"I buried my negatives in the ground in order that there should be some record of our tragedy."

COVER STORY ON PAGE 10

ISSUE HIGHLIGHTS

Understanding and Addressing Sleep Disruptions in Alcohol Use Disorders
Kristen Schmidt, MD and Bhanu Prakash Kolla, MD, MRCPsych

Psychiatric Presentations of Frontotemporal Dementia: A Brain Disease That Challenges Definitions of Mental Illness
Barbara Schildkrout, MD

ADHD and Substance Use: Current Evidence and Treatment Considerations
Chardée A. Galán, MS and Kathryn L. Humphreys, PhD, EdM
The Healing Power of Photographs

Harold J. Bursztajn, MD

Dr. Bursztajn is Associate Professor of Psychiatry at Harvard Medical School and a co-founder of the Program in Psychiatry and the Law at Beth Israel Deaconess Medical Center; he has also had a private practice in clinical and forensic psychiatry and psychoanalysis. His email address is: harold_bursztajn@hms.harvard.edu.

It is easy to deride “selfies” and the scads of photos that people today often compulsively take and share via their cellphones. But let’s not write them all off as meaningless. As I’ve seen in my parents’ remarkable journey from the doomed Jewish ghetto in Lodz, Poland, and in my psychiatry practice, photographs have immense power to heal.

My parents grew up in Lodz, which then was home to one of the largest Jewish communities in Europe. On February 8, 1940, the Nazis established the Lodz ghetto. My father, Abraham Bursztajn, was condemned to be part of a sanitation crew called the Fekalists, literally the feces carriers. It was responsible for removing sewage from the ghetto and preventing the spread of infectious disease. The task, which meant near-certain death, was his punishment for refusing to join the ghetto’s Jewish police force, which answered to and worked for the Nazis.

One day Abraham saw Miriam Bryks, a girl he had met before the war, preparing to board a train bound for Auschwitz. In an act of bravado, he told a German soldier guarding the train that Miriam was an essential member of the sanitation crew, and brought her back with him to the ghetto. They married in secret, worked together as Fekalists throughout the war, engaged in nonviolent resistance, and were among the handful of survivors of the 200,000 Jews who had been imprisoned in the ghetto.

Some of my parents’ history I know from the stories they and their relatives have told over the years, some I know from visiting Lodz, and some I learned from the haunting photographs taken at great risk by Henryk Ross who, with the help of his wife, Stefie, secretly documented life in Lodz under Nazi rule. Hoping to leave behind a record of what happened there, Ross and his wife buried their 6000 negatives in 1944. They returned after the city was liberated by the Russian Army in 1945 and were overjoyed to find that many of the images had survived.

On June 17, I had the honor of speaking about an exhibition of some of Ross’s Lodz photographs, called “Memory Unearthed,” now on display in Boston’s Museum of Fine Arts. At a time when Nazi and Stalinist photographers were using their cameras to generate cold, impersonal images of dominance and superiority, Ross was using his to create images of everyday life in the ghetto that were brimming with compassion and mutual respect. Even in the midst of the Shoah (Holocaust), Ross helped both the photographer and those photographed share with dignity the horror of humiliation, the fear of oblivion, and the pain of grief.

Is this so different from the photographs that are so freely taken and shared today? They establish what philosopher Martin Buber would call an “I-Thou” relationship between photographer and subject. Even with the selfie, where the photographer and the subject are the same, the intention is still to connect with others.

In Ross’s hands, the camera became a creative, artistic, therapeutic instrument that empowered mental health. Seventy years later, these photographs provide much more than simple forensic documentation. They offer inspiration for anyone who has experienced suffering, hopelessness, and the question that was asked by one of the ghetto inhabitants, “When will this ever end?”

Through Ross’s work we can learn much that is otherwise obscure about ordinary life, trauma, grief, and loss, as well as about our capacity to choose good and evil and continue to be creative and resilient in the midst of life and when facing death. In this vein, his work belongs alongside the work of other creative and therapeutic artists such as Rembrandt, Goya, and Hyman Bloom, all of whom depicted the vital rhythms of life in the face of war, encroaching death, and entropy.

Photography and the visual arts can be therapeutic in everyday life. An adolescent patient of mine, traumatized as a young child by a psychotic parent, sometimes shows me a photograph on his cellphone of the dog he loves, and how beautifully and peacefully the animal sleeps. I thank him for showing it to me, admire this act of sharing what he loves, and then we explore his anguish and fears as well as his hopes. The photograph provides a safe bridge from the present to the past.

A fragile older woman shares with me fading photographs of the great beauty she was as a young woman. I am grateful that she feels safe enough with me to share these images, which deepen our ability to explore together what she fears most—the loss of family members and her youthful vigor—and in doing so her mature beauty shines forth and she feels empowered to face the inevitability of entropy.

The ease of sharing cellphone photos provides a way for people to feel connected in this often disconnected world. People who have been traumatized can use them to create a community of trust between themselves and others. The seemingly doomed Fekalists that Ross photographed shared their experience not only with Ross but also with a future most knew they would not see. Today, the patients who share photographs with those whom they trust transcend the isolation and aloneness that are all too often the handmaidens of suffering.

In my field, forensic psychiatry, we sometimes use the term “therapeutic jurisprudence.” It refers to the process whereby victims of abuse feel empowered as a result of the course of litigation. It’s time we start thinking about “therapeutic photography.”

Editor’s note: This article was originally published as “Photos, Even Selfies, Have the Power to Heal.” It is reproduced with permission from STAT, a national publication focused on finding and telling compelling stories about health, medicine, and scientific discovery. 2017 © STAT. The exhibit—Memory Unearthed: The Lodz Ghetto Photographs of Henryk Ross—at the Museum of Fine Arts, Boston, ran from May 25 through July 30, 2017. We are grateful to Maia Sutnick of the Gallery of Ontario for allowing us to use the photographs reproduced herewith. For more photographs from the exhibit, go to: http://agioslodzghetto.com. ²
FROM THE EDITOR
What a Long Strange Trip It’s Been
Allan Tasman, MD | Editor in Chief
I don’t know about you, but I’m exhausted. I’m sure it has something to do with my arthroscopic surgery to repair a torn meniscus and the resulting tendonitis in my other ankle due to too much pressure on an old injury (skateboarding 40 years ago, don’t ask). It’s possible my inability to do my usual relaxation therapy by digging in my garden is playing a role. And it’s possible it’s the several hours a day of rehab and having to walk around with a boot on the leg with the tendonitis, though it’s more likely the onslaught of the crazy news (I was tempted to title this “Bizarro World Redux,” for those of you who read my “Bizarro World” editorial in the April issue).

My wife and I are both political junkies, so we almost always watch the network and cable news at the end of the workday. Lately, though, I’ve been feeling like Alex in A Clockwork Orange trying to listen to music from his favorite composer, Beethoven, after he was treated with the Ludovico technique. For those who don’t remember the book or the movie, the Ludovico technique is described in the book as a form of aversive conditioning treatment.

In Alex’s case, it was used to treat his severely violent behavior by playing Beethoven and giving a nausea-inducing drug while he was watching extremely violent movie scenes. In my case, watching the news even without any nausea-inducing drugs or Beethoven is nonetheless inducing extreme fatigue and fear of nausea.

I’m trying (unsuccessfully) to go cold turkey. Whether it’s the latest Russia-related campaign news, the sadistically misnamed American Healthcare Act, or the latest attempts to dismantle anything the government did between 2008 and 2016, I don’t even have to watch TV anymore. I have endless loops of all this going through my brain paired with the face of my state’s senior senator, Mitch McConnell. Even my wife and I trying to think up potential Saturday Night Live skits about the latest news hasn’t helped much.

But, as I write this, I’ve just about started my summer vacation. I’m hoping the rest cure will work.

If it does work, I’ll be able to think more about some of the advances recently reported, especially in Science, that will affect medicine. I’ve most recently been impressed by a new approach to cancer drugs, recently FDA approved, which can be engineered for any type of solid tumor; amazing advances in tissue regeneration—someday perhaps including the brain; and the recent report linking job loss and economic inequality with mental health status—not that this is much news to us. And, for you quantum mind fans, there’s “Spooky action achieved at record distance.”

Speaking of quantum mind, one thing that did get my own mind off the news is The Book of Strange New Things by Michel Faber. It’s in the sci-fi category but not the usual space cowboy type. It’s about a Christian minister who travels to a distant planet where the native inhabitants have made known their need for someone to preach the Gospel. Knowing the “other” and the “other” in ourselves is a main theme and strongly resonates with current global concerns. Another more gentle literary diversion, one I just re-read, is Kent Haruf’s Plainsong, a modern pastoral take on Our Town. He’s a beautiful writer who died last year much too soon.

