After the recent escalation of sexual scandals, a growing number of Hollywood celebrities have sought treatment in sex addiction rehabilitation centers. While the media presents sex addiction as a recognized psychiatric entity, mental health professionals debate the validity of the diagnosis. A controversial disorder that has not yet made its way into DSM-5, sex addiction is estimated to affect between 3% and 6% of the population, and has recently become the label associated with various kinds of sexual misconduct, cited by Michael Douglas to justify his infidelity or by Harvey Weinstein in response to accusations of sexual harassment and abuse.

The question of whether the term “sex addiction” should be applied to these cases remains unclear as the concept of sex addiction, including diagnostic criteria and treatment options, is not widely accepted by the psychiatric profession. In recent years, efforts have been made to conceptualize sex addiction. Kafka proposed diagnostic criteria for hypersexual disorder (HD), presented as a non-paraphilic sexual disorder with an impulsivity component. HD was a new disorder proposed for inclusion in DSM-5. However, the diagnosis was rejected because of the lack of empirical evidence.

Visual Hallucinations Linked to Timolol Eye Drops

Glaucoma represents the leading cause of blindness in the US and affects about 2.7 million Americans, according to the CDC. While glaucoma can develop in anyone, African Americans, people with diabetes, those with a family history of glaucoma, and people over age 60 are at increased risk.

About 44% of patients with glaucoma are treated with timolol eye drops, a beta-blocker that is systemically absorbed and may cause psychiatric adverse effects. Elderly white women with underlying cognitive impairment may be at risk for visual hallucinations related to the use of timolol eye drops for glaucoma, according to a case series published in the Journal of Glaucoma.

“This case series highlights an important, although rare, adverse effect of this medication that clinicians should be aware of, especially when using it in elderly patients who may have coexisting CNS pathology. It is important that this adverse effect be recognized and appropriately managed to prevent otherwise unnecessary investigations and treatment,” wrote first author Tavish Nanda, MD, of Columbia College of Physicians and colleagues.

The systemic absorption of topical timolol increases the risk of adverse ef-
of a general consensus in the psychiatric field. This month the International Institute for Trauma and Addiction Professionals published a position statement on sexual addiction that stated: “sexual and compulsiveness is a very real problem . . . supported by over 30 years of research in addiction medicine and an abundance of neuroscience studies.”

Assuming the compulsive behavior associated with sex can resemble the characteristics of addiction, the scientific community has been reluctant to attribute the term to a problematic behavior. Gambling disorder and binge eating disorder are the only 2 compulsive behaviors included in DSM-5, and the term addiction has not yet been used in their conceptualization. Such hesitation may arise from the fear of pathologizing normalization. Such hesitation may arise from the fear of pathologizing normalization. The reluctance of the scientific community to recognize sex addiction may also be influenced by social norms. For example, BDSM (bondage-discipline, dominance-submission, sadism-masochism) ceased to be a psychiatric disorder only in 2010, and was excluded from DSM-5, which suggests that there are sexual preferences and sexual disorders that are still poorly understood.

On a more practical level, clinicians have been treating patients with impulsive and self-destructive sexual urges not better explained by the use of a substance or another Axis I disorder for decades. In the absence of diagnostic criteria and guidelines for treatment, clinicians have been prescribing SSRIs, and in refractory or dangerous sexual behaviors, hormonal agents such as leuprolide (chemical castration). Non-pharmacological interventions have been adapted from 12-step methodology (eg, Sex Addicts Anonymous), cognitive behavioral therapy, and psychodynamic psychotherapy. A holistic approach that combines psychopharmacological treatment, personal and group therapy, as well as mind-body activities, is the formula of many (luxury) sex addiction clinics, offering both outpatient and residential programs. The media has recently presented sex addiction clinics in relation to Hollywood celebrities undergoing treatment. From 1-week intensive treatment to 1 month of therapy, the media may have given an altered idea of addiction and recovery. Whether the term sex addiction has been inappropriately used to explain sexual offending behavior, the media has presented sex addiction as the easy way out when the alleged sufferer is caught engaging in any form of sexual misconduct. Such simplistic description may not represent fairly the many troubled patients, still lacking a formal diagnosis, who are undergoing treatment. While the media may not give an adequate representation of (still debated) sex addiction, it has revealed the flaws of the scientific community regarding the ongoing discussion on sexual preference and sex disorders, possibly fueling renewed interest in this controversial topic.

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

References

Visual Hallucinations Linked to Timolol Eye Drops

The researchers note that underlying CNS pathology may have increased these patients’ susceptibility to the adverse effects of timolol. One of the patients had long-standing multiple sclerosis, and 3 had some degree of cognitive impairment or early dementia. Blood-brain barrier dysfunction in these disease states may have been involved.

White women may be more susceptible to the adverse effects of beta-blockers, owing to a genetic predisposition for lower enzyme activity, as well as lower BMI and less muscle mass than men. Moreover, women may be more likely to report psychiatric symptoms than men.

Nanda and colleagues suggest that 2 to 3 minutes of punctal occlusion after instilling eye drops may decrease the amount of topical timolol absorbed systemically, though this technique has yet to be studied.

References
FROM THE EDITOR
Parity? Let Them Pay Out of Pocket!

Allan Tasman, MD | Editor in Chief

Remember the tag line for the ad for the 1975 movie Jaws? “Just when you thought it was safe to go back in the water.” Well, just when you thought you had about all you could stand to be mad about, those sharks at the insurance companies—dah, duh, duh, duh (Jaws shark theme music)—are back. Or more specifically, they never left.

What I’m referring to are the findings in the Milliman, Inc. report released just after Thanksgiving regarding the status of mental health parity. I thought this was really bad timing, since most everyone was in a tryptophan-induced daze.

The title of the November 20, 2017 press release announcing the publication says it all: “Analysis Uncovers Significant Inequalities Between Mental and Physical Health: Lower Payments to Providers and Wide Disparities in Access to Benefits.” In case that wasn’t clear enough, the subheading is: “Data Points to Potential Violations of Mental Health Parity Laws: Shows Higher Out-of-Pocket Cost for Consumers When Compared to Physical Health.” Paul Wellstone and Pete Domenici, the 2 senators for whom the 2008 Mental Health Parity Act is named, must be turning over in their graves.

This report was commissioned by the Mental Health Treatment and Research Institute, LLC, a non-profit subsidiary of the Bowman Family Foundation, and was released by a wide-ranging coalition of mental health and substance abuse advocacy groups, including Mental Health America, National Alliance on Mental Illness, American Foundation for Suicide Prevention, the National Association of Psychiatric Health Systems, and the American Psychiatric Association.

Milliman, a well-respected national actuarial and research firm, drew on 3 years of claims data, from 2013 through 2015, which encompassed information from their databases from over 40 million people and covered the usual array of hospital and ambulatory services in every state. Here’s what they found:

When taken together, the analysis paints a stark picture of restricted access to affordable and much-needed addiction and mental health care in an era of escalating suicide rates and opioid overdose deaths. Further, these disparities point to potential violations of federal and state parity laws, which require insurance companies to treat diseases of the brain, . . . the same way they treat illnesses of the body. . . .

Patrick Kennedy, in a remarkable display of understatement, is quoted as saying, “If nearly 300 people dying each day from overdoses and suicides isn’t sufficient to motivate insurers to take immediate action to improve access to the full range of in-network benefits, we have a real problem—and it’s time to start holding them publicly accountable.”

“[CONTINUED ON PAGE 14]"
Compared with other medical specialties for the same services, such as for those billed under E&M codes. In case you thought maybe we were just unlucky to be working in a bad system that had poorly negotiated the contract with insurers, the Milliman report found this is a ubiquitous situation.

We all know, it’s one of the major reasons so many psychiatrists refuse to take insurance reimbursement. The approximately 20% average payment differential for the same billed code (in a large number of states they found the differential was 2- to 3-fold) is clearly a significant factor in the report’s finding that many more patients nationally use out-of-network mental health services than is the case for physical health.

The percent of outpatient mental health facility visits in 2015 which were out of network nationally was over 31% compared with only 5.5% for medical or surgical visits. This disparity was also found in mental health office visits, with almost 19% out of network for mental health visits compared with only 3.7% for physical health. Hospital care is even worse. In states representing about 30% of the nation’s population, out-of-network inpatient care was between 800% and 1000% higher than for medical care. And, nearly half the states, including my own, had reimbursement disparities as high as 30% to 69%.

Even though this report is damning to the insurance industry, the action steps are too mild. They call on federal regulators to issue more mandates. They call on federal regulators to issue more mandates. They call on federal regulators to issue more mandates.

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Introduction: Neuropsychiatric Disorders of Aging

This Special Report on Geriatric Psychiatry addresses a variety of clinical issues in the rapidly growing diverse population of older adults. With the increase in the population of adults over age 65 years expected to reach 22% of the general population by 2040, neuropsychiatric disorders of aging will become a challenge for many practicing health care providers. This demographic trend has led to an intensive search for effective strategies to diagnose, treat, and prevent mental, cognitive, and physical disorders of aging.

The stigma of mental illness still overshadows proper diagnosis and management of neuropsychiatric symptoms and disorders in the elderly. The boundaries between neuropsychiatric and physical illnesses are often blurred, especially in the acute medical and in long-term care settings, because of frequently comorbid mood, anxiety, cognitive, and physical disorders in older adults. Aging-related physiological changes lead to the increased risk of adverse events such as falls and drug toxicity with pharmacological management.

The growing population of aging baby boomers brings to light new challenges characteristic of this cohort, such as increasing rates of drug abuse and higher rates of depression and anxiety, sleep disorders, and PTSD compared with previous generations. The issue of gender identity and the aging LGBTQ community is coming to the forefront of public and professional awareness of the unique health care needs of its members. It is also becoming more obvious that multiple diseases of aging share common risk factors and may benefit from shared treatment and preventive strategies, such as heart disease, diabetes, and Alzheimer disease.

The 7 articles in this section highlight common clinical dilemmas and outline the nuances of diagnosis, management, and outcomes—and provide helpful practical tips for clinicians. We hope that readers will find the information in this Special Report clinically relevant and helpful in the diagnosis and treatment of neuropsychiatric conditions in older adults.

Dr. Lavretsky reports that she has received research grants from Forest/Allergan.

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Opioid Use in the Elderly

In which of the following cases would you feel comfortable prescribing opioids?

