This forcibly brought home the point that men develop schizophrenia earlier in life than women by several years.

Functional differences

The relatively few women who were eager to attend clinic activities felt outnumbered. As a result, I started a women-only therapy group. The members of this group were very friendly with each other; gossiping about clothes and diets. They went out for coffee after group together. In other words, they showed little flattening of affect, few negative symptoms, few evident cognitive defects, although they harbored many delusions and reported a variety of hallucinations.

Why Sierra Tucson?

Legacy.

I would feel comfortable recommending Sierra Tucson to my own family members.

—George B., psychologist
Because the women’s group was going well, I invited the men to form their own group. By the end of a year of weekly group meetings, none of the eight men who had agreed to join knew the name of any other group member. They didn’t interact. All remarks in the group (mainly about sports, a little about cars) were addressed to me. There was evident poverty of speech, apathy, and many relatively blank facial expressions. There was also a manifest lack of grooming and basic hygiene in this group.

Outcomes over time
In 1985, I left the clinic to work at another hospital. I had learned that women with schizophrenia respond well to treatment. I had also noticed that they rarely had to be rehospitalized. Many of the women worked outside the home. Many stayed in committed intimate relationships and forged strong therapeutic alliances with their care providers. At the same time, I had unfortunately witnessed many male suicides; many men who abused alcohol and many who required extremely high dosages of antipsychotics. Most of the men did not work and continued to be dependent on aging parents.

Eight years later, I returned to the clinic, where I was in for an unexpected shock. The forlorn, listless men I had said goodbye to welcomed me back warmly and told me jokes! In some cases, their parents had died, so they now lived in group homes and were managing surprisingly well. They seemed content, even purposeful. They spent socially productive time in the hospital cafeteria, chatting and laughing with their buddies. On the other hand, the once high-achieving women had lost their jobs, were cycling in and out of the hospital, and were no longer responsive to their medications.

I am generalizing, of course, and there was much overlap between the men and the women, but the pattern was very clear. The men were doing better while the women were doing worse.

Explanations for sex differences in schizophrenia
One explanation for these observations about sex differences in this disease rests on the many and varied neuroprotective actions of estrogens. The hypothesis is that female hormones delay the onset of schizophrenia, allowing women to finish their schooling and to acquire substantial interpersonal skills before illness puts a stop to further socialization. Estrogens help the antipodalaminergic action of antipsychotics so that dosages can stay relatively low in women, preventing adverse effects and, thus, permitting steady dosing and the development of personal relationships. At menopause, however, these advantages are lost.

Further evidence confirmatory of the estrogen hypothesis is premenstrual (low estrogen) exacerbation of psychotic symptoms in women, postpartum exacerbations, and the significant improvement brought about when estrogens or selective estrogen receptor modulators (SERMs) are added to the medication regimen. The estrogen hypothesis is not wholly satisfactory, however. Ovaries are not functional in fetal life, so much of the estrogen found in human fetal brain comes from the testosterone derived from testes in boys. Thus, the brains of girl fetuses are exposed to relatively less estrogen. Because fetal life is when schizophrenia allegedly starts, why are male brains not more (rather than less) protected than female brains at the outset?

Perhaps the early female advantage lies not only in hormones but also in the double X chromosome, in sexually dimorphic microglia, in epigenetic effects on schizophrenia genes, or structural differences in male and female brains, and in gene–environment interactions.

Clinical implications
Prevention. Primary prevention rests in the hands of women and their clinicians. With knowledge and guidance, affected women can minimize the risk of schizophrenia in offspring by choosing male partners without a history of psychosis, who are younger than age 40 (but not too young either), and who live in their country of origin. They can time conception to avoid birth in late winter or early spring. Most importantly, they can be very assiduous in attending prenatal appointments, taking prescribed immunizations and vitamin/mineral supplements, paying attention to diet, avoiding alcohol and drugs of abuse, keeping antipsychotic doses low, managing their stress levels, avoiding infections whenever possible, and not tolerating any form of domestic abuse.

Clinicians need to ensure that pregnant women with schizophrenia are monitored frequently and have adequate incomes, safe housing, and sufficient social support. Children of both male and female parents with schizophrenia require careful monitoring and support throughout childhood and adolescence to prevent the development of psychosis or to catch and sidetrack psychotic symptoms, should they develop.

Finally, contraceptive guidance and genetic counseling are also important aspects of prevention.

Diagnosis. Diagnostic strategies differ in men and women. In men, it can be difficult to distinguish the beginning of schizophrenia from substance-induced psychosis. In women, because affect is preserved, schizophrenia is not easily distinguishable from affective psychosis. Also, in women, differential diagnoses such as anorexia-induced psychosis, steroid psychosis, thyroid disease-associated psychosis, and psychosis secondary to autoimmune disorder and its treatment need to be actively considered.

Treatment
Physical health. Maintenance of physical health is very important in schizophrenia because mortality rates are high. Psychiatrists need to ensure that their patients stay in regular contact with a general practitioner and that men and women are screened for disorders relevant to their sex (ie, cervical smears, breast examinations and mammograms, prostate and colon cancer screening), that they are adequately immunized against infectious agents, and regularly checked for the sequelae of chronic intake of antipsychotic medication (ie, obesity, diabetes, hypertension, osteoporosis, cardiovascular disease). Psychiatrists should advocate for their patients to ensure prompt and state-of-the-art care when they are ill.

Reproductive issues. Antipsychotics have sexual adverse effects that need to be asked about and addressed. Intimate relationships and contraceptive methods require attention. Women with schizophrenia usually have questions about changes in their menstrual periods and many experience premenstrual exacerbations of symptoms. Because of antipsychotic adverse effects, some women may believe that they are pregnant when they are not, whereas women who want to be mothers may find it difficult to conceive. Some pregnant women may deny their pregnancy; others may seek abortions. Pregnant women should be seen often, their medication dosages adjusted carefully, and their domestic situation addressed with referrals not only to obstetrics but also to affordable housing, income support, and substance abuse programs as necessary. Family meetings usually become necessary at this time to garner as much support as possible for the mother-to-be.

The postpartum period is a time of risk for women with schizophrenia. Home visits are important, with monitoring required for both mother and baby. Parenting support is critical and help from a child welfare agency may be necessary. The question of breast-feeding needs to be addressed, with most guidelines recommending no breastfeeding because of unresolved safety concerns about psychotropic medications. If a medication is taken immediately after breastfeeding and just before the infant’s longest sleep period, however, and the infant’s serum drug level is monitored, there are definite advantages to breastfeeding for both the baby and mother. Consultation with a lactation expert is helpful. It is critical that mothers not stop their medications during this vulnerable time.

The menopausal transition is an important one for all women. Most women experience symptoms of menopause that need to be anticipated and effectively treated. The personal meaning of menopause needs to be explored with women who have schizophrenia. Unfortunately, psy-
chotic symptoms may worsen during this time and antipsychotic dosages may have to be adjusted.

Safety. Safety issues are of utmost importance in the treatment of schizophrenia. Patients with severe mental illness need to be protected from their own sometimes very unhealthy lifestyles and from suicidal urges. A suicide in a treatment setting can lead to chain events in a vulnerable population. Treatment with antipsychotics can also pose risks in situations in which being fully alert matters (ie, driving, operating heavy machinery, looking after young children).

Women, more than men, must be protected from exploitation and violence inflicted by others, whether intimate others, co-patients on hospital wards, or strangers. Both men and women need protection from stigmatizing attitudes, in particular on the part of childcare workers (women), police, and the justice system (men) as well as medical professionals (men and women).

There are also understandable safety concerns about individuals with schizophrenia acting on dangerous delusional beliefs and command hallucinations, especially when intoxicated. Family members are most at risk.

Medication dosage. Standard antipsychotic treatment frequently requires modification in women. Women respond to lower dosages and, because they are usually on many more different medications than men and have a more active immune system, they experience more adverse effects. Dosages may need to be adjusted over the menstrual month, during pregnancy, the postpartum, and the menopausal transition. In older age, dosages should be kept low in both women and men.

Several other clinical interventions useful to individuals with schizophrenia, such as exercise programs, substance abuse programs, employment programs, and weight-loss programs also benefit from sex-specific modifications.

Conclusion
In an ideal world, each patient is treated individually because no two persons are identical, but that may be impossible for now. Differentiating between men and women is a first step.

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

References

SUGGESTED READING
Sex Hormones and Gender Vulnerabilities to Anxiety Disorders

Dr. Bronwyn M. Graham, MPsychol (Clinical), PhD

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Large-scale mental health surveys have consistently shown that the prevalence of anxiety disorders and related conditions is approximately 1.5- to 2-fold higher in women than it is in men.1,2 Despite similar patterns that occur across all anxiety subtypes, this sex difference appears most pronounced for PTSD, generalized anxiety disorder, and specific phobias.

Although the sex imbalance in the prevalence of anxiety disorders is undisputed, debate surrounds its source. Social and environmental factors undoubtedly contribute to the imbalance, for example: men may be less inclined to report anxiety symptoms because of stigma.

The socioeconomic status of men and women is often different. Thus, their daily stressors are also different as is their ability to access coping resources. Although men and women may experience trauma similarly, there are stark differences in the nature of these traumas, with sexual assault (itself a strong risk factor for PTSD) being 10 times more prevalent among women.3

Apart from environment, the neurobiology of men and women also differs substantially. Responsible for many of these differences is sexually divergent gonadal sex hormone synthesis, with the male testes primarily producing testosterone and the female ovaries primarily producing estradiol (the main estrogen) and progesterone. Apart from minor diurnal fluctuations, postpubertal males have relatively steady levels of testosterone throughout their adult lives, followed by age-related declines. In contrast, postpubertal females experience dynamic fluctuations in estradiol and progesterone on a monthly basis due to the menstrual cycle and across the lifespan due to hormonal contraceptive use, pregnancy, parturition, and menopause.

Sex differences in the prevalence of many anxiety subtypes do not emerge until puberty. Similarly, many women exhibit increased vulnerability to anxiety during the postpartum and perimenopausal periods, times of substantial hormonal flux. Sex differences in hormone exposure and stability may exacerbate women’s risk for anxiety by interacting with the putative factors that underlie the pathogenesis of anxiety.

Why do anxiety disorders develop and persist over time?

Cognitive-behavioral models posit that genetically vulnerable individuals react in maladaptive ways to negative or stressful precipitating events that trigger the onset of anxiety symptoms (Figure 1). Several key factors subsequently prevent anxiety from spontaneously remitting. In brief, anxious individuals grossly overestimate the likelihood and the consequences of potential threat in a given situation. These catastrophic predictions fuel the physiological and affective symptoms of anxiety, thereby promoting the use of maladaptive behavioral coping strategies, most notably avoidance. Avoidance precludes the individual from acquiring corrective information about the true level of threat in the situation. Thus, the catastrophic cognitions (and in turn, the anxious symptoms) are maintained.

Cognitive behavioral therapy (CBT), the first-line psychological treatment recommended for anxiety disorders, disrupts this self-perpetuating cycle by modifying catastrophic thoughts. CBT comprises exposure therapy, in which the patient is taught to confront anxiety-eliciting situations without engaging in avoidance tactics, and cognitive restructuring, in which the patient collects evidence from multiple sources, including conducting his or her own experiments, to test the validity of (and ultimately undermine) catastrophic beliefs.

Role of sex hormones in persistent anxiety

Aside from their key role in reproduction, sex hormones (in particular, estradiol) facilitate neural plasticity, including initiation of intracellular signaling cascades, gene transcription, and growth of dendritic spines and synapses. This occurs in both females and males—many of testosterone’s actions in the brain result from its aromatization to estradiol.4 Because of cyclic fluctuations in sex hormones, postpubertal females exhibit substantial basal changes in key markers of neural plasticity in brain areas involved in memory formation.

Neural plasticity is essential for learning as well as the formation of new memories—including the learning that occurs during exposure to stressful or traumatic events, and the safety learning that occurs during CBT for anxiety. It is possible that different sex hormone levels create a state of neural plasticity that is more or less permissive for the formation of both kinds of memories. We have proposed a two-pronged model, wherein the consequences of fluctuating neural plasticity in women may differ depending on what is happening in the external environment at the time (Figure 2).5

In brief, high sex hormone levels (and resulting increases in brain plasticity) during stress or trauma may facilitate over-consolidation of these experiences, thereby increasing the propensity to develop anxiety disorders. Conversely, once anxious symptoms have developed, high sex hormones may be beneficial during CBT by facilitating the formation of new safety memories and more adaptive means of coping.

Laboratory and clinical studies provide initial support for the central hypotheses in this model. Results from studies have demonstrated that intrusive recollections (a key symptom of PTSD) of traumatic images and films are stronger in women during periods of high sex hormones.6 Women who experienced traumatic injury during a high hormonal menstrual phase reported more numerous negative flashbacks in the subsequent week compared with women who experienced traumatic injury during a low hormonal phase.7 Women who accepted emergency contraception (which suppresses sex hormonal synthesis) following sexual assault reported reduced post-trauma reactions relating to sexual assault.