Being a movie fanatic, I thought I’d try a few action movies for another approach to de-condition myself. Unfortunately, Wonder Woman was not wonderful, but Baby Driver was great. Not the most ingenious plot I’ve ever seen, but completely satisfying with 2 terrific young actors (playing Baby and his girlfriend) and Kevin Spacey churning up the scenery as usual.

I hope you’ve had time to get away from the news either on vacation, reading a good book, going to see a movie, or whatever else helps you unwind. And speaking of that, why not write to us and let us know what’s your favorite diversion. Just respond to this column on the Psychiatric Times’ website.

References
Psychodynamic Psychiatry: A Case Report

Aerin Hyun, MD, PhD

Dr. Hyun is Assistant Clinical Professor of Psychiatry at Columbia University in New York and is former Trustee of the American Academy of Psychoanalysis and Dynamic Psychiatry. She has a private practice in New York and New Jersey.

I am often asked by psychiatrists who are not trained in psychodynamic psychiatry about what I do and how I think about patients and their treatments. In response, I often say that a key difference lies in how psychodynamic psychiatrists view clinical material, evaluate patients, and make—or know when to withhold, depending on timing—interpretations. We also often turn to supervisors, consultants, and peers. With the goal of engaging more colleagues and encouraging them to pursue this particular mode of treatment, I present the following fictionalized case based on a real patient but with fabricated identifying information.

Sophia is single, in her early 30s, and lives with a roommate in an apartment in the city in which I practice. She commutes to the city daily, where she works full time as an executive administrative assistant. Many years ago, she received a diagnosis of depression and was treated with an SSRI and psychotherapy. She has no medical history and has never been suicidal.

Sophia initially presented to me for evaluation with the chief complaint of “I don’t feel that connected to my life.” She was referred by her longtime psychiatrist (Dr. A), who initially treated her with psychotherapy and later with medication. Dr. A recognized early on that Sophia might benefit from psychoanalysis and discussed this as an option with her. She was interested but did not feel ready to commit until many years later.

During my evaluation, Sophia stated that she was now able to commit the time and effort for psychodynamic psychotherapy, since she was planning to leave her job and return to school full time. She was interested in improving her relationships with people, especially men, and wanted to figure out why she has had such difficulty in choosing a satisfying career path. Sophia had begun to feel that time was running out and wanted resolve these matters before life passed her by.

At the time of my evaluation, Sophia was planning to pursue a career in medicine. She had enrolled in a graduate program but continued to work full time. For the first year of treatment with me (consisting of twice-weekly psychotherapy for 3 years and then converting to 4-times-a-week, on-the-couch psychoanalysis), she continued to struggle with whether she wanted to commit to a career in medicine, become a therapist, or perhaps choose a different career path altogether, such as one as a physicist (she was doing very well in her physics classes).

Her vague way of relating, complaints of poor memory, and not knowing what she wanted to do with her life or whom she wanted to be with made me quite skeptical about the benefits of psychoanalytic treatment for this patient. Her identity diffusion as well as a significant Axis I MDD that might well deteriorate in the face of such an intensive treatment made me initially question Dr. A’s recommendation for psychoanalysis. Furthermore, she had fled treatment with Dr. A on several occasions over the years.

Sophia presented herself and others in her life in a vague, 2-dimensional manner. I think she sensed my wariness and countered in like fashion, often reminding me that she was not committed to staying in town (she was seriously considering transferring to a school in a distant city), to her current job or plans and make—or know when to withhold, depending on timing—interpretations.

I often say that a key difference lies in how psychodynamic psychiatrists view clinical material, evaluate patients, and make—or know when to withhold, depending on timing—interpretations.

Her vague way of relating, complaints of poor memory, and not knowing what she wanted to do with her life or whom she wanted to be with made me quite skeptical about the benefits of psychoanalytic treatment for this patient. Her identity diffusion as well as a significant Axis I MDD that might well deteriorate in the face of such an intensive treatment made me initially question Dr. A’s recommendation for psychoanalysis. Furthermore, she had fled treatment with Dr. A on several occasions over the years.

Sophia described her father as an energetic, personable man “who values intelligence and education.” He has his own consulting firm and also teaches at a local college. Her mother, “a depressive woman,” gave up her career as an accounting assistant to join her husband’s consulting firm, which she now regrets. Sophia’s mother believes the firm is struggling financially because of the rigidly obsessional nature of Sophia’s father and resulting inability to complete projects and bill clients on time.

Sophia’s mother often asked her for money. Before her treatment, Sophia would always readily give it to her, yet worried about ever being able to own a house or even a car. When I questioned Sophia about this, she expressed guilt over being so fortunate in life and felt a duty to help others in need. Sophia regularly paid for lunches and dinners out with friends and family and showered them with extravagant gifts, even when they could well afford to pay for themselves. They rarely, if ever, reciprocated.

Sophia’s older brother is single (previously engaged) and a successful investment banker. Sophia described their relationship as contentious and competitive. For example, they did not speak for a year after she won a game of Monopoly. Her younger sister is single and lives with roommates in another city and works as a paralegal. She and Sophia are extremely close and speak on the phone or text daily. Sophia describes her sister as outgoing, athletic, and adventurous and wonders why “such a catch” remains single.

Sophia has had 2 heterosexual relationships in her lifetime. The first relationship was in high school, and the second was with a man that she met in college and dated on and off over the years. The first relationship was primarily sexual, with a boy who would not acknowledge her as his girlfriend. She described him as athletic, outgoing, and ambitious. Sophia was heartbroken to discover that he was seeing other girls. She became very depressed with increased tearfulness, anhedonia, and loss of appetite; she dropped out of intramural sports and became increasingly socially isolated.

Her second relationship began in her freshman year of college. He was not a student but lived in town and was a distant friend of the family. He held a series of manual labor jobs and had dropped out of school in the 8th grade. They dated on and off while she was in college and maintained a long-distance relationship after she graduated. They became engaged around that time, but Sophia developed cold feet and broke off the engagement. Soon after, he met someone else and fathered a child. Learning this news was the main trigger for Sophia’s second depressive episode.

Over the years, their relationship continued in an on-again, off-again manner; his marriage eventually dissolved and they continued to maintain contact, even living together for a brief time. Each time they spoke of marriage and children, Sophia got cold feet and ended things, although she desperately wanted a partner and children.

In treatment, Sophia initially presented herself as a model patient, showing up early for appointments, rarely canceling, and paying on time, if not early. This continued for the first 2 years, after which things began to change. Around that time, she began canceling and missing sessions, showing up and paying late, and questioning the treatment in general.
When this shift occurred, I initially found myself colluding with Sophia’s passive-aggressive behaviors, allowing myself to become distracted by her apologies and promises that she was going to improve her behavior. This assured my anger until the next time. I soon began to realize that we were avoiding speaking about what might be going on in the treatment that made her cancel or be late for her appointments.

This eventually came to a head after I came back from vacation one summer. Sophia returned from the break stating that she wanted to have fewer sessions each week and also requested early morning appointments. Rather than exploring these requests and what they meant to her, I discouraged her from doing so and told her that I did not have any early morning appointments available. I was commuting into the city daily and felt very resistant to give her early appointments in order to avoid the heavy rush hour traffic.

Sophia responded by canceling more sessions in the following months, showing up late on a number of occasions, and questioning the treatment and whether we were suited to be working together. After I repeatedly asked her about and tried to explore the missed and late sessions, one day she exclaimed:

Sophia: It would be easier to get here on time than talk about why I was 45 minutes late. It would just be easier to be on time. I don’t really enjoy having to dissect why I was late. I get that it says something, I guess I just don’t want to explore what it is saying. I’d just rather be on time.

Me: But you haven’t been. What’s that about?

Sophia: Being late all the time says something about how much or little I prioritize being here. It’s not something I would come out and say, necessarily. Well, I guess I just did. . . . Yeah, but I guess being late says maybe I don’t respect your time as much as I should.

At the time, I was struck by how devalued and not prioritized I felt as a result of Sophia’s declaration. Suddenly, I realized that perhaps she was making me feel the way she feels most of the time out in the world. Knowing this intellectually and really feeling it firsthand emotionally were 2 completely different things, and I REALLY felt it in this moment. I also realized that I had not been prioritizing Sophia either. So I responded:

Me: You saying that, makes me wonder how much of a priority you feel you are with me and with others.

Sophia: Um, priority, I don’t think I’m top priority for anyone. I factor into peoples’ priorities, like my parents. But now that I’m older I don’t feel that top priority with them either. With you, I don’t know what priority I am. As MUCH as I’ve been coming here and we’ve been working together, that says something. But like, I guess I don’t know what kind of priority I am to other people.

Me: Maybe sometimes it’s just better not to look, than to look and realize you are not a priority.

Sophia: Well, yeah, definitely. If you’re not looking at it, then you don’t need to be concerned. I’d rather just not be aware. It creeps into my awareness at times, but it’s pretty simple to think of other people and distract myself.