A. A 78-year-old in hospice care for terminal lung cancer
B. A 68-year-old with a history of depression, anxiety, and chronic pain, and a urine drug screen positive for cocaine, opioids, and benzodiazepines (prescribed)
C. A 66-year-old who has hepatocellular carcinoma, recently enrolled in palliative care, with a comorbid severe alcohol use disorder
D. A 90-year-old who has chronic back pain, a neurocognitive disorder, and a history of falls
E. A 65-year-old in the post-anesthesia care unit after hip replacement surgery
Opioid Use in the Elderly
Continued from page 15

which involved opioids. Since 1999, deaths from opioid prescriptions have more than quadrupled. 1

As is often the case, the origins of this epidemic are multifactorial. Some overprescribing can be traced back to the health care profession’s efforts to recognize pain as the fifth vital sign, which compelled physicians to treat more aggressively. Some pharmaceutical companies may have also contributed to the problem through aggressive marketing of prescription opioids without proper emphasis on their addictive potential. Regardless of the cause, the problem is pervasive, affecting all socioeconomic groups and spheres of society.

While opioid use disorders are more common in younger patients, prevalence among the elderly is growing, and misuse poses unique risks in the geriatric population. From 1996 through 2010, the number of opioid prescriptions provided to older patients increased 9-fold. More alarming, 35% of patients aged older than 50 years with chronic pain reported misuse of their opioid prescriptions in the past 30 days.2,3 The hospitalization rate for geriatric misuse of opioids has quintupled in the past 20 years alone.4 Given the scope of the problem, federal and state governments have begun to implement new guidelines in prescribing opioids, but tighter regulations may intrude on individualized patient care and the benefits of opioid therapy in some patients. Whether these new policies are the best strategies remains to be seen.

Avoiding iatrogenic addictions
Avoidance of iatrogenic addictions may be the first step in addressing the epidemic. Some situations are more straightforward. Most clinicians can distinguish which of the following fictional cases is an inappropriate use of opioids: a 78-year-old in hospice care for terminal lung cancer; a 65-year-old who underwent major surgery that morning; or a 68-year-old with a history of depression, anxiety, and chronic pain, and a urine drug screen positive for cocaine, opioids, and benzodiazepines (prescribed). Contrast that with more complex, typical clinical scenarios in which the distinction can be a real challenge.

Mr. X is a 66-year-old under hospice care for hepatocellular carcinoma, with a comorbid severe alcohol use disorder. Opioids were prescribed until his urine drug screen came back positive for marijuana and cocaine. Two days after opioid therapy was stopped, the patient was found dead due to a self-inflicted gunshot wound. Pain was determined to be a major contributing factor. This case highlights the importance of understanding the delicate balance between risks and benefits when prescribing opioids, and the unique role psychiatrists play in their use.

Understanding opioids
Opioids reduce the perception of pain and produce a sense of well-being by binding to opioid receptors (mu, delta, and kappa) distributed in the brain, spinal cord, and other peripheral tissues. When deeper brain regions are stimulated by opioids, drowsiness and respiratory depression ensue. Opioids are classified by their origin, mechanism of action, or potency. Based on their origins in nature, opium, morphine, and codeine are opiates. Semi-synthetics include hydromorphone, hydrocodone, oxycodone, and heroin. Completely synthetic opioids are made and include fentanyl, methadone, pethidine, levorphanol, tramadol, and dextropropoxyphene. Based on their potency, codeine, hydrocodone, and oxycodone are considered mild opioids; morphine, meperidine, hydromorphone, fentanyl, and methadone are classified as major opioids. All are opioid agonists with the exception of buprenorphine, which is a partial agonist/antagonist.

Prescribing practices
Opioids are generally used for acute and chronic pain, active-phase cancer treatment, palliative care, and end-of-life care. The latter situations are relatively straightforward as the benefits are uniformly perceived to outweigh the risks. Standards for treatment of acute pain are similarly uniform among most physicians, with only minor variations. For treatment of nonmalignant chronic pain, there is far less agreement among providers. There are no clear data to support the long-term effectiveness of opioids in these conditions. Hence, guidelines have been established on when to initiate or continue treatment, selection of the proper opioid, dosage, duration of use, and when to discontinue therapy. These guidelines also outline how to conduct a thorough risk assessment and address potential pitfalls.5,6

Opioids are also used for non-medicinal, recreational purposes. In the elderly, the line between use for physical and psychological well-being is often blurred, which compli-

POETRY OF THE TIMES

Prior Auths

Richard M. Berlin, MD

After seven days in bed with the flu and seventy episodes of The Wire, the word “prior” flashes me back to corner boys with priors serving an extra five at Jessup. Funny how fast we become prisoners with lost convictions. Just look at me. I miss a week at the office and prior auth forms pile up faster than a stack of subpoenas in criminal court, me in a flat-screen cell, no memory of when this hardware first blocked my view of the sky, bureaucrats stealing my hours, devious as Westside drug lords who smuggle product into prisons—powders packed in condoms stuffed up a girlfriend’s pink purse. I moan, fill out the forms, my patients getting sicker while they wait, my captive colleagues and I banging our tin cups for mercy, all of us serving life.

Dr. Berlin is Senior Affiliate in Psychiatry at the University of Massachusetts Medical School. E-mail: Richard.Berlin@gmail.com. His most recent collection of poetry, PRACTICE, is published by Brick Road Poetry Press.

SIGNIFICANCE FOR THE PRACTICING PSYCHIATRIST

In the midst of a nationwide opioid epidemic, clinicians are increasingly confronted with difficult decisions about pain management. Faced with a delicate risk-to-benefit balance and an alarming rise in fatalities, some have opted out of prescribing opioids altogether. In this article, we suggest a less drastic option, particularly when prescribing for the elderly. We advocate strongly for vigilance in oversight, monitoring closely for warning signs of misuse, and thorough documentation. In this article, we cover:

- Classification of opioids and recommended prescribing practices in the elderly
- Clinical scenarios illustrating when opioids are indicated for pain control
- Appropriate screening for “red flags” and warning signs of potential misuse
- Treatment of chronic pain with different types of opioids and monitoring of maintenance effectiveness
- Treatment options in cases where there are signs of misuse, abuse, or diversion
Chronic pain treatment

Non-opioid pharmacotherapy and non-pharmacological therapy are the preferred modalities of treatment for chronic pain. However, in the proper contexts, opioids can be a useful treatment option. They are most beneficial in the short term for acute injuries, including the management of pain postoperatively. Use should be time-limited, except in managing certain cancer-related pain syndromes and as a part of end-of-life care. Particularly in the elderly, appropriate precautions must be taken.

Obtaining a thorough history is the first step. Screen for a history of opioid use disorder or other addictive disorders, including nicotine use disorder and any family history of addiction. A complete psychosocial history, including current stressors, history of childhood abuse or neglect, legal problems, and interpersonal relationship stressors will help to identify high-risk opioid misusers. Comorbid depression and high levels of pain are additional risk factors for misuse of opioids in the elderly. Always screen for cognitive deficits and other psychiatric disorders. Depression and anxiety may increase the perception of pain and require a different approach to pain management altogether.

Be alert for certain findings on the mental status exam such as confusion or any other indicators of a clouded sensorium, disheveled or unkempt appearance, thought content preoccupied with opioids, and dramatic or exaggerated pain-related behaviors suggestive of drug-seeking. While doing a chart review or using prescription monitoring programs, look for doctor shopping and requests for early refills. Other red flags include patients’ keeping only the appointments related to pain management, a history of positive urine drug screens or refusal of such monitoring, losing pain prescriptions, and having multiple providers prescribing the same or similar classes of medications.

After a complete history and examination, if the decision is made to begin opioid therapy, a detailed list of all medical conditions, allergies, and medications—including over-the-counter and herbal remedies—must be obtained and regularly updated. Drug selection should be based on careful consideration of potency needs and individual patient characteristics. Before initiating therapy, realistic treatment goals should be set after careful consideration of pertinent risks and benefits.

Begin with low doses and gradual titration, monitoring regularly for adverse effects and drug-drug interactions (Table). Common adverse effects include constipation, dry mouth, tolerance, dependence, nausea, vomiting, drowsiness, confusion, and low blood pressure. Warn patients about the risk of withdrawal.

(Continued on Page 18)

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Starting dose</th>
<th>Metabolized by</th>
<th>Dosing frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>30 mg</td>
<td>UGT 2B7, UGT 1A3 (potentiated by CYP3A4)</td>
<td>4 hours</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>20 to 30 mg</td>
<td>CYP 2D6, 3A4</td>
<td>3 to 4 hours</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>5 to 10 mg</td>
<td>2D6</td>
<td>4 hours</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>10 to 20 mg</td>
<td>UGT 2B7, UGT 1A3 (potentiated by CYP3A4)</td>
<td>4 hours</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>4 mg</td>
<td>UGT 2B7, UGT 1A3 (potentiated by CYP3A4)</td>
<td>3 to 4 hours</td>
</tr>
<tr>
<td>Codeine</td>
<td>30 to 60 mg</td>
<td>2D6</td>
<td>4 to 6 hours</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>25 μg patch</td>
<td>CYP 3A4</td>
<td>72 hours</td>
</tr>
<tr>
<td>Methadone</td>
<td>2.5 to 5 mg</td>
<td>CYP 3A4, CYP2B6, CYP2C19; to a lesser extent 2D6 and 2C9</td>
<td>12 hours</td>
</tr>
<tr>
<td>Morphine LA</td>
<td>30 to 60 mg</td>
<td>UGT 2B7, UGT 1A3 (potentiated by CYP3A4)</td>
<td>12 hours</td>
</tr>
<tr>
<td>Oxycodone LA</td>
<td>15 to 30 mg</td>
<td>CYP 2D6, 3A4</td>
<td>12 hours</td>
</tr>
<tr>
<td>Oxymorphone LA</td>
<td>5 mg</td>
<td>UGT 2B7, UGT 1A3 (potentiated by CYP3A4)</td>
<td>12 hours</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>2 to 8 mg</td>
<td>CYP 3A4</td>
<td>8 hours</td>
</tr>
<tr>
<td>Tramadol</td>
<td>25 mg</td>
<td>CYP 2 D6</td>
<td>4 to 6 hours</td>
</tr>
</tbody>
</table>

LA, long acting.
Opioid Use in the Elderly

Continued from page 17

with abrupt discontinuation. Serious adverse effects include respiratory depression leading to death, especially when mixed with benzodiazepines or alcohol. The use of benzodiazepines is contraindicated in patients who are receiving opioid therapy.