FIGURE 1. A cognitive behavioral model of anxiety disorders

- Genetic vulnerability + precipitating event(s)
- Catastrophic beliefs
- Physiological/affective anxiety symptoms
- Behavioral avoidance

Significance for Practicing Psychiatrists

This article describes evidence for the mechanisms by which postpubertal fluctuations in sex hormones may facilitate the development of anxiety disorders and modulate the efficacy of anxiety treatments in women.

- Following puberty, women are 2 to 3 times more likely to have anxiety disorders relative to men
- The sex hormones estradiol and progesterone facilitate neural plasticity, which may lead to the overconsolidation of stressful or traumatic experiences, potentially increasing anxiety symptoms
- Conversely, heightened estradiol and progesterone during psychological treatments for anxiety may improve outcomes by facilitating the consolidation of safety memories and adaptive coping methods
Role of sex hormones in fluctuations in anxiety symptom severity

In addition to potentially modulating the development and persistence of anxiety symptoms, fluctuating sex hormones are also associated with changes in anxiety symptom severity. Increases in symptom severity have been observed during periods of declining or low sex hormones in women with panic disorder, social anxiety disorder, PTSD, and obsessive-compulsive disorder, which share clinical features of anxiety.³

Although it is unclear what mediates this effect, it is known that women report maladaptive coping strategies more so than men do. One possibility is that women may alter the types of coping strategies that they use depending on their levels of sex hormones. For example, women report increased use of avoidant coping styles during the premenstrual phase (declining sex hormones).

The impact of a given coping strategy may also differ dependent on sex hormones. Although women tend to ruminate (a maladaptive coping strategy) more during periods of high estradiol, the negative impact of rumination on mood has been found to occur only in women with low estradiol.¹⁰ Hormone-associated instability in coping strategies may further exacerbate anxiety by decreasing women’s ability to self-control symptoms.

Practical considerations for screening, diagnosis, prevention, and treatment

Our understanding of the role of sex hormones in anxiety in women, while increasing, is in its infancy. Current psychobiological models of anxiety (which drive innovations in anxiety treatments) are biased in favor of males because of a preponderance of studies solely focused on male rodents and human studies inadequately powered to assess for sex differences. Regardless of whether the sex imbalance in the prevalence of anxiety disorders is primarily driven by reporting biases, or non-organic factors, female variables such as menstrual cycle and hormonal contraception, which have been historically ignored, are likely relevant to the pathogenesis and treatment of anxiety.

New mandates requiring the consideration of sex as a biological variable in research funding applications may foster a more nuanced understanding of the relevant sex-specific factors to consider when making diagnostic and treatment decisions for anxiety disorders.

In the meantime, clinicians can help to raise the profile of this important issue, and make use of the existing research base, by integrating the following considerations into their practice:

1. Conduct an assessment of the onset and exacerbation of anxiety symptoms in relation to hormonal events (eg, use of hormonal contraception, menstrual cycle, pregnancy, parturition, perimenopause); consider changing/removing hormonal contraception if a link is established.

2. Routinely provide psychoeducation to increase women’s awareness of a potential link between hormones and anxiety, both following symptom onset and pre-emptively (eg, in patients about to experience significant hormonal change, such as preadolescents, before starting hormonal contraception, and in pregnant women and perimenopausal women).

3. For patients with anxiety disorders, encourage incorporation of menstrual cycle phase (or other hormonal events) in routine monitoring of symptom fluctuation. This may increase the sense of control over symptoms by facilitating predictability and fostering targeted use of adaptive coping strategies during identified times of heightened vulnerability.

4. Consider timing exposure therapy during periods of optimal hormonal levels. Women on hormonal contraception may require more extended treatment sessions to achieve benefit. Note that this consideration is based on one clinical study on specific phobia, however, and the utility of this approach for other anxiety disorders awaits more extensive empirical investigation.

5. Women’s tendency to engage in maladaptive coping styles is well established. This should be a focus of attention during clinical assessment of women. Women may especially benefit from targeted cognitive interventions for anxiety (eg, rumination-focused CBT) that directly correct these maladaptive coping styles.

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

References


FIGURE 2. Theoretical consequences of the interaction between high and low hormonal states and environmental events

<table>
<thead>
<tr>
<th>Hormonal state</th>
<th>Environment</th>
<th>Consequence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low sex hormones/reduced neural plasticity</td>
<td>Negative precipitating event(s)</td>
<td>Development of anxiety</td>
</tr>
<tr>
<td>High sex hormones/increased neural plasticity</td>
<td>Cognitive behavioral therapy</td>
<td>Persistence of anxiety</td>
</tr>
</tbody>
</table>

Blue-shaded squares indicate consequences mediated by low hormonal states (via the pathways indicated by unbroken arrows); pink shaded squares indicate consequences mediated by high hormonal states (via the pathways indicated by broken arrows).
Sex and Gender Differences in Alzheimer Disease Dementia

Michelle M. Mielke, PhD

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Alzheimer disease (AD) dementia is the most common form of dementia, comprising 60% to 70% of all cases. AD is a progressive neurodegenerative disease that causes memory loss, cognitive deficits, and behavioral changes. The hallmark characteristics of AD include the presence of extracellular amyloid-beta plaques, intracellular neurofibrillary tangles, and neurodegeneration. With the aging of the population, the burden of AD dementia is growing to epidemic proportions. More than five million people in the US have a diagnosis of AD, and it is estimated that by 2050 14 to 16 million will have a diagnosis unless new treatments or interventions to prevent or delay the onset of AD are identified. A declining trend in the risk of dementia has been reported for several high-income countries in the past 20 to 30 years. The impact of these trends on the future remains uncertain, however, and it is not clear what type of dementia may be driving these trends.

Precision medicine techniques and approaches have emerged over the last decade that have advanced our understanding of the pathophysiological changes associated with the development and progression of AD dementia. However, the examination of sex and gender differences has not been well integrated into these approaches. This is surprising given the extensive literature demonstrating sex differences in brain structure and function over the lifespan.

Several misconceptions also exist about the study of sex and gender in the AD field. The initial focus of this article is on whether women are at greater risk. A few examples of risk factors for AD that differ by sex are provided, followed by an overview of potential differences in comorbid neuropsychiatric symptoms. Throughout, we utilize the definitions of sex and gender from the Institute of Medicine. Sex refers to the biological and physiological differences between women and men, with the sex chromosomes (X and Y) contributing to these differences. Gender refers to a combination of environmental, social, and cultural influences on women and men. Gender is rooted in biology, but it is primarily shaped by environment and experience.

Are women at greater risk for AD dementia?

Historically, the primary reason stated for examining sex or gender differences in AD dementia is that “women are at greater risk” and that there is a need to understand what factors contribute to the greater risk for women. This rationale needs to be reassessed. About two-thirds of persons with a diagnosis of AD dementia are women. However, life expectancy for women is longer than for men, and age is the greatest risk factor for AD dementia. As a result, and similar to other aging-related diseases, the lifetime risk of AD dementia is greater for women. Although the incidence of AD dementia is higher in women, sex differences in the incidence of AD dementia are less clear.

In the US, study data overwhelmingly show that the incidence of AD dementia does not differ by sex, even after the age of 85 years. In other areas of the world, however, women appear to have a higher incidence. Findings from studies in several European countries indicate that women have a higher incidence of AD dementia after the age of 80. Nevertheless, the Cognitive Function and Aging Study in the United Kingdom, however, initially reported a higher incidence for men.

The reasons for these discrepancies are not well understood but suggest that sex and gender differences in the incidence of AD dementia may depend on the period of time and geographic region. For example, the experiences of World Wars I and II were vastly different in European countries compared with the US and in men compared with women. Further study of these worldwide differences is needed and would provide an opportunity to identify modifiable risk factors for AD dementia. Notably, these studies also highlight the fact that AD is not a disease unique to women, but that many men are also affected.

Sex and gender differences in risk factors for AD dementia

Even if women and men have the same incidence of AD dementia (age- and sex-specific incidence rate), the mechanisms, pathways, and risk factors can still differ. Many studies examining risk factors for AD adjust for sex in the analyses but do not determine whether there are actual sex differences (i.e., whether the strength of the association between a risk factor and AD dementia differs by sex). There are multiple scenarios by which sex and gender differences could affect the risk of AD dementia (Table). Examples of sex differences in risk factors. Compared with men, women have twice the risk for depression. Depression has implications for cognition across the lifespan because mood and memory map to some of the same brain regions. Studies report that depression is a risk factor for AD dementia in both women and men. Estimates range as high as a 70% increased risk of AD dementia for those with depression in middle-life. Therefore, because the lifelong prevalence of depression is greater in women, a diagnosis of depression may have a greater overall impact for AD dementia risk among women.

In contrast to depression, men have a greater overall prevalence of sleep apnea, although the prevalence of sleep apnea in women significantly increases after menopause. Sleep apnea and poor sleep quality have been associated with cognitive decline and an increased risk of AD dementia. Given that men have a higher prevalence of sleep apnea, the effect of this risk factor may have a greater overall impact in men. Notably, there is a lack of studies examining whether the association between sleep apnea and AD dementia differs by sex.

Examples of gender differences in risk factors. Lower levels of education have consistently been associated with an increased risk of AD dementia for both women and men. Historically, women have had fewer opportunities for higher education. Therefore, the risk of AD dementia attributable to lower level of education has been greater for women. One study suggested that a lower level of education may have a stronger deleterious effect for AD dementia in women, independent of their access to education. More recently, educational attainment for women has been higher than that for men in the US. The progressive improvement in education in women over the last century may be one explanation why the incidence of dementia may be declining more for women than men.

<table>
<thead>
<tr>
<th>TABLE. Scenarios by which sex and gender differences could affect Alzheimer disease and dementia risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Risk factors with the same frequency for women and men but that have a stronger effect on one sex or another (eg, APOE genotype or other genetic variants located on autosomal chromosomes)</td>
</tr>
<tr>
<td>• Risk factors that have the same effect in women and men but that have a different frequency (eg, historically, women have had less access to education and men have a higher frequency of smoking)</td>
</tr>
<tr>
<td>• Risk factors that differ by sex in frequency and effects (eg, head trauma is more common in men than women, but women may be more susceptible to the adverse effects of a head injury)</td>
</tr>
<tr>
<td>• Risk factors restricted to one sex (eg, pregnancy, oophorectomy; prostate cancer, androgen deprivation therapy)</td>
</tr>
</tbody>
</table>

APOE, apolipoprotein E.
Men who have never married or are widowed are at increased risk for AD dementia compared with women. A possible reason is that women have historically been responsible for the health care of their family (eg, getting partners/husbands to health care providers for regular check-ups, assuring a healthy diet), sometimes at the expense of their own health. Compared with single men, single women are more likely to see a health care provider and to engage in social activities, which are beneficial for cognition. Although these observations are a bit stereotypical and not true in all situations, they may explain part of the difference in risk.

Examples of sex-specific risk factors.
Hypertensive pregnancy disorders (HPD) affect approximately 12% of all pregnancies. A history of HPD has been associated with an increased risk of brain atrophy and cognitive decline decades after the pregnancy. However, the association between HPD and specific types of HPD and the risk of AD dementia has not been examined. The menopausal transition has been associated with a decrease in verbal memory, and early menopause (eg, either natural or surgical) has been associated with an increased risk of dementia. In particular, premenopausal bilateral oophorectomy resulting in the abrupt loss of ovarian hormones has been associated with both an increased risk of dementia and accelerated aging.

There is still much debate regarding the use of estrogen-containing hormone therapies and type (eg, conjugated equine estrogens versus 17β-estradiol patch) for mitigating the risk of AD dementia in women. Although initial results from the Women’s Health Initiative Memory Study suggested that women who were randomized to start taking estrogen therapy after the age of 65 years were at greater risk of dementia, recent clinical trials and observational studies have not found an association with cognitive decline or dementia risk when hormone therapy is initiated within 5 years of menopause. Findings indicate that it is safe to treat menopausal symptoms without worrying about an increased risk for dementia. Nevertheless, additional research is clearly needed.

Androgen-deprivation therapy (ADT) is now used for more than one-half of all men with prostate cancer at some stage after diagnosis. Some studies suggest that ADT is associated with cognitive decline and risk of dementia. Additional studies are needed to determine the long-term effects of ADT for risk of dementia in men.

Psychiatric symptoms of AD dementia
Most patients with AD dementia experience neuropsychiatric symptoms at some point during the course of the disease. These symptoms lead to poorer medical and functional outcomes as well as increased caregiver burden. Recent studies suggest that the distribution of neuropsychiatric symptoms may vary by sex. In a study of patients with newly diagnosed AD dementia who were not treated for AD or neuropsychiatric symptoms, women had a higher mean Neuropsychiatric Inventory score for depression, anxiety, and total neuropsychiatric symptoms.

Findings from another study indicate that women with AD dementia have higher depressive symptoms, whereas men are more likely to have agitation. Better characterization of the sex differences in neuropsychiatric symptoms among AD dementia patients will help to elucidate sex differences in the disease pathophysiology and to identify better treatment targets for women and men.