At the time, and even now in looking back, I experienced this session as a turning point in my work with Sophia. I was beginning to prioritize and think more about her. Perhaps she found both my emotional absence and then my renewed interest equally distressing. I wish I had said that to her in session, that sometimes it’s just as difficult to realize that you are being noticed and paid attention to by another as it is to realize that you may not be.

I wish I could say this session marked a magical turning point with Sophia, and that after this breakthrough she suddenly started coming more regularly to sessions and stopped being late. It did help somewhat, but not drastically, and certainly not right away. More importantly, however, it helped provide me with more insight into Sophia’s experience of being in the world, which she had carefully kept hidden, and her conflicted feelings about me realizing it. Furthermore, she surprised me with her willingness to show up and reflect on events such as these during the sessions. As a result, I have begun to realize that this has been the goal all along, and that the behavioral changes were secondary to being able to consistently show up and reflect on what is going on in the treatment.

Over time, I have observed positive changes in Sophia’s mental status. She has become better groomed; her hair is longer and attractively styled. She went

(CONTINUED ON PAGE 14)
Dr. Lloyd Sederer, Chief Medical Officer of the New York State Office of Mental Health and Adjunct Professor at Columbia University, has written an easily accessible and enjoyable book of practical wisdom relevant to patients, practitioners, and the general public. It is a captivating blend of storytelling and factual context told in a relaxed, warm style.

Improving Mental Health: Four Secrets in Plain Sight presents 4 key elements that are basic to understanding human mental health needs. Dr. Sederer explains how neglect of these elements can lead to distress, dysfunction, and mental illness. Billed as “secrets,” these concepts are fundamental to psychiatric practice: understanding human motivation, maintaining relationships, managing stress, and approaching treatment conservatively. Each of these principles is illustrated by a series of patient vignettes and stories drawn from history and popular media.

The book is divided into 4 parts that explain each element. In Chapter 1, “Behavior Serves a Purpose,” there are several examples of human behaviors that are self-defeating or overtly bizarre, such as hateful or demanding patients and those with violent or psychotically disorganized behavior; these examples are accompanied by a sensitive disregard of the need or vulnerability that drives the behavior. Even experienced clinicians would benefit from Dr. Sederer’s observation that understanding these behaviors “replaces darkness with light, distor- tion with reason, blame with tolerance, dismissal with discussion, and powerlessness with problem-solving.”

The second chapter, “The Power of Attachment,” presents a historical overview of attachment and object relations theory from Klein and Freud to Henry Harlow. This is followed by a discussion of attachment styles and an explanation of how disruption of attachments in early life creates adult dysfunction.

An excellent discussion of the therapeutic alliance explains how a stable and mature attachment can overcome childhood neglect and trauma.

In the third chapter, “As a Rule, Less Is More,” the author provides an honest and unsparring self-appraisal of psychiatry’s misadventures in psychopharmacology and psychotherapy. I, too, trained in the era when rapid neuroleptization was the treatment of choice for acute-phase psychosis, but that practice is now being abandoned for more thoughtful and well-rounded interventions provided by programs for early-onset psychosis. This chapter discusses the importance of early intervention, what these programs provide, and how they benefit patients and families.

The principle of “less is more” also applies to psychotherapy, a topic rarely acknowledged or discussed among psychiatrists. Early-career psychiatrists and mental health practitioners in training would be well advised to read Dr. Sederer’s historical review of recovered memory therapy and the injury this treatment caused to patients and their families. This chapter is a cogent reminder that the wrong psychotherapy, or even an established therapy given for the wrong purpose, can be harmful.

Finally, the chapter entitled “Chronic Stress Is the Enemy” introduces the Adverse Childhood Experiences (ACE) study, which links early abuse and neglect to future psychiatric illness and other negative social consequences. On a more hopeful note, there are several recommendations for evidence-based interventions to prevent these consequences.

The last chapter provides an exhaustive review of the neurophysiologic mechanism of the stress response, as well as an overview of the literature that links PTSD and depression to chronic stress. Of all the material presented in this book, I found this aspect to be the most theoretical. While it is useful as a proposed mechanism to link psychiatric to medical illness, there is less known about the utility of the stress-reduction techniques recommended in the book.

I enjoyed this book because Dr. Sederer’s enthusiasm and love for his work shine through every page, particularly when he discusses the importance of love and social connections. He clearly has taken the time to develop a thoughtful and sensitive paradigm for well-rounded patient care. His emphasis on the environment and social determinants of mental illness is a “call to action” for every mental health professional and lay reader.

Dr. Sederer is Clinical Assistant Professor of Psychiatry at the University of Maryland and Director of the Forensic Psychiatry Fellowship Program.
SUBSTANCE USE DISORDERS: PART 2
Understanding and Addressing Sleep Disruptions in Alcohol Use Disorders

Dr. Schmidt is a Psychiatry Resident, Department of Psychiatry and Psychology, Mayo Clinic, Rochester, MN; Dr. Kolla is Assistant Professor of Psychiatry and Psychology, Department of Psychiatry and Psychology, and Center for Sleep Medicine, Mayo Clinic, Rochester.

Dual diagnosis is a term commonly employed in substance use disorder (SUD) treatment. What is less recognizable is the concept of disturbed sleep as a co-occurring disorder in need of management. As is the case with affective and anxiety disorders, a growing body of evidence is emerging that SUDs share a complicated relationship with sleep that is bidirectional. Findings suggest that a history of baseline insomnia may be predictive of disordered substance use.1,2 It is also interesting that abstinent adolescents with a family history of substance dependence are more likely to experience difficulties sleeping—a fact that may illustrate psychosocial factors or the presence of a genetic association between sleep and SUDs.

Recent evaluations indicate that polymorphisms of clock genes elucidate this association. Clock genes encode for proteins that form part of an auto-regulatory feedback loop that cycles over a 24-hour period. Variations in certain Clock genes appear to influence sleep drive and circadian preferences; one such gene, PER 3, has been linked to insomnia severity in alcoholic patients.3 New frontiers in addiction research have also implicated neuropeptides such as orexin in the dual role of sleep and reward circuitry.4 The lateral hypothalamus contains many of the neurotransmitters and neural networks involved in alertness, concentration, mood, and regulation of the sleep-wake cycle; many of these networks extend to the reward center that is manipulated by substances of abuse.

It may not come as a surprise that while 10% to 15% of the general population experiences insomnia, reports for subjects with active alcohol use disorders and comorbid sleep disturbance range from 30% to 80%.5 Sleep disruption complicates acute withdrawal as well—upwards of 50% of patients report sleep disturbance during acute withdrawal from alcohol.6 Sleep disturbance in early recovery also represents a formidable obstacle for patients with alcohol use disorder; a subset of patients experiences first-episode insomnia with sobriety. While recovery of restorative sleep is possible with sobriety, it has been suggested that disordered sleep may persist for years in people with a history of chronic alcohol use and increases vulnerability to relapse.

Users who perceive their substance of abuse as soporific may be at increased risk for sleep disturbances and relapse. This perception may be based on early experiences of the substance, when moderate use of alcohol may indeed have conferred subjective sleep benefits such as reduced onset to sleep. A recent analysis that looked at the link between sleep disturbance and alcohol relapse in a residential treatment facility suggests that patients who reported use of alcohol as a sleep aid were more than 3-fold more likely to relapse at 12 months (odds ratio [OR] = 3.26; 95% confidence interval [CI] = 1.33-7.95; P = .008).7 Study findings also indicate a significant association between patients’ use of hypnotics at admission and alcohol relapse at 12 months (OR = 4.03; 95% CI = 1.63-9.97; P = .002).

Foster and colleagues queried alcohol-dependent subjects in an inpatient
setting and found a subjective sense of sleep latency to be a predictor of relapse. Findings from other studies also support this association between subjective perceptions of increased awakenings and difficulty falling asleep and relapse risk in early alcohol recovery.

Objective evidence of sleep disturbance exists in alcohol use disorders as well. Polysomnography studies suggest that chronic alcohol use increases sleep latency (defined as the amount of time from lights out to sleep onset) throughout the oscillating stages of use, including active drinking periods, acute withdrawal, post-withdrawal, and early and late recovery. In their review, Angarita and colleagues conclude that total sleep time (the amount of sleep in one complete episode of sleeping) is uniformly adversely affected by alcohol in all of its use stages from active drinking to later recovery.

Persons with alcohol use disorders also appear to suffer from slow wave sleep deficits (stage N3), which may correspond to difficulty with learning, memory, and cognitive performance. Use of alcohol results in suppression of REM sleep. Following 2 to 3 weeks of abstinence, there appears to be a REM rebound, which some patients describe as an increase in vivid dreams.