Combining analgesics with different mechanisms, together with nonpharmaceutical pain management strategies, may improve outcomes and minimize the need for opioid dose escalations. With multiple states enacting laws to legalize marijuana for medical conditions, marijuana may be one remedy for the opioid crisis. Some studies have shown that the hospitalization rates related to opioid abuse and overdose have decreased significantly in the states that offer medical marijuana. However, we should caution that the evidence is still preliminary and in need of further review. Moreover, the availability of multiple preparations and potencies makes uniform recommendations a particular challenge.

When opioids are deemed appropriate for the treatment of pain, monitor use carefully and be vigilant for patient misuse. State-sponsored, prescription drug monitoring programs may be an invaluable tool. Should signs of misuse, abuse, or diversion emerge, clinicians are encouraged to avoid outright dismissals from treatment, opting instead for referrals or in-patient treatment of substance use disorders. Patients should be given the opportunity to choose either med-
ication-assisted treatment with buprenorphine or methadone maintenance or naltrexone. These treatments are often coupled with behavioral therapies to help with addiction.

Patients who are taking opiates should also continue to be monitored for drug-drug interactions, particularly with anti-epileptics, antidepressants, and other drugs metabolized primarily by the cytochrome P-450 system. Opiates are also notorious precipitating factors for delirium, but there is no clear evidence that the risk varies based on the type of opiate used.\textsuperscript{4} If an opioid regimen proves ineffective, clinicians may rotate the opioids or change the formulation based on consideration of pharmacokinetics and metabolism. Urine drug screens are routinely employed to check for the presence of other illicit or contraindicated substances and to investigate suspicions of drug diversion.

There is no evidence to support the long-term use of opioids for the treatment of chronic pain in the elderly. Rather, there is extensive literature that shows possible harm from long-term opioid use. For acute pain management, 3 days of opioid treatment is sufficient. In rare cases, this may be extended to 7 days. Immediate-release formulations are preferred over long-acting preparations. In cases of longer-term opioid therapy, clear and measurable treatment goals should be established and monitored regularly.

Assessments should focus on overall functioning and activities of
daily living. Progress should be re-evaluated no less frequently than every 3 months, with appropriate consideration for the taper or discontinuation of therapy, particularly in the absence of clinically meaningful improvement. We cannot overemphasize that, particularly in

the elderly, opioids are far more effective when accompanied by a comprehensive and multidisciplinary approach using psychological support, physical therapy, and other complementary therapies.

Conclusions

There are legitimate uses for opioids in the treatment of a variety of pain conditions. However, the significant risks associated with opioid prescription must be carefully weighed against the potential benefits. The alarming rise in fatalities seen with the current opioid epidemic provides a vivid illustration of this challenge.

Our “textbook” and real-world cases illustrate the application of prescribing recommendations. Based on these principles, most clinicians would feel justified prescribing opioids for the cases of the 78-year-old in hospice care for terminal lung cancer as well as the 66-year-old in hospice care for hepatocellular carcinoma. However, in the latter case, the patient’s comorbid substance use disorder as well as the evidence of misuse on drug screening provides a more complex, real-world scenario. Such cases require difficult clinical decisions—
sometimes with untoward outcomes. It is our hope that understanding the guidelines, following the standards of care, and documenting the same will help clinicians provide better care to complex elderly patients.

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

References

Tools and Tips for Assessing Cognition in Older Adults: Issues for Psychiatrists

 Priya Sharma, MD and Melinda Lantz, MD

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With the growth of the elderly population has come increased pressure on psychiatrists to offer timely access to quality care that is specific to the needs of the elderly, particularly the recognition of cognitive loss and dementia. Up to 40% of patients with moderate degrees of cognitive impairment remain unrecognized and undiagnosed by physicians. It has been postulated that some clinicians simply believe early detection does not change the trajectory of illness; some may feel that the tests are too time consuming or difficult to administer; still others may assume that their patients will resist the testing, without attempting to suggest it to their patients. However, the benefits of early detection of cognitive loss include counseling patients and their families regarding advanced care planning, preparation for financial needs, treatment of comorbid medical conditions, and maximizing functional status to promote better quality of life.

The cognitive assessment

Cognitive impairment is not always associated with dementia. For this reason, a full comprehensive history is an integral component of any cognitive assessment. Presenting complaints of memory loss or changes in behavior, demeanor, or activity in the elderly population may be reflective of a psychiatric illness including a mood or anxiety disorder, a response to a new medication or a change of dosing, or an underlying medical condition. In some cases, what may appear to be a cognitive impairment may actually be an underlying depression or anxiety disorder in which attention and concentration become difficult. The following Case Vignette illustrates how complex presenting memory loss can be when complicated by both medical and psychiatric comorbidities.

**CASE VIGNETTE 1**

Mr. B is a 76-year-old man with multiple medical problems including diabetes mellitus, hypertension, hyperlipidemia, glaucoma, and obstructive sleep apnea. He is referred by his primary care physician (PCP) because of a decline in cognition over the past 6 months; his Mini Mental State Examination (MMSE) score decreased from 23 to 15. On interview, Mr. B appears tired and complains of poor sleep with frequent awakening during the night. He explains that he has difficulty filling his prescriptions and has not been taking his medications for many months. He also does not regularly use his continuous positive airway pressure device.

Mr. B describes feeling overwhelmed by his medical problems and depressed by his financial state. He is referred back to his PCP for care, given a referral for homecare services, and seen for follow-up. After 3 months of better adherence to his medical regimen, his MMSE score is 20/30. He remains depressed and is treated with sertraline, with follow-up visits at regular intervals that his daughter takes him to.

Complex medical and psychiatric comorbidities need to be identified as part of the cognitive screening examination in order to create an appropriate treatment plan. It is important to consider and rule out metabolic, vascular, and endocrine illness and to consider causes of acute confusional states. Often, identifying and appropriately treating a medical disturbance can improve or restore the level of cognitive function. Cognitive impairment may relate to language, executive functioning, social cognition, perceptual/motor functioning, or complex attention (Table 1).

**Assessment**

A picture of the patient’s functional capacity should be obtained, including ability to perform basic activities of daily living (washing, dressing, grooming) and instrumental activities of daily living including managing finances, shopping, transportation, telephone use, and medication management. Cognitive reserve factors should be well understood including the patient’s level of education, engagement in social and physical activities, and background of performing complex mental tasks.

The remainder of the assessment should focus on gathering a medical history, family history, substance use history, and medication review. Laboratory tests such as a complete blood cell count, electrolyte panel, renal and liver function tests, thyroid function, and serum vitamin B12 levels should be done to rule out any reversible causes of cognitive impairment.

**Table 1. Domains of cognitive impairment**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Example of related skill</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning and memory</td>
<td>Short-term recall, long-term recall, semantic memory, autobiographical memory</td>
</tr>
<tr>
<td>Language</td>
<td>Object naming, word finding, use of speech</td>
</tr>
<tr>
<td>Complex attention</td>
<td>Sustained attention, selective attention</td>
</tr>
<tr>
<td>Executive function</td>
<td>Planning, flexibility, working memory, decision making</td>
</tr>
<tr>
<td>Perceptual/motor</td>
<td>Visual perception skills, coordination of activity</td>
</tr>
<tr>
<td>Social cognition</td>
<td>Recognition and regulation of emotions, appropriateness of behavior</td>
</tr>
</tbody>
</table>

**Cognitive screening tools**

The first step in integrating cognitive screening tools into practice is knowing who to screen and when to perform the evaluation. Generally, it is recommended that clinicians screen individuals with cognitive complaints, those with family who express concern about memory loss, and patients with multiple risk factors or advanced age.

There is no tool that is diagnostic for dementia. The current tools are screening measures, i.e., they are designed to identify people who are at increased risk of disease. A number of cognitive screening tools have been developed, all exhibiting differences in their administration and scoring. They all share the goal of rapidly assessing cognitive functioning in the clinical setting.

**Mini Mental State Examination**

The MMSE remains the most widely used tool as well as the most studied. The tool was compiled from a number of neuropsychological batteries and includes 5 for a possible 30 points:

1. Orientation: 10 points
2. Registration: 3 points
3. Attention and calculation: 5 points
4. Recall: 3 points
5. Language: 9 points

Limitations of the MMSE include poor sensitivity in frontal domains/ executive functioning. In addition, patients with a higher degree of education or intelligence exhibit a ceiling effect.

**Clock Drawing Test (CDT)**

The CDT has become popular with neurologists as well as psychiatrists because of its ease of administration, ease of scoring, and its capacity for testing multiple cognitive domains. The CDT screens through visuospatial, constructional praxis, and frontal/executive domains. The patient is asked to mark the time on a clock and is scored based on his or her ability to draw the circle, appropriately space the numbers on the face of the clock and, finally, for correctly representing the time. Strengths of this particular tool include the universality and cross-cul-
Cultural ease with which representing time is understood. In comparison with other tools, there is less cultural bias involved and it also involves less bias due to intellect or education.

**Mini Cog**
This is a 3-word recall test combined with the CDT. Again, it is considered relatively easy to use and fast to administer to the patient. Cognitive impairment is questioned when a patient is unable to recall any one of the 3 words listed with a normal clock, or if he or she is able to list 1 or 2 words but draws an abnormal clock. This screening test is thought to be useful in determining whether impairment is present; however, it is not useful in monitoring disease progression.

**St. Louis University Mental Status (SLUMS)**
Similar to the MMSE, SLUMS is a 30-point test that was designed to measure ability in the domains of orientation, executive function, memory, and attention. Some researchers argue that the SLUMS scale addresses some of the shortcomings of the MMSE, including being better at detecting aphasia as well as having less emphasis on orientation.

**Montreal Cognitive Assessment (MoCA)**
Some patients may self-refer for an evaluation of memory loss as illustrated in the following Case Vignette. These seniors may be worried by the thought of cognitive loss but have no signs or symptoms. This illustrates the reassuring nature of screening tests and the importance of repeating the screens at regular intervals.

### CASE VIGNETTE 2

**Mrs. V** is an 82-year-old widow who complains of feeling anxious and very worried about her memory. She has a friend who recently received a diagnosis of Alzheimer disease, and **Mrs. V** is fearful that she has this too. She does not describe any clear issues with her memory. She has no active medical problems, and her only medications are vitamin D and calcium. **Mrs. V** scores 30/30 on the MoCA, and her clock drawing is intact and accurate. She is mildly anxious but responds well to reassurance. She is given a referral to a local senior center that provides support and stimulation, including memory-enhancing programs. She is instructed to return in 6 months for clinical follow-up.