Conclusion
The study of sex and gender differences in the AD field is in its infancy compared with other areas of medicine such as cardiology. Research in the field of cardiology has shown that there are sex and gender differences in risk factors, symptom presentation, mortality, and treatment response for cardiovascular diseases. Better understanding of these sex and gender differences has led to improved care and treatment for both women and men.

The same positive outcome can occur for the prevention and treatment of AD dementia. We must

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move beyond the notion that women are at greatest risk and that AD dementia is a woman’s disease to focus on sex and gender differences.

This overview provided a few scenarios of sex and gender differences in risk factors for, and clinical presentation of, AD dementia. There will not be sex or gender differences in all risk factors or mechanisms. Identifying where there are differences, however, will provide better treatment and care for both women and men.

Dr Miele reports that she serves as a consultant to El Lilly and Lyssonoma Therapeutics, Inc. She receives research support from the NIH (R01 AG09704, U54 AG044770, U01 AG06768, R01 AG51513), the Department of Defense (W81XWH-15-1), and unrestricted research grants from Biogen and Lundbeck.

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D
dependence on or harmful use of alcohol and tobacco or illicit drugs is generally higher in men. Epidemiological studies, however, indicate an alarming narrowing in this gender gap especially in adolescents, which may reflect changes in sociocultural patterns rather than biology. Yet, health consequences significantly differ according to gender. In addition, women’s consumption of psychoactive substances during pregnancy may be associated with serious birth and developmental consequences in newborns.

The World Health Organization has defined different risks for occasional and chronic alcohol use in women, which are significantly lower in women: low risk (<20 g/d); moderate risk (>20–40 g/d); high risk (>40 g/d). There is no safe level for tobacco or illicit drug use.

Epidemiological differences

Slade and colleagues’ stratified 68 studies by 5-year birth cohorts from 1891 to 2001. In cohorts born in the early 1900s, males were 3.0 times more likely to drink alcohol (problematic use) and 3.6 times more likely to experience alcohol-related harm. In contrast, among cohorts born in the late 1900s, males were 1.2 times more likely to drink alcohol (problematic use) and 1.3 times more likely to experience alcohol-related harm.

Worldwide, the total alcohol per capita consumption in 2010 was on average 21.2 L and 8.9 L of pure alcohol in male and female drinkers respectively. Europeans and Americans had the highest prevalence of female current drinkers and heavy episodic drinkers—in defined as drinking at least 60 g or more of pure alcohol on at least one occasion in the past 30 days (Figure 1).

In the US, 10% to 11% of women were using alcohol during pregnancy in 2010. In France, findings indicate that on average 15.8% of women used alcohol during pregnancy. The prevalence of reported binge drinking (defined as four or more standard drinks on one occasion) was 3.1% in pregnant women compared with 18.2% in women of childbearing age. Higher rates of substance and alcohol abuse were found among minorities and adolescent LGBT populations.

The highest prevalence of tobacco use was reported in Europe (19.3% of women) followed by the Americas (13.5% of women, 17.5% of men in the US). The prevalence of tobacco use (cigarettes) was very similar among boys and girls in Europe and even higher in girls in the Americas. In the US, 14.9% of pregnant women reported tobacco use in the past month. The worldwide prevalence of cannabis, amphetamine, cocaine, and opioid use was 0.14%, 0.18%, 0.06%, and 0.14%, respectively in females compared with 0.23, 0.31, 0.14 and 0.31% in males (Figure 2). In the US, 12.8% of males and 7.3% of females aged 12 years and older used an illicit drug during the past month in 2015. More men than women aged 12 and up reported using marijuana (10.9% vs 6%), cocaine (0.8% vs 0.4%), and hallucinogens (0.6% vs 0.3%). A notable exception, however, is the non-medical use of tranquilizers and sedatives.

Considering behavioral addictions, the prevalence of food binging (especially chocolate) was higher in women. For sexual addiction, gambling, or internet addiction the prevalence was

Acknowledgements

This work was supported by RE1 AG55151 and U54 AG44170.

References


KEY POINTS

• Differences in how women and men use substances and react to psychoactive substances are influenced by sex (differences based on biology) and gender (differences based on culturally defined roles).

• Psychoactive substance use in women tends to develop into addiction more quickly than in men, and women have different propensities to relapse; until now psychoactive substance use was less frequent in women, but recent epidemiological studies indicate an alarming narrowing in this gender gap.

• Health consequences (especially cancers and cardiovascular diseases) significantly differ according to gender.

• Raising public awareness about the risks of alcohol, tobacco and illicit drug use during pregnancy is crucial, especially in women of childbearing age; patterns of alcohol maternal drinking during pregnancy should be systematically detected.

• Female outpatients are still underrepresented in treatment settings; they are more likely to encounter barriers that prevent them from seeking or continuing treatment.

• The integration of a gender-sensitive perspective in all aspects of research, including pharmaceutical trials, is urgently needed; services such as child care help keep women in treatment.

Gender Differences in Addiction: Clinical Implications

Florence Thibaut MD, PhD

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The worldwide prevalence of cannabis, amphetamine, cocaine, and opioid use was 0.14%, 0.18%, 0.06%, and 0.14%, respectively in females compared with 0.23, 0.31, 0.14 and 0.31% in males (Figure 2). In the US, 12.8% of males and 7.3% of females aged 12 years and older used an illicit drug during the past month in 2015. More men than women aged 12 and up reported using marijuana (10.9% vs 6%), cocaine (0.8% vs 0.4%), and hallucinogens (0.6% vs 0.3%). A notable exception, however, is the non-medical use of tranquilizers and sedatives.

Considering behavioral addictions, the prevalence of food binging (especially chocolate) was higher in women. For sexual addiction, gambling, or internet addiction the prevalence was...
generally higher in men. For exercise, the results were mixed.18

Health consequences
There are important gender differences in terms of pharmacokinetics and pharmacodynamics. The small number of studies on gender differences in addictions is surprising when considering the modulatory role of estradiol in decision making and its interplay with dopamine in modulating reward, motivation, and cognitive processes. Using the same amount of alcohol as men, women usually have greater alcohol blood concentrations, which increases the risk for health problems. Morphine has both a slower onset and offset at μ-opioid receptors in women, thus has both a slower onset and offset at μ-opioid receptors in women, thus.

The protective effect of alcohol at low dose is less clear in women than in men, in whom a clear decrease in RR of ischemic heart disease is observed at doses lower than two to three standard drinks daily. Similarly, the RR of liver cirrhosis increases by 13 with four standard drinks of alcohol in women compared with six standard drinks daily.12

The worldwide proportion of all deaths attributable to tobacco is 12% among adults aged 30 years and older. Cigarette smoking is the leading cause of preventable disease and death in the US, accounting for more than 1 in 5 deaths. Jemal and colleagues10 found a decrease of annual age-adjusted death rates from almost all cancers among women (including breast cancer) except for lung and bronchus cancer, which has dramatically increased since the 1930s. These findings were confirmed by Pirie and colleagues14 in a cohort of 1.2 million women followed for 12 years in the United Kingdom with an RR of 21 for lung cancer in women who smoked.

The total burden (DALYs) of drug dependence remained about half in women, the highest number was seen with opioids.15

Pregnancy and psychoactive substance use
Despite the international consensus recommending total abstinence of psychoactive drug use during pregnancy, prenatal alcohol, tobacco, or illicit drug exposure remains a major public health issue. In particular, alcohol consumption during pregnancy is associated with a wide range of adverse effects including spontaneous abortion, stillbirth, weight and growth deficiencies, birth defects, prematurity and fetal alcohol spectrum disorder.

Based on data obtained in seven countries (Australia, Canada, Croatia, France, Italy, South Korea, and the US) on the prevalence of both alcohol use during pregnancy and resulting fetal alcohol syndrome (FAS), Popova and colleagues10 estimated that 1 in every 67 mothers who consumed alcohol during pregnancy had a child with FAS. Prematurity and low birth weight are also frequently associated with tobacco exposure during pregnancy (smoking or second-hand smoke). The World Federation of Societies of Biological Psychiatry and the International Association for Women’s Mental Health have recently published guidelines for the treatment of alcohol use disorders in pregnant women.17

Vulnerability and environmental triggers
In general, women with addictive behaviors exhibit higher comorbid neuropsychiatric disorders than men (eg, anxiety, depression, stress-related disorders) which are, in turn, more likely to trigger craving and relapse in women. Women are also more likely to have a lower socioeconomic status (eg, lack of education, lower job status, worse financial situation, violent partners, history of sexual violence).

Weight control also plays an important role in women who use tobacco. Women may be using alcohol or tobacco to better fit the societal norm.

Other factors underlying sex differences in tobacco use were identified in several studies: pleasure/rewarding, compulsive, and gesture are important in both men and women. In contrast, transgression as well as psychostimulant effects of tobacco might play a greater role in women who smoke. In women, restrictions, lack of availability of a drug on the legal market, or the price may reduce tobacco smoking or drug intake.18

Men and women are also differentially affected by environmental triggers for relapse to drug taking. Potenza and colleagues19 reported sex differences in neural correlates of cocaine-induced craving. Corticostriatal-limbic hyperactivity was linked to stress cues in women but to drug cues in men. In the same way, women are also less sensitive to the reinforcing effects of nicotine but more sensitive to social cues.

Gender differences in treatment
Women are more likely than men to encounter barriers that prevent them from seeking or continuing treatment (eg, economic barriers, family responsibilities, comorbid psychiatric disorders, feeling shame). World-wide, female outpatients are still underrepresented in specialized treatment settings. Often, women seek substance abuse treatment in primary care and mental health settings. In the US, many women now appear at least as likely as men to engage in and complete treatment. Nevertheless, African American women as well as women with lower incomes or who have psychological problems or greater severity of addictive disorders are less likely to continue with treatment. Yet, addiction treatment is at least as effective in women as in men. (CONTINUED ON PAGE 26)

Resources

The National Center on Substance Abuse and Child Welfare

WHO Guidelines for Identification and Management of Substance Use and Substance Use Disorders in Pregnancy

Women and Smoking: A Report of the Surgeon General
https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5112a4.htm

World Drug Report; 2017
http://www.unodc.org/wdr2017

National Institute on Alcohol Abuse and Alcoholism. Gender and Use of Substance Abuse Treatment Services
A New Treatment for Bipolar Depression: Part 3

Dr. Phelps is Medical Director at PsychEducation.org and Bipolar Disorder Section Editor for Psychiatric Times.

What is the risk of driving thyroid stimulating hormone (TSH) below the lower limit of the normal lab range when using levothyroxine as an adjunct treatment for depression? Here are new data and associated conclusions on that question posed in the October issue, at the end of Part 2 of this series.

Endogenous hyperthyroidism increases the risk of atrial fibrillation and decreased bone density. Population studies also note an increased risk of congestive heart failure and death. But TSH suppressed by exogenous levothyroxine (high-dose thyroid [HDT]) may not carry the same risks as endogenous hyperthyroidism (eg, Grave disease). HDT is used by endocrinologists as an adjunct treatment for high-risk differentiated thyroid cancer. Dr. Tam Kelly scrutinized this literature in two reviews, his monograph provides even more detail.
Bone risk
Two studies followed patients with bipolar disorder for nearly 6 years. Findings from these studies indicate no greater decline in women on HDT than controls matched for age and gender. Together these studies followed 43 patients. Yes, that’s a small sample.

Meta-analyses from the much larger cancer literature were interpreted by a surgical team (they, too, need to know the risks and benefits of HDT). Thus, “detrimental effects on bone metabolism were very small or not significant in both premenopausal women and men; the results for postmenopausal women were less convincing.”

At minimum, accelerated osteoporosis—if it is a risk at all—is associated with years of exposure, similar to tardive dyskinesia (which does not seem to dissuade us from aggressive use of dopaminergic agents). By comparison, the more immediate and potentially catastrophic risks of atrial fibrillation and cerebral infarction (from atrial clot fragments) may be more likely to drive decision-making by practitioners and patients.

Potential catastrophic risks of atrial fibrillation and cerebral infarction may drive decision making.
Consider levothyroxine as an augmentation in depressed patients with a TSH level greater than 2.5 mU/L.

Cardiac risk
Kelly reiterates and expands his earlier review. Trying to follow his analysis is like being back in residency learning how to critique study design, methodology, and statistical methods. I was still hesitant to adopt his conclusions. (Dr Kelly wisely invited me to “be skeptical of your skepticism.”) But an examination of his reviews by other specialists familiar with this literature has just arrived, with additional data on HDT’s cardiac risk.

Pilhatsch and colleagues published the results of a prospective study of cardiac outcomes in 23 patients on HDT (mean dose 463 μg/d). These patients had already been prescribed HDT for an average of 16 months before cardiac monitoring that included echocardiogram, holter, and stress testing, for an average of an additional 20 months. “None of the assessed cardiac parameters . . . was in a range predictive for cardiac dysfunction.” Again, the sample size was small, with no control group. Nevertheless, this article’s 10 authors, including Dr Peter Whybrow—one of the originators of using HDT for bipolar depression—repeatedly
cite Kelly’s analyses in support of the relative safety of HDT.¹

Conclusions and recommendations
Unless you have read Dr Kelly’s Art and Science of Thyroid Supplementation for the Treatment of Bipolar Depression, you should probably hold off on prescribing HDT for bipolar depression. However, while you continue to evaluate this option, three simple steps may better align your practice with available data on the efficacy and safety of levothyroxine in physiologic doses.