Assessment
Polysomnography for the purpose of diagnosing sleep disorders is not practical for many patients and is unnecessary for a diagnosis of insomnia. A clinical diagnosis of insomnia is obtained by meeting the following criteria outlined by the American Academy of Sleep Medicine: dissatisfaction with sleep quantity or quality, with one or more of the following symptoms: difficulty initiating sleep, difficulty maintaining sleep, waking up earlier than desired, resistance to going to bed on an appropriate schedule, or difficulty sleeping without parent or caregiver. In addition, the sleep disturbance may cause impairment in social, occupational, educational, academic, behavioral, or other important areas of functioning. These criteria are detailed in Table 1.

Other sleep disorders such as obstructive sleep apnea may co-occur with alcohol dependence and can be differentiated from insomnia by screening for factors such as obesity, hypertension, snoring, daytime somnolence, and retrognathia. Periodic limb movement disorder may disturb sleep and may be more prevalent in chronic alcohol users; it is diagnosed by polysomnography.

Circadian rhythm abnormalities have also been linked with alcohol use disorders. Research has implicated melatonin deficiency and delay as a potential culprit for sleep-onset difficulty. Recovering alcohol-dependent men and women demonstrate lower melatonin levels in early evening and delayed melatonin peaks compared with controls. Although melatonin assays are commercially available, the practical applicability of such investigations in sleep disturbances in alcohol recovery is limited. Overall, insomnia remains the most common sleep disturbance encountered in alcoholic patients, and a good history is the cornerstone of an accurate diagnosis.

Treatment
Treatment of sleep disorders in previously substance-abusing patients is complicated. Clinicians remain appropriately circumspect about prescribing medications with potential abuse liability, and sleep disturbance may often be perceived by clinicians and patients alike as a natural consequence of substance withdrawal that should remit in time. Whether sleep disturbance is a residue of substance use or substance use is a consequence of historically complicated sleep patterns is up for debate. What has been shown, however, is that a failure to treat the comorbid sleep disorder may predict relapse.

Nonpharmacological interventions such as cognitive behavioral therapy for insomnia (CBT-I) have been effective at minimizing sleep disturbance in recovery populations and may have positive effects on relapse. CBT-I consists of behavioral and cognitive strategies aimed at improving sleep quality and daytime functioning (Table 2). A benefit of this intervention is its applicability to multiple SUDs and its minimal adverse effects. Limitations may include expense, time commitment, and availability of local qualified clinicians.

Light therapy may be helpful in patients recovering from alcohol use disorders who have circadian rhythm dysfunction. Benefits include ease of use and absence of medication interactions. Adverse effects may include activation with possible mania induction in susceptible patients.

Supplementation may also be considered in the treatment schema for patients with an SUD and co-occurring sleep disturbance. It is reasonable to introduce melatonin as a potential intervention for patients with alcohol use disorders who have melatonin deficiencies. Studies that evaluated magnesium supplementation found improved subjective sleep scores and improved sleep latency on polysomnography, with total sleep time gains noted in groups with decreased periodic limb movement symptoms.

Table 3 lists available pharmacotherapeutic agents for alcohol use disorder comorbid with sleep disorders. A 2014 review by Conroy and Arnst noted that gabapentin appeared to be safe and effective for treating insomnia in abstinent alcohol-dependent patients. This was corroborated by a study by Mason and colleagues, which showed significant improvement in sleep quality for alcohol-dependent patients treated with 1200 mg of gabapentin daily. Benefits of gabapentin include nonhepatic metabolism and inability to lower the seizure threshold; adverse effects include sedation, confusion, ataxia, and abuse potential. Trazodone was also shown to significantly improve sleep at doses that
Sleep Disruptions in Alcohol Use Disorders

Continued from page 16

averaged 100 mg nightly in a large placebo-controlled trial conducted in alcohol-dependent patients over 24 weeks. Although there were some initial concerns about an increased risk of relapse with the use of trazodone, subsequent studies have not borne that out. Benefits include tolerability; adverse effects may include priapism, oversedation, and GI disturbance due to serotonergic effects.

An investigation by Litten and colleagues demonstrated improved sleep quality with 400 mg of quetiapine extended release. This study extended earlier findings of Martinotti and colleagues, who reported significant correlations between the reduction in alcohol withdrawal and craving scores and HAM-D (Hamilton-Depression screen) insomnia items. Adverse effects include disruption of the metabolic profile, risk of movement disorders, and possible abuse potential.

A multicenter trial of 371 alcohol-dependent patients found a significant reduction in obsessional thoughts and compulsions about using alcohol and a reduction in sleep disturbance with tolerance use. Melatonin receptor agonists such as ramelteon and agomelatine have also shown some benefit in sleep improvement for alcohol-dependent patients, although further studies are warranted. Adverse effects of ramelteon include somnolence, dizziness, fatigue, and nausea as well as complex sleep behaviors such as sleep driving.

Other considerations

The following case vignettes highlight the complexity and individual nuances of patients who struggle with sleep and substances. These cases also illustrate the importance of asking about caffeine, nicotine, and high-sugar food intake in early-recovery patients with persistent sleep disturbance. Future investigations of substance use and sleep should incorporate an analysis of these features, as patients in recovery may exhibit a tendency toward cross-addiction and increased consumption of caffeine, nicotine, and sugar that may affect sleep quality.

Mr. P had a history of severe alcohol use disorder with 25 years of sobriety following successful chemical dependency treatment. He had a comorbid chronic insomnia disorder that was responsive to a stable 12.5-mg dose of zolpidem extended release. After his primary care provider retired, a new physician tapered off and discontinued zolpidem. Following several other unsuccessful medication trials and a year of disrupted sleep, Mr. P relapsed to alcohol to help fall asleep. He quickly re-verted to previous abusive patterns, and he returned to his second alcohol use disorder treatment. After successful completion of treatment, zolpidem was re-instated and Mr. P has remained sober since that time.

Mr. S had a 10-year history of sleep disturbance and daytime fatigue as well as a history of opioid-use disorder that was in sustained remission. Zolpidem was prescribed to target his sleep disturbance, and within 1 year he escalated the dose to 30 mg nightly. He was referred for chemical dependency treatment for a sedative-hypnotic use disorder, and eventually zolpidem was tapered off. For more than a year, he had persistent sleep disturbance. Mr. S reported that he was drinking more than 7 caffeinated beverages daily and was chewing 1 can of tobacco daily.

He achieved restorative sleep with mirtazapine (15 mg nightly) and gabapentin (300 mg 3 times daily). He was able to taper and discontinue caffeinated beverages and transitioned from chewing tobacco to nicotine gum.

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

References

ADHD and Substance Use: Current Evidence and Treatment Considerations

The presence of comorbid disorders is often the rule rather than the exception in individuals with ADHD. Of particular concern is problematic substance use; alcohol, cannabis, cocaine, and nicotine represent some of the most commonly abused substances. Elevated substance use significantly complicates a patient’s symptom presentation, making the accurate diagnosis, prognosis, and treatment of ADHD challenging even for the most skilled practitioners.

The link between ADHD and substance use disorders
Children with ADHD are at increased risk for alcohol use disorder as they get older, and they are more than twice as likely to develop nicotine dependence and marijuana or cocaine abuse or dependence (Figure). Approximately 15% of adolescents and young adults with ADHD have a comorbid substance use disorder (SUD), while 11% of individuals with an SUD also meet the criteria for ADHD. Findings indicate that the overlap between these disorders is not random, and several explanations have been postulated for their link.

ADHD and SUD have been described as disorders of disinhibition, which suggests an underlying vulnerability that is shared by both disorders. Alternatively, features of ADHD, such as impulsivity, may increase the risk of initiating substance use. In fact, children with ADHD are significantly more likely to try a range of substances during their lifetime compared with their non-ADHD counterparts (see Figure).

The mechanisms underlying the increased risk of SUD among those with a history or current diagnosis of ADHD are not well understood. Persistent ADHD, which might be a marker of increased vulnerability and/or of reduced access or responsiveness to intervention, is associated with much higher rates of SUD. The high co-occurrence between ADHD and SUD merits special consideration.

Issues in identifying suspected SUD
Assessment for ADHD requires the ability to distinguish between ADHD and other disorders that demonstrate significant symptomatic overlap. Among individuals who present with active substance abuse, it is critical to distinguish between a valid ADHD diagnosis and substance-induced impairments that can negatively affect attention, concentration, and impulsivity. Many psychoactive substances have acute effects that can mimic the symptoms of ADHD, such as chronic marijuana use, which has been associated with deficits in problem-solving, organization, and sustained attention that may persist even after 3 weeks of abstinence. Because of this, practitioners might want to prioritize the treatment of substance use and then re-evaluate patients for ADHD after a period of prolonged abstinence.

Unfortunately, this approach is sometimes not feasible, particularly for patients who present with significant and untreated ADHD symptoms that may impair the ability to engage in and benefit from SUD treatment. Thus, a comprehensive evaluation of ADHD symptoms during prior periods of abstinence may be the next best approach for assessing co-occurring SUD and ADHD, with a focus on whether the ADHD symptoms preceded the onset of substance use. While this is a reasonable recommendation, this approach is not without challenges, as it requires patients to recall the onset and severity of their initial symptoms. This may be especially challenging for patients with ADHD and substance abuse because both are associated with neurocognitive deficits.