**Abbreviated Mental Test (AMT)**
The AMT is a 10-item scale for screening cognitive impairment, including domains such as short- and long-term memory, attention, and orientation. A score of less than 8 suggests a cognitive impairment. The benefit of this scale is its rapid administration time (roughly 3 minutes); an even shorter 4-item scale is also available. It is favored in busy clinical settings or in emergency departments, where lengthy screening tools are difficult to use.

**Challenges and barriers**
Cognitive screening tools have advantages and limitations (Table 2). The MMSE can be difficult to administer to patients with sensory or motor impairments, and the MMSE or Mini Cog. The clinician may also consider the use of specific tools that involve less cultural bias. The Rowland Universal Dementia Assessment Scale (RUDAS) is a 6-item screening tool developed to avoid items that may be subject to cultural or educational bias.

**Health care practitioners** should be mindful of cultural barriers in the use of cognitive tools. Psychiatric illnesses, including dementia, can be more difficult to detect in individuals who do not speak English as a primary language, or in those who are not familiar with Western cultural norms. Cultural competency issues may also include communication barriers, varying attitudes among cultures regarding dementia, and varying beliefs on what it is important to report to a clinician.

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

### REFERENCES

### TABLE 2. Comparison of cognitive screening tools

<table>
<thead>
<tr>
<th>Test</th>
<th>Scoring</th>
<th>Cut-off point</th>
<th>Other notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMSE</td>
<td>11 items; 0 - 30</td>
<td>&gt; 24</td>
<td>Most widely used; designed for those fluent in English and with a grade 8 education.</td>
</tr>
<tr>
<td>Mini Cog</td>
<td>3 items + clock</td>
<td>0 - 2</td>
<td>High sensitivity and specificity, very fast to administer.</td>
</tr>
<tr>
<td>CDT</td>
<td>10 points</td>
<td></td>
<td>3 minutes to administer, high reliability.</td>
</tr>
<tr>
<td>SLUMS</td>
<td>30 points</td>
<td>27 - 30</td>
<td>Effective at screening for executive function.</td>
</tr>
<tr>
<td>MoCA</td>
<td>Possible 30 points, 8 domains tested</td>
<td>&lt; 26</td>
<td>Performs well with respect to test/retest reliability and internal consistency.</td>
</tr>
<tr>
<td>AMT</td>
<td>10 items</td>
<td>8</td>
<td>Simple to administer and score, limited validity.</td>
</tr>
<tr>
<td>RUDAS</td>
<td>6 items</td>
<td>&lt; 22 indicates impairment</td>
<td>Designed to minimize the effects of cultural learning and language diversity.</td>
</tr>
</tbody>
</table>

**MoCA** was developed to enable earlier detection of mild cognitive impairment than the MMSE. The score range is the same as the MMSE, but it involves additional tasks that are better able to screen for difficulties with executive functioning. The MoCA also addresses bias due to educational level by adding 1 point for individuals whose level of formal education is less than 12 years.

**Significance for the Practicing Psychiatrist**
This article will assist the practicing psychiatrist in performing an office-based evaluation for cognitive loss and dementia. The strengths and challenges of screening tools, interview techniques, and basic assessments are described.

- Assessment of cognition must first focus on gathering the history and assembling a clinical picture of functional status.
- Use of structured and standardized screening tests is vital for validity and reliability.
- Cultural, language, and educational factors must be considered in the interpretation of cognitive testing.

Additional reading
Food for Thought | Commentary

Cynthia M. A. Geppert, MD, DPS

It is interesting that some of the thorniest ethical dilemmas in psychiatry evolve around food: forced feeding in anorexia nervosa, artificial nutrition and hydration at the end of life, and the subject of the October Ethics Quiz—the covert administration of psychotropic medications.1-3

Here is a brief recap of the case to reorient us before we turn to the quiz answers and commentary. Mr. B, an 85-year-old with vascular dementia, had been transferred to an acute geropsychiatric unit. Mr. B was admitted for psychiatric stabilization after he became aggressive toward residents at the dementia care facility where he has resided since his daughter, who is also his medical power of attorney, could no longer safely manage him.

Initially, the patient responded well to valproic acid and was about to be discharged back to the facility when he began to refuse the drug. His behavioral disturbances rapidly returned and required several emergency administrations of antipsychotics. When none of the environmental and behavioral techniques the team tried could persuade Mr. B to take the mood-stabilizing medication, the pharmacist suggested covert administration in applesauce. The treatment team was sharply divided on whether such surreptitious provision of the medication was ethical and requested an ethics consult to assist them.4

Readers were asked to imagine they were the ethics consultation team leader and to work through a series of 4 questions about the case. There were some very perceptive comments online that I will try to incorporate into the commentary.

1. When reviewing the case summary the attending has prepared, the opinion of the psychologist seems most consistent with which major ethical theory?
   - Option A: Deontologists often take positions diametrically opposed to utilitarianism, and that is the situation here. Deontology comes as close to endorsing absolute values as any theory. The psychologist, although he would likely not use the word, is a deontologist. The theory supports the psychologist in his moral claim that the duty to tell the truth outweighs any other ethical principle.
   - Option B: Deontologists often take positions diametrically opposed to utilitarianism, and that is the situation here. Deontology comes as close to endorsing absolute values as any theory. The psychologist, although he would likely not use the word, is a deontologist. The theory supports the psychologist in his moral claim that the duty to tell the truth outweighs any other ethical principle.
   - Option C: Aristotle’s virtue theory finds the good and right in the character and conduct of exemplary human beings. This is a favored theory among clinicians because we all can easily recognize a “good doctor or nurse.” Yet there are in our scenario no real obstinate villains but only uncertain heroes searching for the cleanest way to promote Mr. B’s welfare.
   - Option D: Principlism would consider the big 4 ethical principles of autonomy, non-maleficence, beneficence, and justice and through a process of weighing and specifying arrive at the optimal resolution of the dilemma. But such a process requires prioritization, and the nurses see not doing harm as most important, the pharmacist as doing good through managing the behavioral disturbances, and the psychologist as respecting the patient’s autonomy. So, while we have succeeded in identifying the salient values, we are no closer to knowing which one prevails in the case.

2. This question underscores the need to involve the daughter in the discussion and to clarify her authority to make the decision.
   - Those who commented on this question on the website hit the target when they asked, “Where is the daughter in all this, and what can she do?” To which the various answers explicated below offered answers.
   - Option A: Before losing capacity, Mr. B named his daughter as what is technically called the health care agent (HCA) in his durable power of attorney for health care. This gives the daughter the legal right and responsibility to make the decisions about covert administration on behalf of her father in some states.
   - Option B: This answer speaks deontological language: the daughter, even if she has the legal authority, does not have the moral authority to consent for a human being to be intentionally deceived.
   - Option C: In many but not all jurisdictions, the daughter as in option A would have the authority to provide informed consent on her father’s behalf to the administration of covert medications. However, in some states, consent for psychotropic medications is reserved to a court-appointed conservator of treatment guardian or even the court itself. Dementia bedevils practitioners and courts alike as there is no judicial or clinical consensus on whether it is a psychiatric or a neurological, or a medical disorder.
   - Option D: This is a variation on option C and would be true in a state where an HCA does not have the legal sanction to provide consent for psychotropic medication and conversely the court-appointed treatment guardian may not always be able to make medical decisions.4 The warrant for the judicial bifurcation is that psychiatric treatment requires a higher level of protection because of the vulnerability of the patient and the risks of the intervention, which is analogous to the more rigorous standard often required in psychiatric research.4

3. Those experts who contend that surreptitious administration can be an ethical option specify conditions that must be met for the practice to be justified.
   - Question 3 assumes the daughter is empowered to provide informed consent for surreptitious medication and asks what ethical qualifications the consultant should stipulate. The answers were phrased in the negative, so readers were asked to pick which of the 4 listed choices should not be included.
   - Option A: As with any treatment, the decision to administer the medication covertly should not be open-ended or unsupervised. The rights and welfare of the patient require that effectiveness of valproic acid in reducing the behavioral disturbances as well as any serious adverse effects such as thrombocytopenia or distressing symptoms such as gastrointestinal distress be monitored. Both the adverse and the positive effects may well alter the risk to benefit balance that underlies the ethical acceptability of the practice.
   - Option B: While—depending on hospital policy—signature informed consent may or may not be required, a written treatment agreement protects all involved by ensuring the entire team has reached consensus about this unusual means of medicating Mr. B and that the daughter as HCA is informed of and concurs with the treatment plan.
   - Option C: A formal treatment plan also is a safeguard against covert administration being a treatment of convenience. The staff should continue to try to
persuade Mr. B to take the mood stabilizer and continue to find any other non-pharmacological interventions that can help manage his behavior.

**Option D:** This answer describes what ethicists call a “right of conscience” or “conscience clause.” Staff who from a virtue or deontological perspective truly believe it is wrong to deceive any patient, even an incapable one, should probably be excused from the care of Mr. B out of respect for their moral beliefs. However, this recusal depends on hospital policy, ethical codes, and the pragmatic consideration of staffing.

4. This question comes back to the ethics consultant who having heard the ethical concerns of all the stakeholders must now make a recommendation. As a prelude to this, he considers the arguments and counter-arguments. Question 4 asks readers to identify the strongest of the latter.

**Option A:** There is a consensus in law and ethics that in a true emergency that endangers a patient, other patients, or staff, psychotropic medication can be administered over the objections of a patient. The risk of course is that staff out of fear, burnout, or convenience will “find” or worse “provoke” the emergency. For this reason, many states require the permission of the court to administer antipsychotic medication on any regular basis against the will of the patient or his or her ethically appropriate decision maker. The nurses also have a humanistic point that holding Mr. B down and jabbing a needle in his arm is more painful and degrading than is sprinkling medication on his pudding.

**Option B:** While beleaguered staff in taxing situations acting out of soft paternalism often question the motives of family members, there is no evidence in the case scenario that the daughter wants anything other than her father’s well-being. She refuses to consent to antipsychotics. As one astute reader pointed out, divalproex is not a benign drug and for real informed consent this would need to be stressed.

**Option C:** Argument C is one of the strongest arguments in favor of covert administration of medication, as it has a track record of getting Mr. B back to the neuropsychiatric baseline where he can return to live in his nursing facility. The caveat being, as readers stated, that he may be given even more psychotropics in that setting without any of the due process protections the ward is utilizing.

**Option D:** This option takes the long and most deontological and virtue theory view of the decision. Despite his dementia, Mr. B may well grasp that he is being “fooled” and become even more resistant to treatment and, more importantly, distrustful of not just the staff, but of his daughter when a nursing assistant, as frequently happens, tells him that his daughter consented to the deception.