Any level of TSH between 1.0 mU/L and median is easily justified . . . if there is no clearly associated risk.

1 Consider levothyroxine as an augmentation in depressed patients with a TSH level greater than 2.5 mU/L, especially in bipolar depression (a nifty alternative to adding an antidepressant, with its attendant risks of inducing cycling and mixed states; or to buy time while slowly tapering an antidepressant).

2 Start with higher initial doses, such as 50 μg (“one half pill daily for a week then one daily”), at least for patients with significant depression.

3 Target a TSH level at least down to median for age. As reviewed in Part 2 of this series, remember: 1.5
mU/L to age 50; 1.6 mU/L to age 60; 1.7 mU/L to age 70; and 1.8 mU/L to age 80.

Any level of TSH between 1.0 mU/L and median is easily justified per the available literature. If there is no clearly associated risk, why not get there? Just as we “push” medications to the top of their dosage range (if fully tolerated yet not fully effective), we should suggest levothyroxine to a TSH around 1.0 mU/L to call its trial adequate.

Dr Phelps stopped accepting honoraria from pharmaceutical companies in 2008 but he receives royalties for his books.

References
A new *Lancet Commission* report on mental health said that mental disorders are on the rise in every country in the world and will cost the global economy $16 trillion by 2030. The economic cost is primarily due to early onset of mental illness and lost productivity, with an estimated 12 billion working days lost due to mental illness every year. The Lancet Commission on Global Mental Health and Sustainable Development brought together 28 global experts in psychiatry, public health, neuroscience, and advocacy as well as people with first-hand experience of mental health conditions. Launched at the Global Ministerial Mental Health Summit in London, the report recommends that mental health be reframed as a fundamental
human right, and that the definition be expanded to promote mental well-being, prevent mental health problems, and enable recovery from mental disorders.

“Mental health is often neglected and underfunded, even though nearly 2 billion people suffer from mental illness every year,” said Lancet report co-author Dr Janice Cooper, who leads the Carter Center’s mental health work in Liberia. “Our work in Liberia shows us that we need to begin with young people and train teachers to identify and refer students for help. We have seen substantial progress working with the Liberian government to ramp up mental health care services in every county, including school-based clinics in more than 20 schools and services in 14 prisons.”

The report shows that in many countries, people with mental disorders still routinely suffer gross human rights violations—including shackling, torture, and imprisonment. Bringing attention to these kinds of abuse and discrimination, the Commission calls for a human rights-based approach to ensure that people with mental health conditions are not denied any of their fundamental human rights—not just to health but also to employment and education, among others.

The report was launched during the first Global Ministerial Mental Health Summit, hosted by the UK Government’s Department of Health in London. During the two-day summit, Carter Center Board of Trustees Chairman Jason Carter spoke about US efforts to ensure mental health and substance use disorders are covered by insurance in the same manner as other health conditions, such as cancer and diabetes. Jason Carter is the grandson of former
US President Jimmy Carter and Rosalynn Carter, and a mental health advocate for more than 45 years.

As young people face the brunt of the global burden of mental illnesses, the report places great emphasis on experiences in childhood and adolescence, which shape life-long mental health. The Commission has inspired a group of young leaders to launch a campaign to fight stigma, inspired a group of young leaders to launch a campaign to fight stigma, the report places great emphasis on experiences in childhood and adolescence, which shape life-long mental health. The Commission has inspired a group of young leaders to launch a campaign to fight stigma, inspired a group of young leaders to launch a campaign to fight stigma.

“We’ve seen a rise in mental illness in young people when, with all the knowledge we have, we should be seeing a decrease,” said Professor Helen Herrman, President of the World Psychiatric Association. “Treatment in hospitals needs to be complemented by care in the communities to bring mental health services to the masses.”

Since 2010, The Carter Center Mental Health Program in Liberia has worked with the Liberian government to pass its first Mental Health Act and build its mental health infrastructure. The Center has trained 268 mental health professionals through the collaboration to improve access to mental health services. More than 100 of these clinicians focus on youth and adolescent mental health. The clinicians work in primary care facilities, hospitals, and other settings children frequent, such as daycare centers and schools, across all 15 counties to provide much needed care as the country seeks to strengthen its mental health services. This group of Liberian nurses, physician assistants, and registered midwives completed a free, six-month, Child and Adolescent Post-Basic Mental Health Training Program at the Tubman National Institute of Medical Arts in Monrovia, Liberia.

The Child and Adolescent Post-Basic Mental Health Training program is part of a three-year initiative to address the psychological effects of Liberia’s Ebola crisis and to promote psychosocial health in the country. The project, Supporting Psychosocial Health and Resilience in Liberia, is funded by Japan through the Japan Social Development Fund, a trust fund administered by the World Bank. The project is expected to reach over 19,000 beneficiaries in Montserrado (including Monrovia) and Margibi counties working through county health teams.

The most recent graduating class of 19 clinicians was the last in the collaboration with The Carter Center and Liberia’s Ministry of Health through funding from the World Bank and the Japanese government. The Ministry of Health, with support from The Carter Center, will continue to train child and adolescent clinicians through the DKI School of Midwifery. The Carter Center’s Mental Health Program in Liberia is supported by contributions from individuals, governments, corporations, and foundations such as the UBS Optimus Foundation.

## Depression Relief in the Eye of the Beholder

**Dee Rapposelli**

Eye movement desensitization and reprocessing (EMDR) may provide additional benefit in the treatment of major depressive disorder (MDD), according to the findings of a small, European, multicenter randomized controlled trial. The research confirms previous studies that show a potential value of EMDR in the management of depression.

The authors argued that the high rate of relapse in depression solely treated nonpharmacologically and persisting challenges related to pharmacologic management necessitate continued search for interventions. In summarizing several studies that showed a strong association between stressful or blatantly traumatic events and risk of depression, the researchers called for heightened exploration of the role of trauma/adversity in the development and progression of MDD. They added that, in light of the current research, complementary desensitizing therapies, namely EMDR, may be of value.

Although the efficacy of EMDR in the treatment of posttraumatic stress disorder has been well researched, its use in depression has only recently begun to receive systematic research attention. The study authors hypothesized that EMDR can provide an additional benefit over treatment as usual (TAU) in patients with acute depressive episodes and that inclusion of EMDR in a treatment regimen can increase the odds of complete remission.

The aim of their study was to replicate previous results showing that EMDR contributes to the improvement of depressive disorders. The total study population was 30 inpatients receiving treatment for a moderate to severe depression. Sixteen patients were relegated to TAU and 14 to TAU + EMDR. TAU consisted of psychodynamic or behavioral group therapy, standard individual therapy, and antidepressant medication. The EMDR + TAU group also received 1 to 2 EMDR sessions per week with the goal of processing one memory per week.

It was pointed out that EMDR replaced some of the individual therapy sessions in the EMDR + TAU group (ie, the EMDR + TAU group received fewer individual therapy sessions than the TAU group). Outcomes were evaluated using the Beck Depression Inventory-II (BDI) and the depression subscale of the Symptom-Check-List 90 Items Revised-Version (SCL-90-R). Statistical analysis was by ANCOVA.

A significantly better improvement in BDI scores was seen in the EMDR + TAU group compared with the TAU only group (contrast value = 74.97; P = 0.02; nP² = 2; P = .23). Complete remission, per BDI scores, was achieved in 50% of patients in the EMDR + TAU group compared with 25% in the TAU group. Better outcomes also were seen on the SCL-90-R in the EMDR + TAU group. Mild to clear improvement was noted in 86% of the EMDR + TAU group versus 75% in the TAU only group.

A significant interaction between treatment group and patient age also was found. Lower BDI scores at the study’s conclusion were seen more in older than younger patients in the EMDR + TAU group, but this difference was not seen in the TAU only group. The finding suggests that older patients may benefit more from EMDR treatment than younger ones.

The study authors concluded that, given the high rate of nonresponders to TAU, EMDR may be an adjunctive resource to improve outcomes.

**Reference**

Opioids, Suicide, Mental Disorders, and Pain

Dr King is in private practice in Philadelphia, and he is Clinical Professor of Psychiatry at the New York University School of Medicine.

When we hear of deaths due to opioid overdoses, we usually think of them being accidental. There is a growing body of evidence, however, that in at least some cases, the overdoses were actually intentional and that the presence of pain may play a role in decisions to end lives via opioid overdoses.

We know that deaths from suicides and deaths from opioid overdoses are rapidly rising. Between 1999 and 2016, suicide rates in the United States rose by nearly 30% and the greatest increase has been in the more recent years. Between 1999 and 2017 deaths from drug overdoses in the US went from less than 20,000 to more than 72,000 in 2017 with the greatest increase related to opioid overdoses. A study of people who presented to emergency departments with opioid poisonings due to prescription opioids found that a little over half (53.5%) were unintentional, 26.5% were identified as being intentional, and for 20% it could not be determined whether the poisonings were in fact intentional.

Based on my experience with patients who are in pain, intentionally taking a potential overdose of opioids is often not an attempt to end one’s life. There are patients who, in an attempt to seek relief when in severe pain, may ignore prescription directions and take higher doses than are prescribed. Others may, because of the opioid’s effect on cognition, lose track of how much they have taken and end up ingesting more than prescribed.

Multiple studies have demonstrated that there is a close association between chronic pain and depression and although it is commonly thought that it is always the former that leads to the latter, we know that pain is a common symptom of depression. Obviously, depression is a major risk factor for suicide and chronic pain seems to be one, too.

Although the relationship between pain, mental disorders, suicide, and opioids has, as yet, been the subject of limited research, a recent study that utilized data available from 18 states participating in the National Violent Death Reporting System provides what is probably the best information we have with regard to the relationship between these factors. The study examined suicides, defined as deaths resulting from the intentional use of force against oneself, between 2003 and 2014. Of 123,181 suicides, 10,789 (8.8%) had evidence of chronic pain with the most common conditions being back pain (22.6%), cancer (12.5%), and arthritis (7.9%). Just over half (51.7%) of those with chronic pain had a mental health problem. Of these, 81.9% had a diagnosis of depression. On average, suicides associated with chronic pain were more likely to occur in older people with the highest incidence among those aged 80 years or older.

As with suicides in persons without chronic pain, the most common method of suicide was by firearms among persons with pain. While only 18.8% of suicides without a history of pain tested positive for opioids, 51.9% of those with pain tested positive. Opioid overdoses were reported to be the cause of death in 16.2% of persons with pain and was the second most frequent method of suicide among this group; it was the cause of death in only 3.9% of suicides when pain was not present.

With regard to other medications, one finding was of special importance. Of the suicides with a history of pain, 47.2% tested positive for benzodiazepines. We have known for years that benzodiazepines are generally contraindicated for persons with chronic pain as extended use can cause hyperalgesia where there is a lowering of the pain threshold and a resulting worsening of pain. Moreover, benzodiazepines are involved in more than 30% of opioid overdose deaths. Finally, because benzodiazepines can interfere with the analgesia provided by opioids, it is pointless to prescribe these two classes of drugs simultaneously. Although many doctors still continue to do so.

Anyone who has treated patients who have survived suicide is aware that the reasons for making these attempts are usually complex without any one factor being the cause. More than half (64.7%) of suicide notes leave behind by those who have a history of pain indicate that a pain condition or the pain itself played a role in the decision to commit suicide. An especially interesting finding in the study was that although increases in the availability of prescription opioids and of the more-deadly illicit opioids have frequently been cited as major causes of the rising suicide rates in the US, the number of people with chronic pain who died by opioid overdoses remained approximately the same over the 12-year period studied.

An earlier study found that among patients with chronic pain, those taking higher doses of opioids were at greater risk of death by suicide, which suggests that this is another factor that needs to be considered in assessing suicide risk.

One commonly reported concern about the risk for suicide is that it is likely to increase in patients with chronic pain who have been prescribed opioids that doctors have sought to discontinue. However, another recent study suggests that this may not be true. Utilizing data from the Department of Veteran Affairs, the study found that when long-term opioid therapy for chronic noncancer pain was discontinued, pain intensity during the 12 months after discontinuation on average did not increase and that in some patients there was a slight improvement in pain. The authors noted, however, that there is a great deal of individual variation with regard to changes in pain intensity after discontinuation so that every patient must be carefully monitored.

So how should we apply the results of these studies in clinical practice? First of all, because chronic pain appears to be a risk factor for suicide, it is incumbent upon clinicians to carefully and continually monitor their patients with chronic pain for suicidal ideation. Unfortunately, the treatment of pain in this country still falls primarily under the specialty of anesthesiology, the practitioners of which often have little training in identifying those at risk for suicide. This is one of many reasons why psychiatrists need to be more involved in the care of patients with chronic pain.

Second, prescription of opioids to patients with chronic pain may be providing them with a way to commit suicide. This is not a reason to deny opioids to patients who may benefit from them, but it is one more reason for all physicians to be very careful when prescribing opioids. Furthermore, if opioids are prescribed, physicians bear the responsibility of monitoring patients for suicidal ideation because they may be arming patients with a method to complete suicide.