Obtaining collateral information from parents and teachers, medical records, and psychological evaluations is recommended to elucidate the patient’s childhood functioning. Although it is not always feasible to access such corroborating information for adults with suspected ADHD, such data can be useful in determining whether ADHD symptoms were present in childhood and in differentiating primary from substance-induced ADHD symptoms.

Malingering, while uncommon, merits consideration in any diagnostic evaluation of co-occurring ADHD and SUD because stimulant medication may be sought for the treatment of ADHD. Methylphenidate and amphetamine salts have a high abuse potential and can produce a feeling of euphoria similar to illicit CNS stimulants.

SIGNIFICANCE FOR THE PRACTICING PSYCHIATRIST
Given the high co-occurrence of ADHD and substance use disorders, careful consideration of how to assess these disorders is warranted. In particular, psychiatrists should consider whether stimulant medication is an appropriate first-line pharmacological intervention, along with psychosocial intervention.

▶ ADHD and substance use disorders frequently co-occur in adolescents and adults.
▶ Substance use may affect the presentation and assessment of ADHD symptoms.
▶ Given their high abuse potential, stimulant medications used to treat ADHD should be carefully considered and monitored in patients with a history of substance abuse or dependence.

FIGURE. Estimated odds ratio for substance initiation and abuse/dependence for children with ADHD

**Note:** Estimate of 1 = no difference in risk between children with and without a history of ADHD, whereas higher values indicate greater odds of substance use initiation or abuse/dependence for those with a diagnosis of ADHD. Error bars represent the 95% confidence interval. Values obtained from Lee et al. Clin Psychol Rev. 2011.
ADHD and Substance Use

Continued from page 19

lant drugs such as cocaine. Some individuals with SUDs may be motivated to feign a diagnosis of ADHD to gain access to stimulant medications.

Information regarding prototypical ADHD behavior is readily accessible via the Internet, which allows individuals who seek stimulants for non-medical purposes to be sufficiently “prepared” before a diagnostic evaluation. Unfortunately, neuropsychological evaluations, which are often used in conjunction with self-report to establish ADHD diagnoses, are also susceptible to feigned symptoms. Thus, incorporating ratings of patient functioning from other sources is advised, with particular attention to instances in which the client reports significantly more symptoms than other informants.

Treatment

Many parents worry that stimulant medications will have iatrogenic effects and potentially increase a child’s susceptibility to subsequent drug use. Conversely, some caregivers, hoping for a rapid response to medication, may want to use stimulant medication as a first-line treatment—even for young children for whom pharmacological intervention should be considered only after appropriate behavioral interventions (eg, parent training). Parents clearly want to do what is best for their children, and psychiatrists and other clinicians should be prepared to provide evidence-based support for recommendations regarding treatment for ADHD in the context of potential risk of a later SUD.

There is little evidence for the sensitization hypothesis, in which the use of stimulant medication increases the risk of a later SUD. Findings from a meta-analysis indicate that the use of stimulant medications to treat childhood ADHD neither increases nor protects against the risk of later development of an SUD.1

The American Academy of Child and Adolescent Psychiatry guidelines include psychoeducation regarding treatment options and the expected course of symptoms, adjunctive school support, and the use of FDA-approved medication if pharmacological intervention is selected. Treatment decisions should be made jointly with the patient and his or her family. The risk-to-benefit ratio of a particular stimulant and its adverse effects (eg, sleep disturbances, loss of appetite, growth stunting) should be discussed, and information about the flexibility that stimulant treatment allows for medication-free “holidays” on weekends and school breaks.

There is inconclusive evidence that stimulant medications are effective in reducing symptoms of ADHD and comorbid substance abuse in adults. While some studies have shown a reduction of ADHD and SUD symptoms following treatment with stimulant medications, others have documented improvements only in ADHD symptoms or no benefits at all.2–4 Unfortunately, the comorbidity of ADHD and SUD is associated with a poor prognosis for SUD treatment; therefore, prioritizing the treatment of ADHD merits consideration.

Yet comorbid SUD is also associated with a poor prognosis for ADHD treatment, and it is often recommended that treatment of active substance abuse should precede the treatment of ADHD. Psychosocial interventions for SUD may need to be individualized to account for a patient’s ADHD symptoms, which may interfere with his or her ability to engage in treatment and increase the likelihood of treatment nonadherence.

Psychotherapy is always recommended for patients with comorbid ADHD and SUD. In addition, non-stimulants (eg, atomoxetine) or extended-release stimulants should be considered when treating co-occurring ADHD and SUD, as these medications are less subject to abuse and diversion and may be preferable for patients at risk for substance abuse. Although non-stimulants are less effective than stimulants in treating ADHD symptoms, they may represent an appropriate middle ground between no medication at all and stimulants. Any psychoactive medication can be misused, so diligent documentation of all prescriptions must be maintained. Repetitive requests for an increase in dosage or early refills should be explored with the patient. For those with a history of substance abuse, medication decisions should ideally be reached through collaboration with the patient, family members, and spouses/partners, and it is critical to emphasize the importance of taking the medications as prescribed. For adolescents at high risk for diversion or misuse, parents can be encouraged to regulate their child’s medication use by storing all medications in locked cabinets.

Conclusion

ADHD is associated with increased risk of substance use initiation as well as abuse and dependence. There is no evidence that stimulant treatment for ADHD increases the subsequent risk of SUD; however, such medications are prone to misuse and diversion. In addition to thorough, multi-informant, and developmentally sensitive assessment, careful consideration of potential abuse of medication treatment for ADHD is warranted. Nonpharmacological or non-stimulant medications may be appropriate for treatment of ADHD for those at risk for SUD, or for those who have a current diagnosis of SUD. In addition, psychosocial intervention is recommended in conjunction with any medication treatment for individuals with comorbid ADHD and SUD.

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

References


20 AUGUST 2017

SUBSTANCE USE DISORDERS: PART 2

Treatment for Cannabis Use Disorders: A Case Report

Christina Brezing, MD
and Frances Levin, MD

Dr. Brezing is a Fellow in Addiction Psychiatry at the New York State Psychiatric Institute and Columbia University College of Physicians and Surgeons in New York City. Dr. Levin is Kennedy-Leapsy Professor of Clinical Psychiatry, Columbia University College of Physicians and Surgeons, Chief of the Division on Substance Abuse, and Director of the Addiction Psychiatry Fellowship Program at New York Presbyterian Hospital.

It is vital that physicians—particularly psychiatrists who are on the frontlines with patients who struggle with cannabis use—are able to identify and characterize cannabis use disorders; provide education; and offer effective, evidence-based treatments. This article provides a brief overview of each of these topics by walking through clinical decision-making with a case vignette that touches on common experiences in treating a patient with cannabis use disorder.

A separate and important issue is screening for emerging drugs of abuse, including synthetic “marijuana” products such as K2 and spice. Although these products are chemically distinct from the psychoactive compounds in the traditional cannabis plant, some cannabis users have tried synthetic “marijuana” products because of their gross physical similarity to cannabis plant matter.

CASE VIGNETTE

Mr. M is a 43-year-old legal clerk who has been working in the same office for 20 years. He presents as a referral from his primary care physician to your outpatient psychiatry office for an initial evaluation regarding “managing some mid-life issues.” He states that while he likes his job, it is the only job he has had since graduating college and he finds the work boring, which has left him feeling discouraged. He is concerned about his co-workers having gone on to law school or more senior positions in the firm. When asked what factors have prevented him from seeking different career opportunities, he states that he would “fail a drug test.” Upon further inquiry, Mr. M says he has been smoking 2 or 3 “joints” or taking a few hits off of his “vaping pen” of cannabis daily for many years, for which he spends approximately $70 to $100 a week.

He first used cannabis in college and initially only smoked “a couple hits” in social settings. Over time, he has needed more cannabis to “take the edge off” and...
has strong cravings to use daily. He reports liking how cannabis decreases his anxiety and helps him fall asleep, although he thinks the cannabis sometimes makes him “paranoid,” which results in his avoidance of family and friends.

More recently, he identifies conflict and regular arguments with his wife over his cannabis use—she feels it prevents him from being present with his family and is a financial burden. He admits missing an important awards ceremony for her work and sporting events for his children, for which he had to “come up with excuses,” but the truth is that he ended up smoking more than he had intended and lost track of the time.

Mr. M reports multiple previous unsuccessful attempts to reduce his use and 2 days when he stopped completely, which resulted in “terrible dreams,” poor sleep, sweating, no appetite, anxiety, irritability, and strong cravings for cannabis. Resumption of his cannabis use revealed these symptoms. He denies tobacco or other drug use, including use of synthetic marijuana products such as K2 or spice, and reports having a glass of wine or champagne once or twice a year for special occasions.