**Summary**

When I was in training, one of my teachers told me, “We will all end up being geriatric psychiatrists,” and he was prescient. As the population, including us clinicians, ages—and sans the miracle cure or preventive for dementia—we all hope to see—dilemmas like this one will increasingly be encountered, which is one reason ethical theory will always have a place in ethical deliberations.

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**References**

More Reasons to End Bullying

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Recent studies have demonstrated the wide-reaching adverse effects of being bullied in childhood. These effects range from impaired academic performance to interest in cosmetic surgery.

Academic performance
Mundy and colleagues examined the relationship between bullying and academic performance. The study was made up of 965 third-grade children from public and private schools in Australia; 44.8% of the students were male. Bullying was assessed by child self-report on a bullying scale. The items on the scale included physical and verbal victimization. Responses were yes or no; if yes, then information was obtained on the frequency of being bullied. Academic performance was assessed via a national achievement test that measured academic performance on 5 domains: reading, writing, numeracy, spelling, and grammar/punctuation.

Just over one-quarter (27%) of the girls and one-third (33%) of the boys reported being frequently bullied (defined as occurring once a week or on most days) during the past month. For boys, physical victimization was associated with lower numeracy scores compared with non-bullied peers. Boys who experienced both verbal and physical victimization had lower reading scores than boys who had not been victimized. For girls, verbal victimization was associated with lower writing and grammar/punctuation scores compared with those who were not bullied. Girls who experienced physical victimization had lower numeracy scores compared with non-bullied peers. Girls who experienced both verbal and physical victimization had lower reading scores than girls who had not been victimized. For girls, verbal victimization was associated with lower writing and grammar/punctuation scores compared with those who were not bullied.

The results of this study demonstrate the lasting impact of bullying in elementary school into high school. Based on these findings, the researchers recommend that all youths be screened for bullying, depressive symptoms, and substance use.

Access to a loaded gun
Simcik and colleagues evaluated the association between bullying and access to a loaded gun without adult permission. Data were obtained from 10,704 students, aged 12 to 18 years, who completed the 2011 and 2013 School Crime Supplement (SCS) to the National Crime Victimization Survey. The SCS assessed school-based bullying during the current school year. Students reported whether they were bullied via traditional bullying (direct and indirect physical and verbal violence, social exclusion, and property damage) or cyberbullying (unsolicited sharing of private information online, social exclusion in electronic format, and threats or insults received via different cyber media). Access to a loaded gun without permission was obtained by self-report during the student’s current school year. Responses were yes, no, or don’t know to the following question: “Could you have gotten a loaded gun without adult permission either at or away from school?”

Access to a gun without adult permission was reported by 4.2% of students. Students who experienced school-based bullying were 3 times more likely to report access to a loaded gun without adult permission than those students who are not bullied: 5.2% of those who experienced traditional bullying; 9.2% of those who experienced cyberbullying; and 15.0% of those who experienced both types of bullying reported access to a loaded gun without adult permission compared with 2.8% who experienced no bullying.

Given these findings, the researchers recommend that access to firearms be specifically addressed in evaluation of adolescents who report being bullied. This intervention may reduce the likelihood of self-inflicted injuries in adolescents who have been bullied.

Cosmetic surgery
Lee and colleagues examined the association between bullying and interest in cosmetic surgery. Students from grades 7 through 11 were screened for bullying involvement (N = 2782). Bullying role (victim and/or perpetrator) was assessed by use of a self-report scale and peer nominations (adolescents identified other students who were perpetrators or victims of bullying). Psychological functioning was assessed using scales that measured self-esteem, body esteem, and emotional problems. Seven hundred fifty-two students (53.3% female) who screened positive for bullying involvement were assessed for their desire for cosmetic surgery. The evaluations were based on students’ responses to the following items:

1. “I would like to have cosmetic surgery so that others would find me more attractive.”
2. “I would consider having cosmetic surgery as a way to change my appearance so that I would feel better about myself.”
3. “If I was offered cosmetic surgery for free, I would consider changing a part of my appearance that I do not like.”

Responses to these items ranged from not all to very much.

...effects [of bullying] range from impaired academic performance to interest in cosmetic surgery.”

Bullying role and percentages were as follows: bully-victim (those who are bullied but also bully others; 39.1%); bully (19.5%); victim (18.2%; 67.6% of these were girls). Psychological functioning was significantly poorer for victims and bully-victims than for bullies and adolescents without a bullying role. Victims of bullying had the lowest self-esteem and lower body esteem than the other groups. Adolescents who had any role in bullying were significantly more interested in cosmetic surgery than adolescents uninvolved in bullying. The desire for cosmetic surgery was highest in victims and in girls compared with boys. Poor psychological functioning was associated with being bullied, which in turn led to increased desire for cosmetic surgery.

The researchers suggest that screening tools be used to assess bullying for individuals who seek cosmetic surgery. Treating the mental health impact of bullying may reduce the desire for cosmetic surgery and possibly unnecessary procedures.

References
Clinical Considerations

Traumatic Brain Injury and Psychosis: Clinical Considerations

Robert van Reekum, MD, FRCP and Emma Alaine van Reekum

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Patients with traumatic brain injury (TBI) and their caregivers are often faced with significant distress (for the patient and his or her family), functional impairment, disability, challenges for rehabilitation and treatment teams, and costs to themselves and society. Although not adequately studied to date, it is likely that all of these consequences are exacerbated when TBI and psychosis co-occur. Psychosis can preexist TBI, and psychosis may increase the risk of TBI. This review, however, focuses on cases of psychosis following TBI (PFTBI).

Psychotic symptoms may also manifest in the period immediately following coma post-TBI, when patients may experience fluctuating levels of arousal, cognitive confusion, and episodic agitation—a clinical presentation that strongly resembles delirium. Psychotic symptoms that arise during this period, generally termed “post-traumatic amnesia,” usually resolve and are not addressed in this paper, beyond noting that if antipsychotic medications (eg, ziprasidone) are used to treat psychosis and/or agitation, they should be used only if necessary (ie, for safety and comfort), at very low doses, and with frequent attempts at dose reduction and discontinuation.

It is hoped that this review will be of assistance to clinicians who work with individuals suffering from PFTBI—while also highlighting the limitations of the research available to inform treatment decisions. Caution about the conclusions and recommendations offered in this article is warranted given the relative dearth of methodologically sound research to date.

A diagnosis of TBI requires exposure of the head to acceleration and/or deceleration forces, along with the clinical evidence available at the time of, or immediately after, this exposure. The clinical presentation of TBI includes alteration in consciousness, and/or in cognition, and sometimes neurological signs (eg, pupillary abnormalities, changes in reflexes). Typical TBI-related sequelae (eg, cognitive impairment, post-concussive symptoms) are not diagnostic of TBI nor required for the diagnosis of TBI.

Psychotic symptoms may include any of a number of symptoms/impairments, including hallucinations, delusions, and thought disorders (eg, tangentiality, loosening of associations). Negative symptoms such as apathy and cognitive impairment are sometimes included in the definition of psychosis; this is problematic in the case of TBI because apathy and cognitive impairment are common post-TBI and are likely related to TBI pathology that involves anterior temporal and frontal systems. Thus, we recommend that the diagnosis of PFTBI be restricted to cases of TBI in which hallucinations, or thought disorders arise after the TBI. Indeed, this approach involves anterior temporal and frontal systems. Thus, we recommend that the diagnosis of PFTBI be restricted to cases of TBI in which hallucinations, or thought disorders arise after the TBI. Indeed, this approach...
seems to be the one generally taken in the available research literature. The exception (for which there is little/no research available) may be in cases of TBI in which the recovery of motivational or cognitive functioning plateaus earlier than expected, or in which a decline in motivational or cognitive functioning is seen. In these cases, it is important to consider and assess for other potential causes (eg, complications of TBI such as hydrocephalus; onset of delirium due to medical/metabolic factors; mood disorder; medication adverse effects).

Clinical features of PFTBI
The research into psychosis post-TBI has thus far lacked standardized operational definitions and criteria, and has employed various terms such as PFTBI, schizophrenia-like psychosis, and psychotic disorder due to TBI or general medical condition. Research also varies with respect to the type of psychotic symptoms being assessed for; consequently, findings have also varied, perhaps at least in part for these reasons. Nonetheless, some common themes appear to have emerged. Delusions and hallucinations are likely to be the most common features seen in PFTBI.1 Delusions tend to be persecutory in nature; however, a full range of delusional themes can be seen (eg, grandiosity, religious, misidentification). Hallucinations are most often auditory but can also be visual. Olfactory and gustatory hallucinations can also occur post-TBI, most often in relation to seizures.1

Behavioral disturbances, including agitation and aggression, are often present.1 Negative symptoms, such as apathy, are also frequent, although they may be less common than in schizophrenia. Comorbid cognitive impairments, particularly involving attention, memory, and executive/frontal functions, are common. Cognitive impairments generally resemble those seen in schizophrenia and in TBI (in the absence of psychosis).

Time to onset of PFTBI has been found to vary considerably. Typical onset is within the first year or two after the TBI; however, some data indicate the mean time to onset may be greater than this, at roughly 55 months.1 The latter finding should be interpreted with caution because of the wide range of time to onset, from weeks to nearly 2 decades was observed.1 Other findings indicate that the rate at which PFTBI arises does not vary significantly over time (up to a maximum of 17 years’ follow-up) post-TBI.1 It appears that psychotic symptoms can arise at any time post-TBI.

Because of their similarity to psychosis seen in other disorders (eg, schizophrenia, mood disorders), the clinical features of PFTBI cannot be relied on to distinguish between various diagnostic possibilities. Rather, differential diagnosis must rely on prior history, presence of associated symptoms and, when present, neuroimaging abnormalities consistent with TBI (eg, hemorrhagic contusions, diffuse axonal injury). Guerreiro and colleagues1 suggest that neuropsychological and laboratory testing, along with EEG, may be useful in distinguishing PFTBI from other psychotic disorders.

It should be noted that TBI appears to considerably increase the risk of mood disorders and of schizophrenia or bipolar disorder.2,21 As such, PFTBI may arise as part of another disorder such as schizophrenia. Indeed, it remains uncertain that PFTBI exists as a separate entity; it may be that PFTBI should be managed as would psychosis caused by any other mental illness. It may be that PFTBI should be managed as would psychosis caused by any other mental illness.