Third, based on current research, we need not fear that discontinuation of opioids in patients with chronic pain will inevitably lead to worsening of the pain and thereby increase the risk that patients will turn to suicide.

Of greatest importance, is the need to continue to improve the care patients with chronic pain receive. We know that many people with chronic pain never receive care close to anything recommended by published guidelines on the management of pain. The myth that opioids are always the most effective treatment for pain is still widespread not only among the general public but also among many physicians who prescribe these medications.

Accidental deaths from opioid overdoses may be difficult to prevent and in many cases the best we can do is to increase availability of opioid antagonists to reverse the effects of the drugs after they have been ingested. But, in those who commit suicide and especially those who do so who suffer from pain, there are many things health care professionals, and especially mental health care professionals, can and should be doing to prevent the overdoses from occurring in the first place.

References
Screentime Solutions for Depression and Bipolar Disorder

Dr Aiken is Director of the Mood Treatment Center, Winston-Salem, NC. Editor in Chief of The Carlat Psychiatry Report; and Instructor in Clinical Psychiatry at the Wake Forest University School of Medicine.

Evening light can disrupt mood in bipolar disorder. In short, blue spectrum light emitted by many digital devices suppresses melatonin, worsening two systems that are already fragile in people with mood disorders: sleep and circadian rhythms. There are simple solutions to correct this problem, and they may also help the 40% of Americans who’ve made screentime a part of their bedtime.

Blue light blockers

The first step is to wear amber tinted glasses that block blue spectrum light in the evening. This approach was studied in a small randomized controlled-trial of inpatients with mania. Manic symptoms improved over 7 days with the blue-light blockers, and the effect size was large. The protocol for this Dark Therapy required patients to either wear the glasses or remain in a pitch-black dark room from 6:00 pm to 8:00 am. After they recovered, they were able to ease the routine to a later start time. Blue light blockers appear to have preventative benefits as well, and, it’s reasonable to wear them 1 to 2 hours before bedtime when symptoms are mild or prevention is the goal.

Which glasses work?

To work well, the glasses should block at least 90% of blue light, and most products don’t have that rigor. The Dark Therapy trial used glasses from lowblueights.com (any pair will work from that site). Other studies have used the less expensive Uvex models, which also earned high marks in a Consumer Reports test. For under $10, there’s the Uvex UltraSpec 2000 model S360X, which fits over regular glasses, and the Uvex Skyper model S1933X.

Pitch-dark bedroom

Blue blocking glasses are uncomfortable to sleep in, so a pitch-dark bedroom was part of the overnight protocol in the Dark Therapy trial. Eliminating bedroom light may help depression as well as mania. Bedroom light as low as 5 lux (ie, a nighttime) has been linked to higher rates of depression, so pitch dark is the goal here. Ideas for darkening the bedroom include black-out curtains, eye masks, electrical tape over LEDs, towels or draft snakes under doors, or sleeping in the basement.

Sleeping with the TV on

What if patients find it difficult to sleep without the TV? Familiar voices are comforting, and patients often use TV to drown out the ruminative thoughts that would otherwise keep them up all night. Some TV sets allow the monitor to turn off, but for others the only solution is to shift to podcasts, radio, or music. Weightless, an ambient track by Marconi Union was developed in conjunction with sleep researchers. In a small study, it produced greater relaxation and sleep than comparably mellow tunes.

Brain friendly night lights

Sometimes a pitch-dark bedroom is just not comfortable or safe. Fall risks and fears of the dark can affect anyone, although they are particularly common in the young and old. Theoretically, a low-blue nighttime could solve this problem, and at least one study used this approach. Blue-free nightlights, flashlights, and bulbs are available for $10 to $20 at lowblueights.com or Amazon (Maxxima MLN-16 Amber LED Night Light, SCS Nite-Nite Light Bulb, and Lighting Science Good-Night Sleep).

Screen filters

The health risks of nocturnal blue light extend beyond sleep and mood. They include obesity, diabetes, cancer, cardiovascular and neurologic diseases, gastrointestinal ulcers, and adverse reproductive outcomes, according to a position statement from the American Medical Association. To avoid the fate of the cigarette industry, manufacturers of smartphones and tablets have added settings that lower blue light at designated times. For laptops, there are free apps that do this (f.lux for Windows or Candlelight by Oliver Denman for Mac). All this is well intended but, like cigarette filters, they should not be relied upon. They won’t make a serious dent in those health risks because much of the problem comes from energy efficient lighting.

Warnings and caveats

Many patients expect blue-light blocking glasses to cure their insomnia. Rather, it seems they protect the brain against some of the mental and physical consequences of not sleeping. In the Dark Therapy trial, patients who wore the blue-light blockers did not sleep more (they actually slept a little less!) although their sleep did become more regular. While some patients give up too early, others go overboard. Amber glasses have a calming effect, causing some individuals to wear them to relax during the day. Wearing them before 6:00 pm, however, could cause depression by flipping the circadian rhythm in the wrong direction.

What to expect

The benefits of blue-light reduction has the best evidence for bipolar disorder, particularly for mania, mixed states, and rapid cycling. Can it work for unipolar depression as well? Epidemiologic and animal studies suggest so, but controlled trials are mixed. The one with positive results was small (N=27) and centered on postpartum depression, where nocturnal awakening is the norm. Women who used blue-light blockers and low-blue light bulbs had greater improvements than those who used placebo glasses and bulbs. The study with negative results was also small (N=20) and included depressed patients with insomnia.

A few studies have ventured into the general population, and the results are encouraging. Reducing blue light deepens sleep, promotes earlier bedtimes, and improves concentration the following day.

Dr Aiken does not accept honoraria from pharmaceutical companies but receives honoraria from W.W. Norton & Co. for Bipolar, Not So Much, which he co-authored with James Phelps, MD.

References

In recent years, hardly a day has passed without some news outlet mentioning the latest opioid epidemic. Indeed, there is a lot to cover: the origins of the epidemic in the promotion of opioid analgesics, the way opioids have torn apart families and communities across the country, and how lawmakers have attempted to respond. Doctors, patients, politicians, and journalists have all weighed in with different perspectives. As psychiatrists we see the destruction in our hospitals and clinics and many have grown weary of reading more and more tales of woe and chicanery masquerading as treatment.

Since so much has already been written, it is reasonable to wonder whether we need another book about this phenomenon? Dr Adam Bisaga, an addiction psychiatrist at Columbia University, makes the case for why we need more information—and urgently—in Overcoming Opioid Addiction: The Authoritative Medical Guide for Patients, Families, Doctors, and Therapists. Despite the multitude of articles and books on the subject, there is little in the way of guidance for addressing opioid use disorder (OUD) that specifically addresses patients, their families, and non-expert medical professionals. Worse, there is even less accessible literature that is grounded in sound scientific evidence. Dr Bisaga, along with his co-author, health writer Karen Chernyaev, seeks to fill that gap with this practical, intelligently constructed book.

The book is divided into four parts. Each can be read independently of the others since they cover similar material but address separate audiences. The first part describes the nature of OUD and its role in fueling the latest iteration of an opioid epidemic. The next part delves into the details of treating OUD with medication-assisted treatment (MAT), the only evidence-based means of managing OUD. The project of explaining and promoting MAT lies at the heart of the book and distinguishes it from other approaches to OUD that ignore, or may be hostile to, using any medications to treat OUD. The third section addresses the needs and concerns of family members of OUD sufferers, and the fourth part addresses patients.

(Continued on Page 29)
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Psychiatry’s Ancient Origins

When did psychiatry begin? Was it with the discovery of the unconscious? Or was it the discovery of neurotransmitters? As it turns out, healers have been treating mental disorders for thousands of years. Modern psychiatry reflects some, but not all, the values and concepts held by early civilizations. Ancient Greek, Indian, Chinese, Egyptian, Hebrew, European, Arabic, and other cultures explored dimensions of mental and physical health and disease. In the Group for the Advancement of Psychiatry’s (GAP) 2018 most recent installment in our series of videos on the history of psychiatry, the Committee on Arts & Humanities explores how mental illness was understood from post-stone-age cultures through the Middle Ages.

Early civilizations relied on shamans, sorcerers, magicians, mystics, priests, and other approved healers to treat illnesses. Using rituals, incantations, and offerings, sickness could be prevented or healed. Somatic therapies, not unlike neurosurgery, can be inferred from archeological findings from France (6,500 BCE) and China (5,000 BCE). For example, skeletal remains of children with marked skull abnormalities and traumas suggest the ways in which humans cared for mentally impaired children 77,000 years ago. Some ancient peoples believed diseases occurred due to loss of the soul. Shamans entered into trances or altered states of consciousness, enabling their souls to journey into spirit worlds, sometimes into the underworld. During the journey, shamans connected to souls of the dead and to living souls that had strayed or been stolen. Interacting with demons and lost souls without losing their own souls, they brought about cures. The shaman acted as both priest and healer.

In Classical Greece (fifth century BCE), philosophers taught “naturalism,” the belief that laws of nature shape our world, as opposed to gods and demons determining human fate. Alcmaeon, for example, believed the brain, not the heart, was the “organ of thought.” He tracked the ascending sensory nerves from the body to the brain, theorizing that mental activity originated in the CNS and that the cause of mental illness resided within the brain. He applied this understanding to classify mental diseases and treatments.

Hippocrates developed a theory of chemical imbalance based on four humors: black bile, yellow bile, phlegm, and blood. Disease mental illness were attributed to patients’ sins committed during current or previous lives. For example, disregarding important deceased persons, superhuman agents, ghosts, deities, and celestial beings could bring about various symptoms, depending on which spirits were offended.

Chinese texts from 3000 year ago mention neuropsychiatric illness, including descriptions of mania and psychosis with or without epilepsy. “Imbalance” was the mechanism of psychosis. Other conditions described include confusion, visual illusions, intoxication, stress, and even malingering. Psychological theories about stages of human development can be traced to the time of Confucius, about 2500 years ago.

During Europe’s Middle Ages, the focus of theories about mental illness shifted back from physiology to spirituality. As Christianity spread, ideas about sin dominated, and the “psychotherapists” of the era were priests rather than physicians. The notion of demons in the Old Testament continued into the writings of the New Testament. Demonic possession remained a basic assumption. Christian physicians embraced some of the old beliefs of the Greeks and Romans, however, the natural therapy of the Greeks was lost as treatment turned to astrology, alchemy, theology, magic rites, and exorcism.

Preoccupation with witches raged throughout the seventeenth century. Tens of thousands of suspected witches, mostly women, were killed. Those accused of witchcraft included individuals who exhibited aberrant behaviors that today would be considered examples of mental illness, while some had no symptoms.

The interplay between supernatural and natural thinking can be seen across ancient cultures. Mental health practices continued to progress and regress throughout the centuries, eventually including the idea of dedicated institutions for the care of the mentally ill. Tensions among culture, religion, and science will continue to shape concepts about the treatment of individuals with mental illnesses. Studying psychiatry’s origins and evolution gives us perspective on our own beliefs and practices.

Psychological theories about stages of human development can be traced to the time of Confucius, about 2500 years ago.

References
Terror in America

>> Harold I. Eist, MD

Dr Eist is Past President of the American Psychiatric Association and Clinical Professor of Psychiatry at George Washington University School of Medicine and Behavioral Health, Washington, DC.

EDITOR’S NOTE: This article is the opinion of the author and does not necessarily reflect the views of Psychiatric Times and its publisher. If readers would like their comment to be considered for posting at the end of this article online, please send an email to editor@psychiatrictimes.com, with your comment and your full name, title, and affiliation.

Terror in America, an APA poll finds that anxiety is increasing and reducing our sense of safety.1

September 11, 2001

It was just after 4 PM, when the phone rang. It was the program manager of a local TV station. She said the station had a telephone bank for use during crises, and that it was currently being inundated by calls from people looking for help in contacting loved ones. She wanted to open the phone bank and focus local calls that evening from 6 to 9 pm on the concerns, fears, and worries of the public. This idea was timely and generous. She asked, “Can you recruit 6 psychiatrists, have them here at the station by 5:30 for a briefing, and ready to go on the air at 6 pm?” “Yes,” I said. “It’s a good idea, we can make it work.”

Each psychiatrist called to serve answered “Yes” immediately. All they asked for were directions to the TV station.

People in general were cooperative and helpful. Surprisingly, this was most obvious on the roads. Drivers were more patient and polite than usual, there was less irritation, right of way was freely given, and people offered to help one another. Anger seemed absent from public interactions; kindness and shared concern were the prominent emotions. It was as if it was widely understood that everybody was anxious and needed kindness, not road rage.

Over 300 phone calls from anxious, worried people were taken during a 3-hour period by the 6 psychiatrists. Each psychiatrist spoke with about 50 people; the calls lasted approximately 5 minutes each. Many of the callers reported the phones at the Pentagon were down and wondered if the TV station could get through to loved ones. It appeared that talking to a professional for a few minutes reduced the callers’ sense of crisis and in that, it was helpful even if precise information was not available. One of the many things we learned from 9/11 was that we needed backup communication systems. Clearly, losing touch with loved ones can be terrifying.