The diagnosis

In the transition from DSM IV-TR to DSM-5, cannabis use disorders, along with all substance use disorders, have been redefined in line with characterizing a spectrum of pathology and impairment. The criteria to qualify for a cannabis use disorder remain the same except for the following:

1. The criterion for recurrent legal problems has been removed.
2. A new criterion for craving or a strong desire or urge to use cannabis has been added, and the terms abuse and dependence were eliminated.

To qualify as having a cannabis use disorder, a threshold of 2 criteria must be met. Severity of the disorder is characterized as “mild” if 2 or 3 criteria are met, “moderate” if 4 or 5 criteria are met, and “severe” if 6 or more criteria are met. Mr. M demonstrates 3 symptoms of impaired control: using longer than intended, unsuccessful efforts to cut back, and craving; 3 symptoms of social impairment: failure to fulfill home obligations, persistent problems with his wife, and reduced pursuit of occupational opportunities; 1 symptom of risky use: continued use despite paranoia; and 2 symptoms of pharmacological properties: tolerance and withdrawal. As such, he meets 9 criteria, which qualify him for a diagnosis of severe cannabis use disorder.

You summarize Mr. M’s symptoms and counsel him about severe cannabis use disorder. He becomes upset and states that he was not aware one could develop an “addiction” to cannabis. He expresses an interest in treatment and asks what options are available.

Treatment options

Psychotherapeutic treatments, including motivational enhancement treatment (MET), cognitive behavioral therapy (CBT), and contingency management (CM), have demonstrated effectiveness in reducing frequency and quantity of cannabis use, but abstinence rates remain modest and decline after treatment. Generally, MET is effective at engaging individuals who are ambivalent about treatment; CM can lead to longer periods of abstinence during treatment by incentivizing abstinence; and CBT can work to enhance abstinence following treatment (preventing relapse). Longer duration of psychotherapy is associated with better outcomes. However, access to evidence-based psychotherapy is frequently limited, and poor adherence to evidence-based psychotherapy is common.

In conjunction with psychotherapy, medication strategies should be considered. Because there are no FDA-approved pharmacological agents for cannabis use disorder, patients should understand during the informed consent process that all pharmaceuticals used to treat this disorder are off-label. A number of clinical trials provide evidence for the off-label use of medications in the treatment of cannabis use disorder.

The current strategies for the off-label treatment of cannabis use disorder target withdrawal symptoms, aim to initiate abstinence and prevent relapse or reduce use depending on the patient’s goals, and treat psychiatric comorbidity and symptoms that may be driving cannabis use. Here we focus on the evidence supporting these key strategies.

Targeting withdrawal and craving

Cannabis withdrawal is defined by DSM-5 as having 3 or more of the following signs and symptoms that develop after the cessation of prolonged cannabis use:

- Irritability, anger, or aggression
- Nervousness or anxiety
- Sleep difficulty
- Decreased appetite or weight loss
- Restlessness
- Depressed mood
- At least one of the following physical symptoms that causes discomfort: abdominal pain, shakiness/tremors, sweating, fever, chills, or headache

Withdrawal symptoms may be present within the first 24 hours. Overall, they peak within the first week and persist up to 1 month following the last use of cannabis. In the case of Mr. M, insomnia, poor appetite, and irritability as well as sweating are identified, which meet DSM-5 criteria for cannabis withdrawal during the 2 days he abstained from use. He also identifies strong craving and vivid dreams, which are additional withdrawal symptoms included on marijuana withdrawal checklists in research studies, although not included in DSM-5 criteria. These and other symptoms should be considered in clinical treatment.

Medication treatment studies for cannabis withdrawal have hypothesized that if withdrawal symptoms can be reduced or alleviated during cessation from regular cannabis use, people will be less likely to resume cannabis use and will have better treatment outcomes. Studies have shown that dronabinol and nabilone improved multiple withdrawal symptoms, including craving, and quetiapine, zolpidem, and mirtazapine help with withdrawal-induced sleep disturbances.

Combining dronabinol and lofexidine (an alpha-2 agonist) was superior to placebo in reducing craving, withdrawal, and self-administration during abstinence in a laboratory model. However, in a subsequent treatment trial, the combined medication treatment was not superior to placebo in reducing cannabis use or promoting abstinence.

Six double-blind placebo-controlled pharmacotherapy trials in adults with cannabis use disorder have looked at withdrawal as an outcome. Of these studies, only dronabinol, bupropion, and gabapentin reduced withdrawal symptoms.

In addition to reducing withdrawal symptoms, nabiximols/Sativex (a combination tetrahydrocannabinol [THC] and cannabidiol nasal spray not available in the US) increased retention (while actively on the medication in an inpatient setting) but did not reduce outpatient cannabis use at follow-up.

All of the medications available for prescription in the US can be monitored reliably with urine drug screening to assess for illicit cannabis use except dronabinol, which will result in a positive screen for cannabis. When using urine drug screening, remember that for heavy cannabis users the qualitative urine drug screen can be positive for cannabis up to a month following cessation. When selecting a medication, take into account the cost of the medication, particularly since insurance will likely not cover THC agonists such as dronabinol for this indication, and possible misuse or diversion of scheduled substances (eg, dronabinol, nabilone). In addition,monitoring for reductions in substance use and withdrawal symptoms is key.

Abstinence initiation and relapse prevention

Other clinical trials have looked at medications to promote abstinence by reducing stress-induced relapse, craving (not as a component of withdrawal), and the reinforcing aspects of cannabis. Of these trials, the following results show potential promise with positive findings: gabapentin reduced quantitative THC urine levels and improved cognitive functioning (in addition to decreasing withdrawal), and buspirone led to more negative urine drug screens for cannabis (although the difference was not significant compared with placebo).

However, in a follow-up larger study, no differences were seen compared with placebo and women had worse cannabis use outcomes on buspirone.

N-acetylcysteine resulted in twice the odds of a negative urine drug screen in young adults and adolescents (although there was no difference between adolescent groups in self-report of cannabis use).

Gray and colleagues reported that no differences were seen between N-acetylcysteine and placebo (results of the trial are soon to be published). Topiramate resulted in significantly de-
Treatment for Cannabis Use Disorders

Continued from page 21

Say that his insurance will not cover the prescription for dronabinol and he cannot afford the high cost. Given his main concern of cannabis withdrawal symptoms, you select gabapentin up to 400 mg 3 times daily and continue weekly individual CBT.

Mr. M calls back several days later and reports that he has made some improvements in reducing the frequency of his cannabis use, which he attributes to the medication, but he thinks he needs additional assistance. After reviewing the treatment options again, he gives informed consent to start 1200 mg of N-acetylcysteine twice daily. After 10 weeks of this medication, his urine screens are negative.

You continue to provide relapse prevention CBT. He reports to you that his anxiety and insomnia are almost resolved, and you suspect that withdrawal was the cause of these symptoms. He reports significant improvement in his relationship with his family and recently received a promotion at work for “going above and beyond” on a project he was given the lead.

Over the next 6 months, he has 2 relapses that in functional analysis with you are determined to be triggered by unsolicited contact from his former drug dealer. Together, you develop a plan to block any further contact from the drug dealer. After several months, both the gabapentin and N-acetylcysteine are tapered and discontinued. Mr. M continues to see you for biweekly therapy sessions with random drug screens every 4 to 6 weeks.

Conclusion

Based on the available evidence, gabapentin, THC agonists, naltrexone, and possibly N-acetylcysteine show the greatest promise in the off-label treatment of cannabis use disorders. System considerations, such as medication cost, need to be factored into the decision-making as well as combination medication and psychotherapy approaches, which—as demonstrated in the case of Mr. M—may ultimately work best. Until further research elucidates the standard of medication practices for cannabis use disorder, the best off-label medication strategy should target any co-occurring disorders as well as any identified problematic symptoms related to cannabis use and cessation of use. When available, referral for evidence-based psychotherapy should be made.

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

References

Life-changing steps forward.

When your patients are not responding to treatment, The Retreat at Sheppard Pratt can help. Our residential program offers individualized, compassionate and comprehensive care that empowers residents to manage even the most challenging mental health disorders. The Retreat is part of the Sheppard Pratt Health System, ranked among the nation’s top 10 psychiatric hospitals by U.S. News & World Report for more than 25 years. For more information, visit our website or contact us.

retreat.sheppardpratt.org
410.671.5441
E-Cigarettes, Vaping, and Other Electronic Nicotine Products: Harm Reduction Pathways or New Avenues for Addiction?

Smita Das, MD, PhD, MPH and Judith J. Prochaska, PhD, MPH

Clinical Scenario: During a routine return medication visit, your patient, a 54-year-old man with bipolar disorder, asks you about using an e-cigarette. You recall that he is a pack-a-day smoker, and when you last discussed his smoking about a year ago, he wanted to quit.