Epidemiology
Findings in adult populations have varied widely, from 0% to 20%.14 Most studies place the incidence of psychotic symptoms in the 3% to 8% range.9 Duration of psychotic episodes and prevalence (aside from point prevalence) have not been well studied. A meta-analysis yielded an odds ratio of 1.65 for schizophrenia following moderate to severe TBI.22 Another review concluded that the initial severity of TBI may influence the frequency of subsequent psychosis, with rates of 2% to 5% in mild to moderate cases, and 10% or more in severe cases.11 However, this conclusion has not been adequately validated, and other studies have found that the initial severity of the TBI does not influence the frequency of subsequent psychosis.12 Overall, the frequency of PFTBI appears to be much lower than that of mood and anxiety disorders post-TBI.7

Risk factors for PFTBI
Research into risk factors for PFTBI has been relatively sparse and has yielded significantly different (and sometimes diametrically opposed) results. The Table presents potential risk factors for PFTBI. In addition, mood and seizure disorders post-TBI may lead to psychosis.2,23 The presence of psychotic symptoms has also been noted in individuals who have developed chronic traumatic encephalopathy following exposure to repeated acceleration-deceleration forces directed toward the head.24

Monitoring for the future onset of psychosis in the TBI population is clearly warranted. Our current understanding suggests some possible risk factors for future onset of PFTBI; however, the limitations of the research data highlight the importance of monitoring for PFTBI in all cases of TBI. Remediation of modifiable risk factors (eg, cessation of psychoactive drug use, improvement in sleep) is likely to be important in the management of PFTBI when it does arise, and consideration of the possible risk factors (eg, caution with medications such as dopaminergic agents, efforts to reduce substance use) might contribute to reduction in the future onset of PFTBI.

Approach to differential diagnosis
The first step in working through the differential diagnoses for PFTBI is to determine whether symptoms are truly psychotic in nature, versus the affective, behavioral, cognitive, and motivational impairments often seen after TBI. This differentiation can be particularly problematic for cognitive symptoms, such as the identification of delusions versus confabulation, or thought disorder versus cognitive impairment. Evoking the possibility of psychosis as a cause for these impairments often involves assessment for premature plateauing (eg, less than 2 years or so after the TBI) or worsening of impairments. If this is the case, additional assessments should be conducted to rule out other possible causes (eg, hydrocephalus, onset of seizure disorder, medical illnesses, substance use).

Assessment for hallucinations is also not without challenge, in large part because of possible cognitive impairments such as lack of insight and communication impairments after TBI.8

Reliance on all sources of data, including the observations of family members and the rehabilitation team, is important. Any change in affect, behavior, cognition, motivation, or functioning should elicit at least consideration for the possibility of PFTBI. The second step in working through the differential diagnosis of PFTBI follows determining that psychotic symptoms are pres-
ent, and involves identification of potential risk factors and of potential causative comorbidities.

**Mechanisms**

TBI can produce disturbances in neurotransmitter systems (eg, dopamine, acetylcholine) and, more generally, in neuronal systems (particularly involving frontal, temporal, and subcortical structures). It is at least possible that these neurobiological disturbances underlie the production of psychotic symptoms in many cases of PFTBI. Although the cerebral lateralization of TBI pathology and consequent production of psychotic symptoms have been examined, the research is limited and has produced contradictory results. This is not surprising given that TBI tends to produce widespread cerebral pathology (eg, coup-contrecoup contusional lesions, diffuse axonal injury).

Factors such as seizure disorder, mood disorders, and substance use may contribute to the onset of PFTBI. It may be that TBI—and its associated stresses and losses—also leads to a stress-diathesis interaction with preexisting neurobiological vulnerability. It may also be that the cognitive impairments of TBI lead to psychotic symptoms, with semantic processing, language, and executive impairments and impaired verbal memory/learning implicated as potential contributors.

**Clinical management**

Assessment for PFTBI involves a full history and complete medical, neurological, and mental status examinations. Use of neuropsychiatric symptom inventories can be helpful for initial quantification of psychotic symptom severity and for monitoring treatment response over time. Evaluation for potential contributors to the psychotic symptoms should be considered, including metabolic/drug testing and EEG (should seizures be suspected). It is unlikely that currently available neuroimaging modalities (eg, CT, MRI) are helpful in the assessment of PFTBI.

There is little evidence for pharmacological management of PFTBI, and to the best of our knowledge, there are no randomized clinical trials. As such, pharmacological interventions should be considered with caution, especially given the likelihood of increased risk of adverse effects in the TBI population with most available agents. Indeed, it is prudent to question whether psychotic symptoms warrant pharmacological intervention with each patient; factors such as the level of distress and/or the behavioral/final functional impairment resulting from the psychotic symptoms should be considered.

Not all psychotic symptoms require pharmacological intervention. As a general recommendation, it is probably most appropriate to first treat delirium, seizure disorder, mood disorder, and substance disorders if present, and to eliminate any potential contributing medications. Exceptions include cases in which the psychotic symptoms are producing significant distress, safety risk, and/or significant behavioral/final functional impairments. In particular, first-generation antipsychotics should be avoided given the increased risk of falls, parkinsonian adverse effects, tardive dyskinesia, and possible delay of neurorecovery post-TBI.

Antipsychotics with significant anticholinergic activity should also be avoided, particularly given the risk of worsening TBI sequelae such as anergia and attentional/memory impairment. Low doses of second-generation antipsychotics may be first-line agents for PFTBI that is causing significant distress and/or behavioral/final functional impairment. Arciniegas and colleagues recommend starting doses of one-third to one-half of the usual starting dose for PFTBI. Periodic trials of decreasing doses and discontinuing medications altogether are advised given the risks of antipsychotic medications in the TBI population.

Non-pharmacological interventions for PFTBI have received little in the way of research attention but are widely used in clinical practice. It is likely that rehabilitation with a focus on cognitive, behavioral, affective, and functional impairments of TBI will also be of benefit for PFTBI. However, PFTBI may limit the ability of the affected individual to participate in, and benefit from, rehabilitation efforts; when this is the case, considerable multidisciplinary planning and problem-solving may be required. Pharmacological interventions may first be necessary in some cases.

**Conclusions**

Clearly, much more research into our understanding and management of PFTBI is warranted and required. In the meantime, clinical judgment, with a focus on minimizing risk, is necessary. TBI commonly produces impairments in mood, behavior, motivational functioning, and cognition, and less commonly is associated with psychosis. When present, psychotic symptoms can exacerbate TBI impairments and result in distress, safety risk, and reduced response to rehabilitation efforts.

Monitoring for future onset of psychosis in the TBI population is clearly warranted. Our current understanding suggests some possible risk factors for future onset of PFTBI; however, the limitations of the research data highlight the importance of monitoring for PFTBI in all cases of TBI. A history should be taken with respect to the possibility of previous TBI for all patients with psychosis who present to a mental health clinic or primary care center.

Clinicians may find working with PFTBI cases to be difficult and disconcerting. Teamwork, ideally involving multiple disciplines and areas of expertise, should be stressed for both the patient’s and the provider’s benefit.

**References**


**Additional reading**


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**Post-tests, credit request forms, and activity evaluations must be completed online at www.cmeoutfitters.com/PT (requires free account activation), and participants can print their certificate or statement of credit immediately (80% pass rate required). This Web site supports all browsers except Internet Explorer 9 and later. For complete technical requirements and privacy policy, visit www.neurosciencemce.com/technical.asp.**

**PLEASE NOTE THAT THE POST-TEST IS AVAILABLE ONLINE ONLY ON THE 20TH OF THE MONTH OF ACTIVITY ISSUE AND FOR 18 MONTHS AFTER.**
HealthPartners is a dynamic multi-specialty medical group headquartered in the Twin Cities of Minneapolis/St. Paul, Minnesota. Our Behavioral Health group has a large outpatient practice with 21 adult and 4 child psychiatrists, 7 clinical nurse specialists and 60 therapists. Practicing as generalists, each provides integrated outpatient services to our diverse patient population within our primary care and specialty clinics.

We have exciting practice opportunities for BC/BE Outpatient Adult Psychiatrists, and offer:

- Full-time and part-time practices
- Competitive pay
- A generous benefits package, including relocation assistance, employer-matched 401(k) and 457(b), malpractice coverage, and competitive PTO and CME
- Minimal outpatient call requirements (pager/phone)
- Affiliation with multiple hospitals and clinics, including inpatient psychiatry, intensive day programs, chemical dependency programs and eating disorder programs
- A large internal referral base
- Exceptional nursing support and psychotherapy colleagues
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HealthPartners’ integrated health care system is recognized locally and nationally for great care and leadership. We believe outstanding health care is delivered when we merge the science of medicine with the compassion, spirit and humanity of our hearts. We refer to this as “Head + Heart, Together,” inspiring constant improvement and lasting success. As a unified team, we engage patients, families and the community and put them at the center of everything we do.

Learn more by emailing your CV and cover letter to lori.m.fake@healthpartners.com or by applying online at healthpartners.com/careers.

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

Rutgers Robert Wood Johnson Medical School

The Division of Consultation Psychiatry at the Rutgers Robert Wood Johnson Medical School (RWJMS) has an opening for a full time psychiatrist – with protected teaching time. The position is at the Assistant/Associate Professor level. Responsibilities include providing direct clinical care to patients who are being treated at our primary teaching hospital – Robert Wood Johnson University Hospital - as well as teaching medical students and residents from multiple services. Outpatient work with medical patients can be part of the responsibilities, at the successful applicant’s discretion.

Teaching is protected and is an integral part of the service. Research/scholarly activity is encouraged and the successful candidates will be expected to develop an area of expertise. Fellowship training a plus but not required.

The Division of Consultation Psychiatry is based at Robert Wood Johnson University Hospital (RWJUH) which is the primary teaching hospital for RWJMS. RWJUH is a quaternary referral hospital with Level I trauma, transplant services, a Children’s Hospital and an NCI designated cancer center. The Department of Psychiatry offers a full range of clinical services and multiple research opportunities.

The Rutgers Robert Wood Johnson Medical School (RWJMS) is a vibrant medical school located on the campus of Rutgers University in New Brunswick, New Jersey – midway between New York City and Philadelphia. This is a great opportunity for someone interested in psychosomatic medicine and an academic career.

Please email your CV and cover letter to:

Anthony Tobia, MD
Chief Division of Consultation Psychiatry
Rutgers Robert Wood Johnson Medical School
tobiaat@rwjms.rutgers.edu

Rutgers, The State University of New Jersey

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American Academy of Child & Adolescent Psychiatry

CME Events

AACAP’s 2018 Pediatric Psychopharmacology Update Institute
Cutting-Edge Psychopharmacology: Fads vs. Facts?
January 26-27, 2018 • • Brooklyn, NY

New York Marriott at the Brooklyn Bridge
Laurence L. Greenhill, MD & Jeremy Veenstra-VandeWeele, MD, Co-Chairs

This institute includes the latest findings on the treatment of bipolar disorder and disruptive mood dysregulation disorder, disruptive behavior disorders and dysfunctional aggression, attention-deficit/hyperactivity disorder, tics, Tourette’s disorder, obsessive-compulsive disorder, and autism spectrum disorder and features talks on addressing substance use disorders and genetic drug response testing.