After the phone bank experience, I assessed what was happening to my anxious patients. There was no overall increase in psychiatric visits, but there was a significant increase in anxiety and depression. Some patients called for telephone sessions and asked for higher doses of their medications. Many cancelled visits were filled by other agitated patients. They were asking for medication because they had either run out or were close to running out; some wanted to come in and talk.

Two patients who had frequently seen one another in my office waiting room, because their appointments followed one another, struck up a conversation. During the exchange, they traded their next appointment on the same day of the following week. They asked me if this was okay. I said it was fine. (This reminded me that Freud’s patients traded appointments in his waiting room with his agreement.) Though they had often seen one another in the waiting room, but they rarely spoke.

One thing became clear. Patients with anxiety broke into 2 groups: those who showed up when they felt terrible, and those who clung to home when their anxiety intensified. The bad feelings are the disease, but different patients dealt with it differently. Most patients with chronic anxiety insisted that, contrary to the psychiatric literature, benzodiazepines were the best anti-anxiety medications. They struck at the inner distress rapidly and reduced insomnia.

Steve M. Mirin, MD, past Medical Director of the American Psychiatric Association wrote a brief piece for Newsweek, “Life After 9/11: Coping with Anxiety and Depression.” Mirin quotes a post-9/11 poll conducted by the Pew Research Center for the People and the Press that found more than half of all Americans experienced one or more symptoms of anxiety and/or depression.

November 8, 2016

This was the day of the presidential election. US citizens were restive, and when the results were announced, there was great public shock and fear, particularly in our area (a blue state). There were complaints about the election and the electoral college, which most of my patients who came into the office thought unfair. People talked about impeachment of the President and signs were planted in several neighborhood yards and a few knew that the votes of 68 senators were required to impeach. I couldn’t help but wonder if all the fear being expressed was a basic fear of government or a fear that the power of this government would capriciously turn against them. This fear intensified. Our new president campaigned on decreasing government and reducing its negative impact in our lives. However, to many people, things seem to be going in the opposite direction, and this has been generally disturbing, disappointing, and frightening.

Stephen J. Rockower, MD, President of the Maryland Medical Association wrote, a column, in his President’s Message, “Reflections on Political Machinations” in which he states, “We are experiencing a very strange time in America. Since the election and inauguration of President Donald Trump, Americans have been at each other’s throats, hurling accusations and passing judgement.” In the midst of all this unprecedented turmoil and drang, he wonders, “What’s to become of health care?”

For a period after 9/11, people were more anxious, vulnerability and risk seemed enhanced; since November 8, 2016, people remain palpably fearful, more isolated and suspicious. Helping hands, a strong characteristic of our land, seem fewer and far between.

People are witnessing free expression of racism, the increase in mass shootings, murder and lack of respect for women and authority, the rampant dishonesty of our leaders as a high level “ideal” for corporate mendacity and irresponsibility. A criminal sheriff convicted by the courts for taking the law into his own hands and disobeying it egregiously was pardoned by the President before sentencing. The President wonders if he can pardon himself if he is deemed guilty of breaking the law.

Widespread fear has led many patients to say they are moving away.2 After 9/11, the population was interested in repair, and now they are interested in escape. People no longer feel safe in America.

References
1. Moran M. APA poll finds Americans’ anxiety is increasing, especially about health, safety, and finances. Psychiatric News. 2018;53(11).9
When No One Is Watching

Dr. Tolscik is Clinical Assistant Professor in the Department of Psychiatry at Texas Tech University Health Sciences Center at Amarillo. She specializes in women’s mental health and is in private practice in Amarillo, TX.

Pure unadulterated and uncensored joy was what came to mind as I sat quietly behind a silver-haired woman and a cherub-faced young boy, taking in their intricate interaction. I was in a darkened theater, after having casually glanced their way, noticing them both staring with wide-eyed amazement at the vibrantly costumed performers cheerfully belting out a lively song-and-dance number during a live musical production.

Each time the little boy, who appeared to be about 5 years old, turned his tiny head and grinned broadly in excitement, the woman would gently lean in and whisper something with a highly expressive and animated demeanor that made the little boy giggle and clap his hands in pure pleasure and glee!

The older woman’s fully engaged and responsive body language during this loving exchange with the young child was very special and not something I had ever observed to any comparable degree at a theatrical production, except maybe on stage between the actors. These two had a deep connection that was electric. Their heightened level of personal interaction, comfort, and ease with one another was palpable and quite moving to observe.

I thought to myself, “This is how we should all act with those we love and care for when we think no one is watching.” This pair was so connected to each other and to the magic unfolding before them; they appeared to be in their own little world. Pure rapture, I thought.

Several days later, the woman from the theater came in for a session. I pondered whether it made sense to bring up the theatre experience. In case she had noticed me there and wondered why I had not acknowledged her, I chose to share my observation of her heartwarming exchange with the little boy. When happened next, I could not have anticipated. This woman, who had been slowly and very painfully emerging from under the oppressive burden of a longstanding family stressor, a recent life-threatening illness and impairing mood symptoms, as well as her psychotropic medications.

Had this experience in the darkened theater gone unnoticed, she may have continued to struggle and not be able to live her life to its fullest emotional potential.

Several days later, the woman from the theater came in for a session. I pondered whether it made sense to bring up the theatre experience. In case she had noticed me there and wondered why I had not acknowledged her, I chose to share my observation of her heartwarming exchange with the little boy. When happened next, I could not have anticipated. This woman, who had been slowly and very painfully emerging from under the oppressive burden of a longstanding family stressor, a recent life-threatening illness and impairing mood symptoms, as well as her psychotropic medications.

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Addiction
Continued from page 18

Conclusion
Despite a higher prevalence of substance use observed in men, women begin using drugs at younger ages. They develop addiction more quickly, with a stronger motivation to take drugs and have different propensities to relapse. Despite this, female outpatient are still underrepresented in specialized treatment settings. Training care providers in primary care and mental health settings may help to identify and refer women to specialty addiction services. Providing services such as child care, also helps keep women in treatment. Finally, raising public awareness about the risks of alcohol, tobacco, and illicit drug use during pregnancy is crucial, especially in all women of childbearing age.

References

GENDER ISSUES
NOVEMBER 2018

Vietnam
Continued from page 4

American forces began to assume a secondary combat role to South Vietnam units, accompanied by a steady drop in casualties, the US military saw plummeting morale and widespread misconduct, racial incidents, drug use (especially heroin). psychiatric reasons—primarily for war, one out of every eight soldiers was deployed psychiatrists had only a limited capacity for making things bearable for them. And yet the doctors believed that it was the duty of the mental health contingent to relieve them of their untenable situation.

Furthermore, colleagues at home added to the strain as an increasing number of Americans denounced the conflict in Southeast Asia. Public criticism of military psychiatry and its doctrine came from psychiatrists and other physicians who had served in Vietnam as well as from those who had not. In March 1971, 67% of American Psychiatric Association members who responded to a poll indicated that they wanted the US government to terminate all military activity in Vietnam. This was followed by a Board of Trustees resolution condemning the war and their elimination of the military psychiatry section at the annual convention.

The Action Paper passed by the APA Board of Trustees that resulted in the November 1st event at the Vietnam Veterans Memorial culminates in the following proclamation

Despite the enormous personal and professional challenges and risks these psychiatrists faced, the extant record amply demonstrated their sustained devotion to providing the best care for the troops that they could, their willingness to overcome hardship pursuant of that end, and their record of capable and commendable service. The arrival of the war’s 50th anniversary offers a unique opportunity to honor those who selflessly performed to the best of their ability what they believed was their duty to their country.

As a career Army Medical Corps officer who served a year in Vietnam as psychiatrist and director (commanding officer) of one of two fully-staffed Army psychiatric treatment units in South Vietnam, the APA’s commemorative event signifies to me—and I would venture, to my fellow psychiatrist veterans as well—a greatly appreciated if belated “welcome home.” It serves to repair our status and the record of military psychiatry in Vietnam after our having been rebuked by colleagues during and after the war for cooperating with the US military.

References
Suicide Risk and Sleep: What’s the Link?

Since 1999, the frequencies of suicide and outpatient visits for sleep problems have significantly increased in the US. Although the cause of these increases is not clear, research studies spanning this period have shown significant associations between sleep disturbances and suicide risk. An association between symptoms from several sleep disorders and increased risk for suicidal ideation, nonfatal suicide attempts, and suicide among adolescents and adults has also been seen (Table 1). Notably, these associations have remained significant even in the presence of concurrent symptoms of psychiatric conditions (e.g., depression, anxiety). Despite the robust appearance of the sleep disturbance – suicide risk relation, some studies have shown null relations or a weaker relation after controlling for confounding variables. This fact and the increasing evidence for sleep disturbance as a suicide risk factor, and possible warning sign, have led researchers to explore for mechanisms behind the association of sleep disturbance and suicide. This research, still in its infancy, has the potential to improve our understanding of the contexts in which sleep disturbances confer increased risk for suicide.

Dissatisfaction with the quality, timing, and duration of sleep, as well as the subsequent distress or impairment during waking hours, are considered typical manifestations across all sleep-wake disorders. It is not clear if such dissatisfaction or impairment can uniformly explain why those with sleep problems are at increased risk for attempting suicide. It has been hypothesized, however, that difficulty sleeping through the night may confer increased suicide risk via a number of factors including hyperarousal, hypothalamic-pituitary-adrenal (HPA) axis dysfunction, and concomitant serotonin dysfunction.

It has been suggested that HPA axis dysfunction and poor serotonin turnover negatively affect frontal lobe functioning and subsequently result in executive dysfunction and poor decision making. Impaired decision making increases the risk for suicide when access to suicide methods increases and social support decreases. The hypothesis that being awake at night increases the risk for suicide was supported by findings from a recent study indicating that completed suicide was more likely to occur at night and in the early morning hours.

Clinical implications

Sleep is an important factor to weigh when evaluating psychiatric patients in light of data showing a bi-directional relationship between sleep problems and psychiatric illness. Given the prevalence of sleep problems in the general population and the growing evidence linking sleep problems with suicidal ideation, screening patients with sleep problems for suicide risk is prudent. Tools, such as the Columbia Suicide Severity Rating Scale (C-SSRS), can assist with differentiating suicidal ideation with different levels of risk.

Christopher W. Drapeau, PhD, has no conflicts to report. Todd M. Bishop, PhD (peer/content reviewer), has no conflicts to report. Applicable Psychiatric Times staff and CME Outfitters staff have no disclosures to report.

1. Physicians (CME)
2. Other

This activity offers CE credits for:

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

- Explain the clinical implications of the link between sleep disturbance and suicide risk
- Describe the risks associated with hypnotic medications
- Recognize the use of cognitive behavioral therapy for insomnia as a means to manage sleep problems

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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Table 1. Brief summary of sleep disorder—suicide risk

<table>
<thead>
<tr>
<th>Sleep disorder</th>
<th>Brief summary</th>
</tr>
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<tbody>
<tr>
<td>Insomnia</td>
<td>Associated with suicidal ideation, nonfatal suicide attempts, and suicide across the lifespan (often independent of depressive symptoms); at least 2 of 3 main insomnia symptoms (eg, difficulty with sleep-onset, sleep-maintenance, early-morning awakening) may confer the greatest risk for suicidal ideation, nonfatal attempts, and suicide</td>
</tr>
<tr>
<td>Nightmares</td>
<td>Associated with suicidal ideation, nonfatal suicide attempts, and suicide across the lifespan; associations are independent of insomnia, depression, and anxiety symptoms; frequent nightmares or of longer duration (several months) may increase the risk of a suicide attempt in adults</td>
</tr>
<tr>
<td>Narcolepsy</td>
<td>Associated with elevated odds of depression, anxiety, and suicide-related behavior; findings from one study indicate a 7-fold increased risk for suicide</td>
</tr>
<tr>
<td>Hypersomnia</td>
<td>Associated with suicide-related thoughts (eg, attempt planning), nonfatal suicide attempts, and suicide; risk may be highest with hypersomnia and co-occurring depressive and insomnia symptoms; decreased suicide risk with co-occurring fatigue, poor concentration, indecisiveness, elevated appetite, weight gain</td>
</tr>
<tr>
<td>Sleep apnea</td>
<td>Associated with suicidal ideation and suicide attempt planning; the greatest risk for suicide may be among patients with co-occurring sleep problems (eg, sleep-related breathing symptoms and a concurrent sleep movement disorder)</td>
</tr>
<tr>
<td>Restless legs syndrome</td>
<td>Associated with an increased risk for suicidal ideation as well as depression, insomnia, anxiety, and pain disorders</td>
</tr>
<tr>
<td>Behaviorally induced insufficient sleep syndrome (BISS)</td>
<td>Adolescents with behaviorally induced insufficient sleep syndrome (BISS) show a higher risk for suicide than adolescents without BISS; oversleeping on the weekend may be an independent risk factor for suicide among adolescents (independent of depressive symptoms)</td>
</tr>
</tbody>
</table>

C-SSRS forms including the Lifetime-Recent, Risk Assessment, and the Last Contact can help guide assessment and management of suicide risk across patient appointments.