This clinical scenario is increasingly common for psychiatrists. Among people with mental illness, 15% have tried e-cigarettes compared with 7% of the general population, and use rates are on the rise.

In a study comprising 956 cigarette smokers hospitalized for mental illness, trial use of e-cigarettes went from 0% in 2009 to 25% in 2013. In the general US population, among smokers, lifetime use of e-cigarettes increased from 10% in 2010 to 37% in 2013.

Given the disproportionate burden of tobacco health harms in psychiatric patients, e-cigarettes are being considered as a potential tool for harm reduction. This article summarizes recent data on e-cigarettes, provides recommendations and resources to learn more, and emphasizes the evidence for treating tobacco addiction in people with mental illness.

E-cigarettes defined

E-cigarettes (ie, vaporizers, vape pens, e-hookah) are battery-operated devices that generate an aerosol from an e-liquid for inhalation. Consisting of a metal tube resembling a traditional cigarette, a battery, an atomizer, and a replaceable cartridge, e-cigarettes usually contain liquid nicotine, propylene glycol (an irritant in antifreeze), glycerin, flavoring, and other chemicals. A user puffs on an e-cigarette, and the heating element evaporates the cartridge solution. Many of these are intended to simulate a cigarette.

Tank or open systems, discussed below, allow users to fill the device with any substance of choice.

Developed and commercialized in China in 2003, e-cigarettes entered the US market in 2006; however, tobacco companies such as Philip Morris have been researching precursors to e-cigarettes since 1990. Over the past decade, advertising and sales of e-cigarettes have increased exponentially every year, and the major tobacco companies now dominate the market.

While tobacco advertising has been banned from television and radio since 1970, e-cigarettes are promoted widely on these media channels, on the web, and in social media, with many ads reaching youth. In August 2016—10 years after entering the US market—e-cigarettes came under the regulatory authority of the FDA, but regulatory evaluations of the products are still in progress.

E-cigarette concerns

Nicotine exposure. Nicotine is a psychoactive drug that can be addictive. Nicotine delivery with e-cigarettes varies by device (greater with the tank systems than with the cigarette-like products) and by experience level of the user. As the technology improves, the speed and the amount of nicotine absorbed are likely to increase over time, along with addiction. Mislabeling has been found with nicotine present in products labeled as nicotine-free or at higher concentrations than labeled. Flavors and appeal to youths. Flavored options (eg, candy, alcohol, unicorn vomit) can appeal to youth, whose brains are vulnerable to early addiction exposure. E-cigarettes are widely available for purchase online, in convenience stores, and in neighborhood vape shops. Past-month e-cigarette use nearly tripled from 2013 to 2014 among high school students (4.5% to 13.4%), surpassing all other tobacco use. For the first time in decades, the percentage of US youth exposed to any nicotine product increased, from 2013 to 2014 and again from 2014 to 2015. Moreover, e-cigarettes may be a gateway to conventional smoking. Two studies of adolescents who were never-smokers at baseline found that e-cigarette use predicts greater risk of cigarette smoking at follow-up.

Vaping other substances. Modifications to e-cigarettes (“mods”) and open tank systems allow users to vape other substances, most commonly cannabis oil. In an anonymous study of more than 7000 high school students, nearly 1 in 5 adolescents who use e-cigarettes reported using the device to vape cannabis oil.

Toxicity and poisoning risks. Nicotine in high doses, especially in children, can be dangerous and even fatal. Poison control calls for nicotine poisoning have increased from one call in September 2010 to 215 calls per month related to e-cigarette exposure in February 2014.

E-cigarettes: harm reducing?

Combustible cigarettes kill two-thirds of long-term smokers. E-cigarettes do not involve combustion; therefore, if a smoker switches to e-cigarettes, carbon monoxide exposure and health harms will be reduced. Yet, the evidence regarding e-cigarettes as a cessation aid is limited; dual use with combustible cigarettes is common; and the safety of e-cigarettes has not been established.

Half of current smokers report regular use of e-cigarettes. Any use of cigarettes is harmful, and the concern is that individuals who use e-cigarettes will continue to smoke conventional cigarettes rather than quit. The strongest evidence in support of e-cigarettes for quitting smoking has come from observational studies in the UK. One study, a time-trend analysis, concluded that for every 1% increase in e-cigarette use, the success rate of quit attempts increased by 0.098%.

In contrast, a second study in the UK found that daily use of e-cigarettes was associated with increases in quit attempts and reductions in number of cigarettes smoked, but not with smoking cessation.

Meta-analyses have been conducted to synthesize the findings in the literature. A systematic review of 20 controlled studies concluded that the odds of quitting cigarettes was 28% lower in those who used e-cigarettes than in those who did not use e-cigarettes. Observational designs are challenged by confounding variables related to who self-selects to use an e-cigarette. Only 2 randomized controlled trials have evaluated e-cigarettes as a method for quitting conventional cigarettes. The quality of evidence was judged to be low grade, and in both trials, e-cigarettes with nicotine were no different in efficacy for quitting smoking than placebo (nicotine-free) e-cigarettes. To date, research does not support the use of e-cigarettes for cessation.

The American Heart Association’s (AHA) policy statement on e-cigarettes does not recommend their use; however, if a patient has tried and failed evidence-based tobacco cessation methods or is unwilling to try them, the AHA recommends:

• No dual use of traditional cigarettes with e-cigarettes
• That a quit date is also set for the e-cigarettes

Substance Use Disorders: Part 2

Significance for the Practicing Psychiatrist

This article summarizes recent data on e-cigarettes, provides recommendations and resources to learn more, and emphasizes the evidence for treating tobacco addiction in people with mental illness.

• The prevalence of smoking is 2- to 4-fold higher among people with mental illness than among the general population, and they face tobacco-related disparities in morbidity and mortality.
• With e-cigarette use on the rise, especially among people with mental illness, many psychiatrists are curious about the risks and potential for abuse with these devices.
Smoking cessation treatment

Cessation pharmacotherapy. There are 7 FDA-approved nicotine replacement therapies (NRTs) that significantly improve quit rates: 3 over-the-counter NRTs (patch, gum, lozenge); 2 prescription NRTs (spray, inhaler); and 2 oral pills (bupropion, varenicline). NRT reduces nicotine cravings and withdrawal without the reinforcing effects of smoked nicotine. It is important to educate the patient on the proper use of NRTs. For example, people use the gum like normal chewing gum, when in fact nicotine in the gum is best absorbed in the oral mucosa by parking the gum in the cheek.

Bupropion is well known in psychiatry and acts on dopamine, noradrenaline, and nicotinic-cholinergic receptors to decrease cravings and withdrawal symptoms. Varenicline is a partial agonist at the α4β2 neuronal nicotinic acetylcholine receptor; it relieves craving and withdrawal and reduces the reinforcing effects of smoked nicotine by blocking dopaminergic stimulation. The best evidence is for varenicline and combination NRT (eg, a patch plus gum or lozenge). The choice of medication depends on history, patient input, cost, previous attempts, and severity of dependence/withdrawal and breakthrough symptoms.

Cessation counseling. Cessation medications are most effective when combined with counseling. Integrating the Public Health Service guidelines of the 5 As—Ask, Advise, Assess, Assist, Arrange—into regular practice for treating smoking is an evidence-based approach. The AAR method is also effective and takes less than 5 minutes: Asking about smoking, Advising to quit, and Referring to a program.

The national toll-free quit line (1-800-QUIT-NOW) and the National Cancer Institute’s smokefree.gov website offer evidence-based resources. For patients who are not yet ready to quit smoking, empathy and a focus on the benefits of quitting (health, financial, social) are recommended to maintain rapport and raise motivation.

Best practices

In the clinical scenario presented at the start, the psychiatrist had not inquired about tobacco use for a year. It is recommended that psychiatrists assess tobacco use at every visit. Since tobacco use can affect clinical presentation (withdrawal symptoms) and medication levels, asking about tobacco use is clinically indicated. Systems changes (eg, including tobacco use in a standard assessment, providing clinician prompts) can help integrate tobacco treatment within clinical practice. Furthermore, supporting a culture of health where facilities are smoke-free fosters the best outcomes for smoking cessation. Smoke breaks should not be promoted nor should clinicians engage in smoking with patients. Treating patients with empathy and encouraging the use of NRT can be extremely helpful.

The Sidebar highlights 3 evidence-based accessible clinician resources on e-cigarettes and tobacco cessation treatment. We encourage psychiatrists and other mental health care providers to continue to follow the growing fields of research and regulation on e-cigarettes and tobacco.

Dr. Prochaska has been a consultant for Pfizer, which makes smoking cessation medications, and has been an expert witness for plaintiffs’ counsel in court cases against the tobacco companies.

Acknowledgments: Dr. Prochaska’s research is funded by the NCI (grant R01CA204356), the NHLBI (grant R01HL117736), and the TRDRP (grants 2RT0-003 and 25R-0032).