For more information, visit www.aacap.org/psychopharm-2018.

AACAP’s Douglas B. Hansen, MD, 43rd Annual Review Course
March 2-April 13, 2018 • • NEW for 2018: Entirely Online!
Gabrielle A. Carlson, MD & Shawn Siddhi, MD, Co-Chairs

Join us for the first ever ONLINE Review Course, one of the newest online education programs available from AACAP. Over a 6-week period, our newly redesigned course will open you to connect with colleagues, interact with experts, and learn about the most sought-after topics in the field, including attention-deficit/hyperactivity disorder, autism, depression, impact of social media, substance use disorder, and more — all on your own schedule, in your home or office.

For more information, visit www.aacap.org/ReviewCourse-2018.

AACAP’s 65th Annual Meeting
October 22-27, 2018 • • Seattle, WA
Washington State Convention Center

Submissions to the Call for Papers for AACAP’s Annual Meeting are due Thursday, February 15, 2018, or Friday, June 15, 2018, for (late) New Research Posters. The online Call for Papers submission form is available at www.aacap.org/AnnualMeeting-2018, all submissions must be made online. Abstract proposals are prerequisites for acceptance of any presentation. Topics may include any aspect of child and adolescent psychiatry.

For information about all of AACAP’s meetings, visit www.aacap.org, email meetings@aacap.org, or call 202.966.7300, ext. 2006.
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Our mission is to be the leader in innovative, high quality, accessible behavioral health solutions. Explore opportunities in multiple states—both tele and non-tele positions available.

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Please contact: Sandra Williams
Director of Recruitment
Ph: (818) 584-1785 or 818-814-7790
Email: swilliams@alignedth.com

CALIFORNIA
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. OASAS as a Personal Service contractor with an income potential of over $325 K per year for adult psychiatrist and over $355 K per year for child psychiatry 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. 1 J applicants are welcome.

Fax CV to Uday Mukherjee, MD at (209) 558-4326 or Email: umukherjee@stanbhrs.org

THE DOCTORS OF TRADITIONS BEHAVIORAL HEALTH are the largest provider of MD psychiatric services to adult populations in institutional and community based programs in California. We provide services to the seriously and persistently mentally ill and have openings in the San Francisco Bay Area, Santa Barbara, San Diego and Los Angeles. Overall we plan to add 50 more Fulltime psychiatrists in California to bring our medical staff team to 400 psychiatrists.

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

www.tbthcare.com or Email your letter of interest and CV to our company President, Gary A. Hayes, Ph.D. at: Drhayes3@tbthcare.com

TBH is an equal opportunity employer

Outpatient Psychiatry Opportunity
San Joaquin County Behavioral Health Services is seeking to fill Outpatient Adult [General], and Sub-Specialty Psychiatry (Child Psychiatry, Geriatric, Forensic, Addiction and Psychosomatic Medicine) positions in a multidisciplinary, recovery-oriented clinical setting. Services are provided either on-site or using a hybrid model of on-site and telepsychiatry practice. The positions offer a very competitive salary with a guaranteed base, plus incentive opportunities, Board Certified Psychiatrists have the potential to easily earn over 300K+ a year with participation in the county defined benefit retirement plan. Also offered is an option to forego retirement participation earning 350K+ a year. Sub-Specialty trained physicians may have the potential to earn more. The compensation package includes comprehensive health insurance, deferred compensation plans, 30 days of paid time off that increase with tenure, and additional CME time. Signing and moving bonuses are also available. Interested J-1 and H-1B candidates are welcome to apply.

Contact Khurram Durrani, MD at: kdurrani@sjchhs.org; Fax CV to 209-468-2399. EOE.

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Tel: 707.266.7788
Email: wonona@mhnfcareers.com

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Office spaces available for Adult or Child Psychiatrist, Psychologist, F/T/P. Solo practitioner set up fee/Rent all inclusive (adm. support, billing, patient resources). No cap on income. We are located in San Diego. Contact: Office: (619) 258-6730 or ninisoffice@gmail.com; Paul Liederman MD @ (619) 871-9250

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Camp Lejeune NC, Camp Pendleton CA, Groton CT, Jacksonville FL, Pearl Harbor HI, and San Diego CA

There could not be a better time to join our team! As a member of the Bureau of Medicine and Surgery (BUMED) team you will have the unique opportunity to provide healthcare to the men and women who protect and serve our country along with their families, and retirees at medical facilities around the globe. In addition to this great honor, BUMED provides excellent compensation and benefits. Therefore, if you are interested in making a difference while enjoying a rewarding career, BUMED would like to hear from you.

To apply to our position, email your complete resume including beginning and ending dates, month and year, detail description of duties performed, etc., directly to medjobsl@navy.mil, and insert F* followed by the Announcement Number (i.e. PT-DE-10074250-17-JP) in your subject line. Please include various announcement numbers in the subject line if interested in more than one location.

To learn more about our positions, please visit https://www.usajobs.gov/Search/?f=DE-60253d&V=18&g=1

The POSITION TITLE, SERIES, GRADE, LOCATION AND ANNOUNCEMENT NUMBER are listed as a PT Independent Contractor at Atascadero State Hospital or Coalinga State Hospital. Includes malpractice & CA lic. assistance.

PHYSICIAN PSYCHIATRY, GP-0602-15 Camp Lejeune CA DE-10074250-17-JP
PHYSICIAN PSYCHIATRY, GP-0602-14 Groton CT DE-10050515-17-JP
PHYSICIAN PSYCHIATRY, GP-0602-15 Jacksonville FL DE-10024266-17-JP
PHYSICIAN PSYCHIATRY, GP-0602-15 Pearl Harbor HI DE-10033212-17-JP
PHYSICIAN PSYCHIATRY, GP-0602-15 San Diego, CA DE-10038759-17-JP

Requirements:
√ Accredited MD/DO/ECP/MG or Fifth Pathway for Foreign Medical School.
√ Active physician license awarded by any state.
√ For GP-15 grade level, 5 years of residency training or equivalent experience and training in Psychiatry (e.g., completion of 3 years Psychiatry residency and 2 years fellowship and/or experience).
√ For GP-14 grade level, 4 years of residency training or equivalent experience and training in Psychiatry (e.g., completion of 3 years Psychiatry residency and 1 year fellowship and/or experience).
√ Current Clinical Competence – independently practiced as a Physician Psychiatrist within the past 2 years.
√ U.S. Citizenship is required.
√ Possession of Basic Life Support (BLS).

For additional information, contact Jill Pandora at 215-697-0384.

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January 2018
PACIFIC COAST PSYCHIATRIC ASSOCIATES has openings for Adult, Child and Adolescent Psychiatrists (full and part-time). Our physicians have the opportunity to practice both therapy and med management without restrictions in our San Francisco, Lafayette, and Los Angeles (in the West Hollywood, Bever- lly Hills, Century City and Culver City area) offices. We are a collaborative practice of psychiatrists and therapists with full-time office staff to provide complete administrative support.

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

We strive to simplify records management for our patients, our providers, and the environment.

Our competitive compensation includes:
- Malpractice/Disability Insurance
- Paid medical license and DEA renewal fees
- 401K with 3% Contribution (after the first year)
- Health Insurance (including dental and vision)
- Four weeks of paid vacation & six paid holidays
- Minimum 15 hours to full-time positions available
- EARNING POTENTIAL UPWARDS OF $290,000.

Please contact us to learn more: careers@pcpsaf.com or visit us at www.pcpsaf.com

Psychiatrist Position
J-1 Visa Opportunity in California

Imperial County Behavioral Health Services is currently recruiting for a full-time psychi- atrist. Imperial County is located 80 miles by freeway to the city of San Diego to the west, and 90 miles to Palm Springs to the north. Located in a rich farming area, Imperial County has a population of 180,000 and borders with Yuma, Arizona and with the cosmopolitan city of Mexicali, Mexico population 1.2 million. San Diego State University maintains a satellite cam- pus in Calexico and there are a number of private and public universities located in Mexicali, the state capital of Baja California Norte. Imperial County's location and divers- ity make it the perfect place for a psychia- trist to relocate under the J-1 Visa program 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 behav- ioral disorders. Qualified candidate must have CA medical license or ability to obtain. Send CV to Imperial County Behavioral Health Services, 202 North 8th Street, El Centro, CA 92243.

J-1 applicants welcome.

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

www.svcnm.org
www.sccmhd.org
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SANTA CLARA COUNTY
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Santa Clara Valley Health and Hospital System, a public healthcare system in the heart of Silicon Valley, is seeking BE/BC psychiatrists for a variety of settings including specialty mental health clinics and inte- grated primary care behavioral health clinics. As the largest public health care system in northern California, we offer comprehen- sive healthcare to a large and diverse patient population. Psychiatrists are clinical leaders of interdisciplinary teams of staff that provide innovative, evidence based health care to patients.

Psychiatrists are eligible for numerous ben- efits including 7 weeks of annual leave, 1 week of educational leave, 12 holidays, $45000 educational funds, health benefits, life insurance and CalPERS retirement plan. If you are interested in working in a dynam- ic and collegial work environment, please submit a CV and letter of interest directly to:
Dr. Tiffany Ho,
Behavioral Health Medical Director:
tiffany.ho@hhs.sccgov.org
(408) 885-5767

The County of Santa Clara is an Equal Opportunity Employer

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Opportunities available in Outpatient Community mental health and Private insur- ance pay type programs. M-F, weekends/ evenings and services as needed shifts. 9-5, No call, exceptional support staff. Locum, temp and seasonal assignments available with excellent pay and daily allowance for travel. Call us for more details!

If you’re interested in helping to support our mission and building a healthier behavioral health community, our group offers a wide range of opportunities. Our clinics are the perfect place to express your talent, compas- sion, and commitment within a dynamic multi-disciplinary team-based environment. Nursing, Pharmacists and Lic’d clinicians, makes this very a pleasant and opportunity. We offer competitive salaries, excellent benefits, relocation incentives and sign-on incentives for FT positions: medical, dental, vision, life, EAP and 401k retirement savings plan. Reimbursement/salary based on experience and board certi- fication. Independent Contractor or Employee Status.