The BEARS pediatric sleep screening tool evaluates for Bedtime problems, Excessive daytime sleepiness, Awakenings during the night, Regularity and duration of sleep, and Snoring. It differentiates between developmental levels (preschool, school-aged, and adolescent) and can easily be inserted into a clinical interview. For screening adults, the Sleep Disorders Questionnaire is a self-report tool that has been designed specifically to help health care professionals identify individuals at elevated risk for a sleep disorder.

Theories of suicide suggest that it may be certain variables (eg, pain and hopelessness, low connectedness, means for suicide) rather than a specific psychiatric condition that predict who may be at highest risk for attempted suicide. Although it is important to assess for and address suicide risk across multiple levels of care (eg, public health model, upstream prevention approaches), the primary focus must be on immediately alleviating the patient’s suffering by treating any problems that convey suicide risk. Such an approach does not mean that relieving symptoms of a psychiatric illness (or sleep condition) is irrelevant to decreasing suicide risk. Instead, it is argued that clinicians collaborate with the patient to identify and ameliorate what appears to be driving suicide risk. The following cases provide examples of instances in which sleep concerns appeared to be the main drivers of suicide risk.

**CASE STUDY 1**
A 74-year-old man presented to his primary care physician with depressive symptoms (ie, depressed mood, hopelessness, anhedonia, impaired concentration, fatigue, suicidal ideation), excessive daytime sleepiness, snoring, sleep dissatisfaction due to frequent night-awakenings that likely followed periods of apnea, and three suicide attempt plans. He refused voluntary psychiatric hospitalization and stated that he would not attempt suicide in the near future (1-2 days). He also refused antidepressant medication for religious reasons. He reported that nothing was more distressing to him than his sleep problems and that he would believe that life was worth living if he could improve his ability to sleep at night and maintain alertness during the day. Polysomnography revealed severe sleep apnea that was subsequently treated via nasal continuous positive airway pressure. This treatment led to an improvement in sleep quality and consequent resolutions of sleep complaints, depressive symptoms, and suicide risk.

**CASE STUDY 2**
A 64-year-old man was admitted to a psychiatric hospital after attempting suicide via an opiate overdose. A thorough review of his medical history revealed chronic insomnia disorder. The patient reported that his feelings of hopelessness and desire to attempt suicide were secondary to insomnia distress resulting from a worsening of symptoms (ie, 2 continuous days without sleep). The patient noted that he had experienced perceived short sleep duration, difficulty falling asleep, night-awakenings, and low quality of life for the past 25 years.

Standard insomnia treatments such as cognitive behavioral therapy for insomnia and pharmacotherapies (hypnotics, benzodiazepines, antidepressants) did not relieve symptoms. Symptoms ultimately remitted however, with a combination of electroconvulsive therapy and olanzapine. Once his sleep improved, feelings of hopelessness and suicide-related thoughts resolved.

**Restless legs syndrome (Willis-Ekbom disease)**
Restless legs syndrome (RLS) is another sleep problem that may promote increased suicide risk. Patients with RLS have a higher risk for conditions associated with suicide including depression, insomnia, anxiety, and pain disorders. Study data show that between 21% and 38% of sampled patients with RLS had suicide-related thoughts. Moreover, depressed patients were more likely to blame RLS symptoms as the reason for their depression, sleep disturbances, and suicidal ideation. In such instances, the argument can be made that focusing treatment on ameliorating sleep disorder symptoms is warranted as part of reducing the patient’s suicide risk.

**Sleep medication and suicide risk**
Hypnotic medication is often used for treating insomnia; however, these medications have been linked to suicide-related thoughts, plans, and attempts. Moreover, use of hypnotics has been shown to be a more robust predictor of suicidal ideation and suicide attempts than insomnia symptoms.

It is unclear why hypnotic use may increase risk for suicide, but caution is needed when prescribing hypnotic medications. To decrease the risk for suicide when prescribing hypnotics, McCall and colleagues outlined 10 steps for physicians to follow, along with a thorough review of the current literature on individual hypnotic medications and suicide.

Cognitive behavioral therapy for insomnia (CBT-I) has demonstrated longer-lasting benefits for the treatment of insomnia than hypnotic medications alone. Based on the accumulating empiric evidence, the American Academy of Sleep Medicine (AASM) and the American College of Physicians recommend CBT-I as the first-line therapy for chronic insomnia in adults. The AASM practice guideline notes that “Short-term hypnotic treatment should be supplemented with behavioral and cognitive therapies when possible.” Readers are referred to the AASM practice guideline for additional information about CBT-I and recommendations about the pharmacologic treatment of chronic insomnia in the event that patients are unable to receive CBT-I or may continue to experience symptoms.

**Conclusions**
Sleep disturbances have been identified as a robust predictor of past and future suicide risk across the lifespan. This growing literature emphasizes the need for mental health professionals to remain cognizant of patient sleep concerns when assessing psychiatric symptoms and suicide risk, and to be thoughtful about prescribing hypnotics to improve sleep disturbances (Table 2). Treating sleep problems may be an effective method for decreasing sui-
Table 2. Recommendations for managing patients with sleep disorders and co-occurring suicidal ideation

- Screen for sleep problems during every new patient appointment and at follow-up appointments
- Screen for suicide risk using evidence-based tools, like the C-SSRS, when patients present with sleep and psychiatric complaints
- Review the article by McCall and colleagues22 and follow the 10 steps for periodically screen for suicide risk when patients are prescribed hypnotic medication
- Refer patients suspected of having a sleep disorder to a sleep physician certified by the American Board of Sleep Medicine
- Refer patients with insomnia to a licensed mental health professional with expertise in CBT-I (see Society of Behavioral Sleep Medicine, https://www.behavioralsleep.org/)

C-SSRS, Columbia Suicide Severity Rating Scale; CBT-I, cognitive behavioral therapy for insomnia.

References


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John W. Winkelman, MD, PhD, Ryan M. Bottry
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He is remarkably conciliatory towards engaging with nonmedical modes of treatment—as long as those other methods do not interfere with MAT. For example, he encourages patients to try attending support groups such as Narcotics Anonymous, a 12-step program modeled after the popular Alcoholics Anonymous. However, he warns that some people in Narcotics Anonymous may not be accepting of individuals recovering with the use of MAT. The goal is to have MAT serve as a bedrock for patients to lead meaningful lives in a way that makes sense for each patient.

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Why join the IU School of Medicine and IU Health Physicians?
- IUSM is the largest medical school in the nation.
- IUH is a top healthcare provider in the nation and the most comprehensive health care system in the state of Indiana.
- IU Health has recently committed to a large strategic investment to improve the behavioral health of the citizens of Indiana.
- A career with IU Health Physicians means an opportunity to work among 80 percent of Indiana’s top doctors.
- Recently restructured and improved compensation package with forgivable loan options and comprehensive benefits.

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

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

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

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

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

The School of Medicine will be the cornerstone of a dynamic venue for the exchange of ideas, the development of healthcare and research thought leaders and practitioners, and the discovery of novel therapies to meet the medical challenges of the future.

“Ocean Medical Center’s psychiatry program will be a community-based program,” said Ramon Williams, MD, professor of psychiatry and behavioral sciences, and chief of psychiatry at Ocean Medical Center. “Our new psychiatry residency program will be a community-based program,” said Ramon Williams, MD, professor of psychiatry and behavioral sciences, and chief of psychiatry at Ocean Medical Center.

Ocean Medical Center has become a vital part of the community since its opening in 1984. The School of Medicine will be the anchor in the development of healthcare and research education, and in-home settings, and to advancing medicine through clinical education and research.

We foster a culture of excellence within a collaborative environment. We actively seek innovative solutions, technologies and partnerships to support sustainable financial growth and to ensure communities we serve have access to a comprehensive continuum of integrated services that meet their present and future health care needs.

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

For more information regarding positions or to apply, please visit our website at: www.fcspsy.com

Qualify For A Free Subscription Online @ www.psychiatrictimes.com
Department of Psychiatry
With the continued growth of our Department of Psychiatry and our New General Psychiatry Residency Programs at Ocean Medical Center and Jersey Shore University Medical Center our vision for Behavioral Health is Bright.

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

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

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

For immediate consideration, please contact Renee Theobald, at: Renee.Theobald@hackensackmeridian.org or call: 732 751-3957

Hackensack Meridian Health

Outpatient Adult and Child Psychiatrists are needed for Stanislaus County Behavioral Health & Recovery Services, in the Central Valley less than two hours from San Francisco and Yosemite. Recovery-oriented treatment provided in a multidisciplinary setting with friendly and dedicated staff members. Recently revised rates with full malpractice coverage and pension plan (PARS) as a Personal Service contractor with an income potential of over $325 K per year for adult psychiatrist and over $335 K per year for child psychiatrist for F/T work.

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

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

### Psychiatrist Position

**J-1 Visa Opportunity in California**

Imperial County Behavioral Health Services is currently recruiting for a full time psychiatrist. Imperial County is located 90 miles by freeway to the city of San Diego to the west, and 90 miles to Palm Springs to the north. Located in a rich farming area, Imperial County has a population of 180,000 and borders with Yuma, Arizona and 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 public and private 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

**Your Career in Paradise! Psychiatrist Job Opening In Santa Barbara, CA**

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

Live the good life in Santa Barbara County! Visit: http://www.getpsychhelpsb.com/
Contact Tom Widroe at 805.680.7772 or tomwidroe@icloud.com

Hackensack Meridian Health

The doctors of TRADITIONS BEHAVIORAL HEALTH are the largest provider of MD psychiatric services to adult populations in institutional and community based programs in California. We provide services to the seriously and persistently mentally ill and have openings in San Francisco Bay Area, Santa Barbara, San Diego and Los Angeles. Overall we plan to add 50 more Fulltime psychiatrists in California to bring our medical staff team to 400 psychiatrists. Our packages vary from a minimum of $300,000 per year plus $10,000 in bonuses and a benefit package valued at approximately $90,000, to up to $500,000, for the industrious physician. Our generous benefit package includes almost 7 weeks paid time off per year. If you are creative and think outside the box, if you value diversity and cultural competency, if you like innovative programs that are patient driven, using a rehabilitative, rather than illness model, if you want more time to work with patients, to get the best results, then TBH is the company for you. To learn more about the specific job openings and salary and benefit packages, check 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
Butte County Behavioral Health Department is seeking a Medical Director based in Chico, California to manage department programs. The incumbent will perform approximately 50% direct services and 50% administration work. In collaboration with the Assistant Director – Clinical Services, directs, evaluates, plans, establishes, and implements the medical services component and all clinical services of the department; participates in coordination of services across county departments and agencies; provides medical direction and consultation to all mental health programs and consultation to contracted agencies; particularly in the areas of quality improvement, medication monitoring, and peer review.

Starting salary is dependent on experience and is negotiable. The Department will also consider a Medical Director on a contract basis. Salary for a contracted Medical Director is negotiable. For additional information please contact Geoff Davis, at (530) 891-2986 or gдовis@buttecounty.net for a recruitment packet and appointment to speak with the Behavioral Health Department Director. Please visit the Butte County Human Resources Department website for more information, to review the recruitment packet, and to apply for the opportunity:

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

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

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

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

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

Quality of practice. Quality of life.

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

We are currently recruiting psychiatrists at our five locations:

• Medical, dental and vision benefits
• Private practice permitted
• Retiree healthcare
• Psychiatrist-led treatment teams
• Patient-centric, treatment first environment
• Relocation assistance may be available

To find out more, please contact Laura Dardashti, MD.
at (916) 854-2609.
You can also email us at DSH.Recruitment@dsh.ca.gov or visit our website at www.dsh.ca.gov

County Human Resources Department

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

The University of Miami Miller School of Medicine Department of Psychiatry and Behavioral Sciences is recruiting several full-time psychiatrists at the assistant or associate professor rank to join our faculty. We are in an exciting phase of growth and we are recruiting psychiatrists for several services including inpatient, outpatient, consultation-liaison and emergency room. Faculty rank and compensation are commensurate with experience. The University of Miami also provides a moving bonus and faculty stipend. The UM Department of Psychiatry is ranked 25th in the nation in NIH Funding and there are extraordinary opportunities to participate in research, resident education and medical school teaching.

Position Requirements:

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

To be considered for a position please send a copy of your CV to Radu Saveanu M.D., Professor and Vice Chair, Department of Psychiatry and Behavioral Sciences at psychiatry@med.miami.edu
GEORGIA

PSYCHIATRIST POSITIONS IN GEORGIA

Georgia Department of Behavioral Health & Developmental Disabilities has hospital based psychiatrists positions available at our facilities in Atlanta, Augusta, Columbus, Milledgeville and Savannah. In addition we are seeking a Clinical Director for our forensic hospital in Milledgeville, GA.

Job Description

Adult Mental Health: Job duties include leading a multidisciplinary team that provides inpatient stabilization for individuals admitted to the hospital and coordinating the integration of the individual back into the community once stabilized (Caseload unit length of stay varies based on if the unit is an Admitting Unit or a Chronic Unit).