Group also seeks part-time Intake MD or NP to conduct news, 8-16 hours per week in Oakland or Union City. 1 Child Psychiatrist 2-3 days per week. Excellent reimburse- ment rate.

Forward Confidential CV to: Management Company, mrrecruitment@bhcrorp.org or FAX to: (925) 520-0010 Attn: Cedric.
Or call Cedric Hurskan at:
(925) 520-0005 ext. 10

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FLORIDA

FLORIDA LIC, BE/BC CHILD / ADULT PSYCHIATRIST

We are an extremely busy, upscale practice comprised of four psychiatrists, and twen- ty five psychologists, LCSW’s, and LMHC’s. We have two beautifully deco- rated offices in Boca Raton and Coral Springs Florida. If you are seeking an out- standing opportunity for a full-time pri- vate practice in a warm and friendly envi- ronment, we invite you to call Linda Berlin, Psy.D at (954) 227-2700 Option 1.

Meridian Behavioral Healthcare, Inc. is a CARF accredited community mental health care facility located in the heart of Florida. Currently, we have full time posi- tion Staff Psychiatrist position available with an excellent salary and benefits package. Looking for someone who can work with a flexible schedule – preferably Adult and Child, with the mixture of inpatient and outpatient to be discussed. Meridian has been a part of the lives of thousands since 1972; providing a safety net for those in cri- sis. Since then, Meridian has expanded to 16 sites across Central Florida, touching over 22,000 lives through over 325,000 direct care visits a year, Gainesville is home to the University of Florida and serves as the cultural, educational and commercial center for the north central Florida region.

For more information, contact: Logan Anglin, Vice President – Staffing/Recruiting @ 352-374-5660 x8294 or email confidential C.V. to logan_anglin@mhibc.org MBH is an Equal Opportunity Employer and a Drug Free Workplace. Please visit our website: www.mhibc.org

GEORGIA

Horizon Health in partnership with Upon Regional Medical Center, in Thomaston, GA, is seeking a Medical Director for a new, 18-bed Geriatric inpa- tient psychiatric program. Attractive compen- sation package and flexible schedule! Telemedicne coverage possible. Thomas- ton is within 60 miles of three of Georgia’s major cities: Atlanta, Macon, and Colum- bus, an area known as the Golden Triangle. This excellent location provides the luxuries of a peaceful rural life along with the benefits that the larger cities have to offer. For more information contact: Mark Blakeney, Voice: 972-420-7473, Fax: 972-420-8233
Email: mark.blakeney@horizonhealth.com EOE

CONNECTICUT

CLOSE TO HARTFORD AND NEW HAVEN - OUTPATIENT PSYCHIA- TRIST - Seeking Adult Psychiatrist to work full-time on outpatient BH service in Bristol Hospital—a Magnet facility in Bristol, CT. Involves on-call coverage shared with other MDs and NPs for inpatient adult psych unit. Only 19 miles from Hartford; 30 miles from New Haven; and only 2 hours from NYC and Boston. Also, seeking Psychiatrist and PMHPN for weekend on-call position on new inpatient unit opening in January 2018. Please contact Terry Good at 804-684- 5661; email: terry.good@horizonhealth.com; Fax: 1-804-684-5663; EOE
CHICAGO!

Horizon Health is seeking a Medical Director for a 12-bed Geriatric and 30-bed Adult inpatient psychiatric service line in metro Chicago. The Medical Director provides program administration and oversight services regarding service line policies, practice, development, compliance, and performance improvement. Also provides training, supervision, and consultation to staff. Previous Medical Director experience and Board Certification required. Excellent compensation. For more information:

Mark Blakeney, Voice: 972-420-7473, Fax: 972-420-8233; email: mark.blakeney@horizonhealth.com
EOE

FOOTHILLS OF THE SHAWNEE NATIONAL FOREST – Seeking Psychiatrist who loves the less stressful lifestyle of small town living with an abundance of outdoors sports such as hunting, fishing, hiking, etc. and who also wants a place with a big professional opportunity—a place where you can really make a difference. Adult Psychiatric Unit with fair number of geriatric patients in the Harrisburg Med. Ctr.—24 miles from Marion and an hour from Evansville, IN. There is an onsite Psychiatrist and NP to share the work. Work with a top-notch BH team in a very supportive hospital. Offering employment with benefits, or practice opportunity.

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

Explore the world of Correctional Psychiatry which offers regular hours.

MHM Services Inc., in partnership with the MA Department of Correction and Mass Partnership of Correctional Healthcare, is staffed by a mission oriented, multidisciplinary team committed to providing comprehensive healthcare to the underserved. MHM, a progressive leader in the dynamic field of correctional healthcare, is seeking BC Psychiatrists for F/T or P/T hours at various facilities in Massachusetts. Collaborate with a multidisciplinary mental health team and consult with the medical physicians. Provide assessment, diagnosis, medication management and follow-up appointments. Outpatient services for male patients/inmates. Mentor and supervise mid-levels. Competitive compensation with comprehensive benefits offered.

For Details Contact: Diana Connett, diana@mhmcareers.com 508-214-4524

NEW JERSEY

PSYCHIATRISTS for clinical staff and leadership positions

The State of New Jersey is seeking motivated BC/BE Psychiatrists for full time inpatient work in our Joint Commission Accredited state psychiatric hospitals and forensic center. Psychiatrists with management experience are also needed to serve as Medical Director or Associate Medical Directors in some facilities. Staff psychiatrists work with a multidisciplinary mental health team and are assisted by interns assigned to each unit. Competitive salary and excellent benefits package provided for full time positions. Voluntary paid on call opportunities also available.

Hospital Locations:
- Greystone Park Psychiatric Hospital, Morristown, NJ (Northern NJ)
- Trenton Psychiatric Hospital, Trenton, NJ (Central NJ)
- Ann Klein Forensic Center, Trenton, NJ (Central NJ)
- Special Treatment Unit, Avenel, NJ (Northern NJ)
- Ancora Psychiatric Hospital, Hammonton, NJ (Southern NJ)

Candidates must possess NJ medical license.

Interested candidates should send cover letter and detailed resume to:
Robert Eilers, MD, Medical Director Robert.Eilers@doh.nj.gov (609) 438-4147

MICHIGAN

Sparrow

Psychiatry Opportunity with Sparrow Medical Group

Sparrow Medical Group (SMG), a multi-specialty physician group and the premier physican 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 exciting opportunity by contacting:
Barbara Hilborn, Manager Provider Recruitment Office: 1.800.968.3225
Email: barbara.hilborn@sparrow.org
Visit our website at www.sparrow.org

More information on the Lansing area can be obtained at www.lansing.org

NEW YORK

Westmed Medical Group: Director of Behavioral Health/Psychiatry

An excellent opportunity exists for a Director of Behavioral Health/Psychiatry to begin June, 2018 with the Westmed Medical Group - a large, progressive, and financially thriving, physician-owned, multi-specialty practice. Within commuting distance from NYC, CT, and NJ, we offer an excellent, competitive compensation and benefits package. Responsibilities include carrying a full time caseload, supervision and recruitment of staff, attending administrative meetings and participating in quality care initiatives.

Candidates must be board certified in adult psychiatry with preference given to candidates double boarded in Psychosomatic or Geriatric Psychiatry with expertise in Behavioral Medicine and mindfulness/MBCT. Candidates should have a minimum of seven years post residency/fellowship clinical experience with demonstrated leadership roles.

To apply, email CV to: hrphysician@westmedgroup.com

Academic Addictions Psychiatrist Assistant/Associate Professor

Rutgers Robert Wood Johnson Medical School

The Division of Addictions Psychiatry at the Rutgers Robert Wood Johnson Medical School (RWJMS) has an opening for a full time psychiatrist – with protected teaching time. The position is at the Assistant/Associate Professor level. Fellowship training a plus but not required.

Responsibilities include providing direct clinical care to patients who are being treated at our primary teaching hospital – Robert Wood Johnson University Hospital (RWJUH) - as well as outpatient work with patients with substance use disorders. RWJUH is a primary teaching site for our medical students and residents. The successful applicant would also be expected to participate in a variety of ongoing grant funded projects and to develop an area of expertise within addiction psychiatry. Teaching with medical students, residents and allied professionals is a core responsibility.

The Rutgers Robert Wood Johnson Medical School (RWJMS) is a vibrant medical school located on the campus of Rutgers University in New Brunswick, New Jersey – mid way between New York City and Philadelphia. This is a great opportunity for someone interested in an academic career.

Please email your CV and cover letter to:
Jill Williams, MD
Chief, Division of Addictions Psychiatry
Rutgers Robert Wood Johnson Medical School
williajm@rwjms.rutgers.edu

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

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

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U.S. Department of Veterans Affairs

Tomah VA Medical Center, Tomah, and Wisconsin Rapids Outpatient Clinic, Wisconsin Rapids, Wisconsin, offer all the benefits of small town living – fine restaurants, museums, movie theatres, performing arts, and golfing – while being within a few hours drive of Milwaukee, Madison, Minneapolis/ St. Paul, and Chicago. Fishing, boating, hunting, skiing, biking and other outdoor year-round recreational activities are fun for the whole family.

PSYCHIATRISTS
Tomah VA Medical Center
Inpatient - Outpatient - Weekend Hours
ACADEMIC PSYCHIATRIST
Wisconsin Rapids Outpatient Clinic

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The incumbent for this position may be eligible to apply for the Education Debt Reduction Program, depending on the type of employment, schedule, amount/type of qualifying debt, and funding availability. The employee will begin to receive the benefit upon acceptance into the program – not backdated to the date employment begins. Questions? Contact Lisa Doherty: 800-872-8662, x67735 - Lisa.Doherty@va.gov
Mail CV to: Office of the Chief of Staff
500 E. Veterans Street, Tomah, WI 54660
Fax CV to: (608) 372-1654
Tomah VA website: www.tomah.va.gov
Equal Opportunity Employer - Random Drug Screen

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

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

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

Successful candidates should have strong teaching as well as clinical skills and, 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:
Tami Tenbus Physician Recruiter
Phone: 717-331-5065
Email: tenbus@hmc.psu.edu

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

WISCONSIN
Psychiatry positions - Wisconsin
Our not-for-profit, university-based organization maintains the largest listing of child and adult Psychiatry positions in Wisconsin. We are currently aware of 25+ adult and C/A positions in both rural and urban communities statewide. Some are eligible for state/federal educational debt assistance. This is our 37th year of assisting psychiatrists with their job search here in Wisconsin. Most positions are with large, multi-specialty medical groups.

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