Forensics: Job duties include leading a multidisciplinary team that provides inpatient stabilization and long-term treatment to individuals referred from the surrounding courts who are incompetent to stand trial or Not Guilty by Reason of Insanity. Forensically trained psychiatrist may also participate in competency evaluations and court testimony as needed (Caseload and length of stay vary based on if the unit is an Admitting Unit of a Chronic Unit). Qualifications:

• Licensure to practice medicine in the state of Georgia
• Board eligible or board certified in psychiatry

Talk to us about H-1B Sponsorship availability

Contact Greg.Short@DBHDD.ga.gov for more information.

INPATIENT OR OUTPATIENT PSYCHIATRY POSITIONS THAT FIT YOUR NEEDS!

Baystate Health (BH), home of the University of Massachusetts Medical School-Baystate, has an outstanding Psychiatry opportunity available to fit your schedule.

Whether you want to work part-time, full-time, or per diem, BH wants you to work with us to find the right fit and schedule that works for your life!

Opportunities are available for physicians in a variety of practice settings ranging from our:

• Large academic medical center including our well established Psychiatry Residency Program.

• Award winning community hospitals and growing group practices in urban, suburban and rural areas

• Inpatient and outpatient adult or child psychiatry opportunities, working with high performing multidisciplinary teams

Locations include Ware, Springfield, Westfield and Greenfield, MA

At Baystate Health, we value the skill and commitment you make to your patients. Our well-resourced staff is comprised of Psychiatrists, Psychiatric nurses, Psychologists, Psychiatric Social workers and Master’s prepared specialists, Occupational and Recreational therapists and unit counselors.

Baystate Health offers a very competitive compensation package that includes generous salary, paid time off, full medical benefits and CME reimbursement and time allowance.

Candidates must be BC/BE by the American Board of Psychiatry. Role modeling of exceptional clinical teaching and communication skills is in a collaborative and multidisciplinary environment is expected.

Learn more and apply online: choosebaystatehealth.org

You may also contact: Ariana Caraballo, Physician Recruiter
Phone: 413-794-8701 • Fax: 413-794-5059
Email: Ariana.Caraballo@baystatehealth.org

Baystate Health is an Equal Opportunity employer. All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, marital status, national origin, ancestry, age, genetic information, disability or protected veteran status.

MARYLAND

The Johns Hopkins Department of Psychiatry and Behavioral Science is recruiting board certified/eligible adult psychiatrists for full-time faculty positions. All faculty are involved in clinical, teaching and research activities. The inpatient service includes various subspecialties and there are opportunities available among a number of services including Young Adult Mood Disorders, Psychogeriatrics and Eating Disorders. For more details please email Dr. Bernadette Cullen, Vice Chair for Clinical Affairs at: bcullen@jhmi.edu.

The Johns Hopkins University is an equal opportunity/affirmative action employer committed to recruiting, supporting, and fostering a diverse community of outstanding faculty, staff, and students. All applicants who share this goal are encouraged to apply.

INPATIENT OR OUTPATIENT PSYCHIATRY POSITIONS THAT FIT YOUR NEEDS!

INDIANA

NORTHWEST INDIANA!!

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

Regional Mental Health Center is a private non-profit mental health center that has successfully served Indiana for over 30 years. Experienced and collegial group of 12 mostly full-time psychiatrists, an extremely favorable malpractice environment.

OP work, call q 12 wks. Regional is a leader in psychiatrist-directed integrated care services. Incentive bonus available, full benefits.

Please contact Kobie Douglas, MD: kobie.douglas@regionalmentalhealth.org

219-736-7232

Michigan

Sparrow Psychiatry Position with Sparrow Medical Group

Sparrow Medical Group (SMG), a multispecialty physician group and the premier physician organization of Sparrow Health System (SHS), located in Lansing, Michigan, is seeking a dynamic BC/BE psychiatrist for an adult inpatient position. Position is hospital-employed and offers excellent compensation and benefits including relocation assistance, 401(k) with matching funds, generous CME benefits and malpractice insurance that includes tail coverage.

Learn more about this position by contacting:
Barbara Hilborn, Manager Provider Recruitment Office:
1.800.968.3225
Email: barbarahilborn@sparrow.org
Visit our website at www.sparrow.org
More information on the Lansing area can be obtained at www.lansing.org

MISSOURI

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

Apply online at www.compasshealthhome.org
or send your CV to cgrigg@compasshhn.org.
Candidates with J-1 or H-1b visa status are welcome to apply.

EOE

BRAND NEW ADOLESCENT 15-BED INPATIENT PSYCHIATRY UNIT OPENING IN 2019 – Small Town, Big Opportunity – Medical Director position available. Be in on the beginning of a new unit helping to mold and develop the program. Open to employment, or independent contractor arrangement. Located in southeast MO near Cape Girardeau, this is a low cost of living, low crime rate area but close to a local airport that has direct flights to Chicago. It’s also only two hours from Memphis and St. Louis. This designated underserved area is also located in the Delta Regional Authority so J1 Waivers can also be obtained through the DRA as well as the state. Position can be integrated into existing hospital.

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

NEW YORK

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

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

Massachusetts

DIRECCTOR OF PSYCHIATRY RESIDENCY TRAINING

Come join our vibrant Mental Health team at the VA Boston Healthcare System (VABHS), New England’s premier referral center for Veterans’ healthcare. VABHS consists of (3) academic medical center campuses and (3) community clinics. Our Mental Health Service has a strong academic affiliation with the Harvard Medical School (HMS). Harvard South Shore is an ACGME accredited program with 32 residents. This residency is fully integrated into the Mental Health Service at VABHS with a rich clinical environment across a broad continuum of psychiatric care.

HMS and VABHS seek an outstanding psychiatrist with strong academic credentials, significant executive or program administrative experience, and the energy and vision to lead the training program. Applicants should be commensurate with academic appointment as assistant professor or associate professor of psychiatry at HMS. Successful applicant must be board certified in psychiatry with a minimum 5 years of experience post-residency. Experience as a training director or associate training director is preferred. U.S. citizenship is required.

VABHS, an academic leader with strong research programs and affiliations with several nationally recognized clinical research centers, offers a highly competitive salary commensurate with experience and academic rank, liability protection, and a generous leave and benefits package.

For more benefits information visit: www.vamc.bemmahealthcare.gov.
This position is eligible for the Education Debt Reduction Program (EDRP). Please email your letter of interest and CV to the search committee co-chairs at: BeakyPsychiatryPositions@va.gov
Learn about VA Boston Healthcare System at:
http://www.boston.va.gov

Affirmative Action/Equal Opportunity Employer
WISCONSIN

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

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

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

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

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

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

Pennsylvania

**LANCASTER, PA – MEDICAL DIRECTOR POSITION – Full-time or Part-time:** 10-bed inpatient Geriatric Psychiatry Unit in the UPMC Pinnacle Lancaster Medical Center. Involves clinical care and part-time administrative duties that can be done while at the hospital. Lovely area, close to Reading, York, Harrisburg and Hershey.

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

PennState Health

**PennState Health Milton S. Hershey Medical Center**

The Penn State Hershey Medical Center Department of Psychiatry is currently recruiting board eligible/certified psychiatrists for inpatient and outpatient positions in both adult and child psychiatry. We are a growing, vibrant department in a strong academic medical center. We host specialty clinics and research programs, including research that crosses the translational spectrum. Our educational programs include adult psychiatry residency, child psychiatry, 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, optimally, potential for scientific and scholarly achievement. We offer an attractive compensation package commensurate with qualifications. Tenure-track positions are possible.

For consideration, send your CV to:
Jenna Spangler Physician Recruiter Phone: 717-531-4271 Email: jsongp2@pennstatehealth.psu.edu

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

Virginia

**Psychiatrist Opportunity**

Southwestern Virginia Mental Health Institute is located in Marion, Virginia, sitting in the heart of the Blue Ridge Mountains. Our 79-bed behavioral health facility offers an exciting career in a wide range of interesting pathology in psychiatric treatment while providing a highly desirable work-life balance.

We have opportunities in our inpatient setting for Psychiatrists for our Adult Admissions and Geriatric Units. These positions are employed positions offering a competitive salary with generous state benefits and paid malpractice insurance, loan repayment, CME stipend/leave, sign-on bonus, and relocation allowance. No on-call required, with compensated on-call available. If you are licensed or eligible for licensure in Virginia, and have completed a psychiatric residency, please send your current CV to kmsayress@svh.org or you may contact a member of our Human Resources staff at 276-783-1204 to discuss this opportunity. We invite you to join a team of dedicated physicians and hospital staff who are committed to promoting a life of possibilities for all Virginians.

For more information, please visit:
www.svhmi.dbhds.virginia.gov;
www.smythcounty.org;
www.abletingon-va.gov

Texas

**South Texas Behavioral Health Center is recruiting an employed Outpatient Psychiatrist to the warm tropical area of Edinburg, Texas. Samantha Barnett - 956.388.2218**

The Clentem J. Zablocki VA Medical Center in Milwaukee, Wisconsin is an academic tertiary care facility closely affiliated with the Medical College of Wisconsin. We are seeking a BC/BE psychiatrist with US Citizenship to work in our outpatient mental health clinic in Milwaukee. Milwaukee is a city which offers low commute times and many different leisure activities. Few cities our size have the breadth of sporting events, concerts or festivals that we can offer. Mental Health outpatients care involves treating a wide range of patients, with mental health issues in a setting with a strong multi-disciplinary orientation and collaborative approach to care. We staff a mental health urgent care clinic that is a walk in clinic and a portal for admission to our many treatment programs. There are opportunities to participate in the clinical training and education of medical students, residents and fellows in the clinic. Successful candidate should possess strong clinical and interpersonal skills. Call is in weekly coverage allotments and the applicant can expect to cover 2 or 3 weeks a year. Our Emergency Room is covered after hours by PHS.

Find a competitive salary, annual bonus, guaranteed salary increases, sign-on bonus, pension plan, 401(k) type plan, 44 days PTO, insurance programs, and free liability protection, flexible scheduling and a group of highly skilled and supportive Mental Health Staff. Faculty appointment with the Medical College of Wisconsin is available, with appropriate credentials.

The incumbent for this position may be eligible to apply for the Education Debt Reduction Program depending on the type of employment, schedule, amount/time of qualifying debt, and funding availability.

Inquiries may be directed to Gunnar Larson, M.D. at Gunnar.Larson@va.gov

Submit cover letter and CV to Amber DiGiorgio:
Human Resources (HRA), VA Medical Center
5000 W. National Ave., Milwaukee, WI 53295
email: Amber.DiGiorgio@va.gov

1-800-684-5663

**The Health of New Jersey is an Equal Opportunity Employer**

36 CLASSIFIEDS

November 2018

WISCONSIN

ChooseVA

* Psychiatric Physician – Outpatient
  Milwaukee, Wisconsin

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Submit cover letter and CV to Amber DiGiorgio:
Human Resources (HRA), VA Medical Center
5000 W. National Ave., Milwaukee, WI 53295
email: Amber.DiGiorgio@va.gov

1-800-684-5663

**The Health of New Jersey is an Equal Opportunity Employer**

36 CLASSIFIEDS

November 2018

WISCONSIN

ChooseVA

* Psychiatric Physician – Outpatient
  Milwaukee, Wisconsin

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Find a competitive salary, annual bonus, guaranteed salary increases, sign-on bonus, pension plan, 401(k) type plan, 44 days PTO, insurance programs, and free liability protection, flexible scheduling and a group of highly skilled and supportive Mental Health Staff. Faculty appointment with the Medical College of Wisconsin is available, with appropriate credentials.

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Inquiries may be directed to Gunnar Larson, M.D. at Gunnar.Larson@va.gov

Submit cover letter and CV to Amber DiGiorgio:
Human Resources (HRA), VA Medical Center
5000 W. National Ave., Milwaukee, WI 53295
email: Amber.DiGiorgio@va.gov

1-800-684-5663

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- Interactive features and webinars with thought leaders involved in the research and treatment of neurological disorders
- Educational quizzes that put your diagnostic skills to the test
- The sharing of best practices to help neurological professionals improve patient outcomes

…and more!

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#1 TMS CHOICE OF DOCTORS

YES

3D POSITIONING ensures precise coil placement

CONTACT SENSING continuously monitors patient contact

REAL-TIME FEEDBACK relays treatment info and alerts to technicians

MT ASSIST® guides MT location and determines treatment dose

NO

NO

NO

NO

NO

Unlike NeuroStar Advanced Therapy, basic TMS systems don’t come close to providing the precision technology you need to help transform patients’ lives.

INDICATION
NeuroStar® is indicated for the treatment of Major Depressive Disorder in adult patients who have failed to receive satisfactory improvement from prior antidepressant medication in the current episode.

IMPORTANT INFORMATION
The most common side effect is pain or discomfort at or near the treatment site. These events are transient; they occur during the TMS treatment course and do not occur for most patients after the first week of treatment. NeuroStar Advanced Therapy should not be used with patients who have non-removable conductive metal in or near the head.

NeuroStar Advanced Therapy is available by prescription only. Please visit NeuroStar.com for full safety and prescribing information.

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