References

Frontotemporal Dementia: A Brain Disease That Challenges Definitions of Mental Illness

Barbara Schildkrout, MD
Dr. Schildkrout is Assistant Professor of Psychiatry, Part-time, Harvard Medical School, Beth Israel Deaconess Medical Center, Boston, MA. She is the author of 2 books, Unmasking Psychological Symptoms: How Therapists Can Learn to Recognize the Psychological Presentation of Medical Disorders and Masking Symptoms: Uncovering Physical Illnesses That Present as Psychological Problems.

Chad stopped seeing me after 8 months. He felt somewhat better after talking about his life in psychotherapy and taking an SSRI. But his sexual preoccupations continued, and he planned to seek help from a psychologist who specialized in “sexual addiction.” Chad’s story does not end well. He was suffering from a disease that would end his life, but it took 2 years of declining functioning before MRI evidence of his disorder became clear. Chad’s wife wrote to tell me that Chad had received a diagnosis of frontotemporal dementia (FTD). I always think of Chad when I learn of new findings about FTD. Much has been discovered about this disorder in the years since I saw him.

Introduction to frontotemporal dementia

FTD is the second most common cause of dementia (after Alzheimer disease) in the population under age 65. The age of onset is usually between ages 45 and 65 but can range from 30 years to over 80. Prevalence is estimated to be about 15 to 22 per 100,000.

Chad had the most common subtype of FTD, now called the behavioral variant (bvFTD). Patients with bvFTD frequently present with psychiatric symptoms, often years before other features of the disease emerge. These individuals may look like they have late-onset major depression, psychosis, bipolar disorder, or OCD. Mental health professionals are very likely to be consulted, either by the patient or by family members. This, in and of itself, makes it important for psychiatrists to be familiar with FTD.

FTD is a brain disorder. But, in masquerading as what psychiatrists call primary psychiatric disorders, FTD challenges us to re-examine how we think about the relationship between “mental illness” and “brain disease.” Indeed, FTD inspires us to expand our knowledge-base and our clinical acumen into realms beyond the usual boundaries of our field.

In this article I will present a summary of what psychiatrists need to know about FTD. I have included summaries of case examples from the literature to convey the wide variety of possible psychiatric presentations of bvFTD.

What is frontotemporal dementia?

In 1892, the Czech psychiatrist Arnold Pick described the first case of what would today be classified as a FTD. The term FTD actually refers to a large class of neurodegenerative disorders that vary in both clinical presentation and underlying pathology, but all of these disorders manifest with cortical degeneration in the frontal and temporal lobes.

FTD has been the subject of intensive research, including efforts to categorize various clinical and neuro-pathological subtypes. Researchers have found an association between FTD and mutations in a small number of genes (most commonly, C9orf72, MAPT, and GRN). There also are accumulations of protein aggregates (for example, tau or TDP-43) in neural tissue, and it is hypothesized that these may spread from cell to cell in a way that is similar to what occurs in prion disease. In addition, there is some evidence that functional connectivity patterns may differ in bvFTD and Alzheimer disease.

With many of the clinical subtypes of FTD, patients and their families are likely to consult with neurologists because the first symptoms are disturbances of language or movement, making it clear that the problem is probably a brain disorder. These types of FTD include primary progressive aphasias, progressive supranuclear palsy, corticobasal syndrome, and FTD with motor neuron disease. (Amyotrophic lateral sclerosis [ALS] is the most common motor neuron disease in adults.)

FTD-behavioral variant. Patients who have the most common type of FTD, the behavioral variant (bvFTD), are much more likely to come to the attention of a psychiatrist because they first present with changes in behavior and personality, impaired executive functioning, and/or symptoms that mimic late-onset primary psychiatric disorders. BvFTD often erodes qualities that are considered to be the very essence of the patient’s tempera-
ment, character, identity, and sense of values.

The most common early symptoms of bvFTD include various combinations of the following:

1. Disinhibition manifests as behaviors that are socially inappropriate, impulsive, or careless, or that exhibit poor judgment and lack of consideration of consequences. Poor manners, lack of social decorum, and an absence of any sense of embarrassment are characteristic. Patients may also be irritable, superficially jovial and euphoric, or depressive.

2. Apathy may express itself as inertia, disinterest, social withdrawal, and/or a lack of engagement, drive, or motivation.

3. Lack of empathy may manifest as self-involvement, diminished interpersonal warmth, loss of sympathy for others, and/or lack of regard for the effect of the individual’s behaviors on the feelings of others.

4. Repetitive, stereotyped, or perseverative behaviors may include simple movements or speech patterns or more complex rituals and compulsions.

5. Substantial changes in food preferences and eating habits may involve a shift to over-consumption of sweets and carbohydrates, binge eating, gluttony, and substantial weight gain. Hyperorality eventually may include mouthing of non-food objects.

6. Impairment of executive functions is common, while memory and spatial orientation are relatively preserved.

7. The lack of insight may be profound.

The diagnostic challenge of bvFTD for psychiatrists. The gradual emergence of symptoms in bvFTD can make it difficult, early on, to recognize this disorder as being something other than situational. In addition, when patients and their families believe the problem is psychiatric, this “frames” the problem and may bias the initial diagnostic impression for the clinician with whom they consult.

Patients with early bvFTD are also a diagnostic challenge because of the substantial overlap between the symptoms of FTD and the symptoms of certain primary psychiatric conditions: disinhibition and hypomania or ADHD; stereotyped/repetitive behaviors and OCD; and also apathy and depression. MDD is the most common psychiatric diagnosis given to patients who eventually receive a diagnosis of bvFTD.

A case presentation in The New England Journal of Medicine included this testimony from the wife of “A 31-Year-Old Man with Personality Changes and Progressive Neuropsychologic Decline.” This patient was remarkably young and had an unusually rapid downhill course. The wife succinctly describes characteristic behavioral changes of bvFTD in her husband and, sadly, the number of medical professionals who missed his diagnosis.

During my pregnancy, my gregarious husband became socially withdrawn. His behavior became erratic: he bought things we could not afford, began having trouble meeting deadlines and following the work dress code, and withdrew from his friends. He became obsessed with listening repeatedly to Harry Potter audio books, to the extent that when I was in labor, I had to ask him to put his iPod away.

By the time our child was 6 months old, my husband was functioning so poorly that I did not feel comfortable leaving him alone together. Accompanying him to a routine appointment, I said to his primary care physician, “My husband is acting so weird, does he have a brain tumor?” She was the first of eight medical and mental health professionals who failed to make the diagnosis.

This patient died just after his child turned 4. The cause of his bvFTD was thought to have been a spontaneous mutation in the MAPT gene, one of a small set of genes that have been associated with FTD.

Most cases of FTD are due to mutations that are sporadic (sporaneous). However, in 40% of FTD cases there is a family history of dementia, psychiatric disease, and/or motor neuron disease, and in 10% to 20% of these cases the mutations are autosomal dominant.

Behavioral variant FTD associated with mutations in C9orf72

In 2011, 2 groups of researchers independently identified the most common genetic cause for bvFTD as an expansion mutation (extra hexanucleotide repeats: GGGGCC) on chromosome 9 (C9) of the C9orf72 gene. This mutation was also found to be probably the most common genetic cause of ALS and the FTD-ALS complex.
Tardive Dyskinesia
A Review of the Literature

read the supplement at psychiatrichomes.com/dyskinesia

Published as a supplement to
Psychiatric Times

NEUROPSYCHIATRY | Frontotemporal Dementia
Continued from page 27

Case examples of patients with C9orf72 mutations
As part of their longitudinal studies on aging and neurodegenerative disease, the University of California, San Francisco Memory and Aging Center found that some of their patients had expansion mutations in C9orf72. This gave them an opportunity to prospectively follow individuals who carried this mutation and to “characterize psychiatric symptomatology during the earliest phases of the illness.” In 2015, they published a paper that included 3 of these patients, summarized below.

FTD developed in each of these 3 patients; however, given that these are single case examples, one cannot assume a simple causal relationship between the C9orf72 gene mutation and the patient’s psychiatric symptoms. These case examples demonstrate how the diagnosis of neuropsychiatric disorders is a dynamic process that unfolds over time and that it is important to include FTD in the differential when encountering these kinds of presentations.

Late-onset psychosis and a C9orf72 mutation. Mr. M first began to have delusions and auditory hallucinations at age 58. He heard “voices from other continents that spoke to him through his hearing aid and eyeglasses.” He would cover mirrors to keep from being observed and hide in the closet to elude the Mafia. He also began to think that he was a “sex god,” and he went into his neighbors’ homes with the idea that they were interested in having sex with him. These delusions and hallucinations lessened over 2 years, giving way to apathy and a voracious appetite; often he would eat whatever was in front of him, food as well as non-food objects.

Late-onset bipolar disorder and a C9orf72 mutation. Ms. G had a first manic episode at age 53. Her symptoms included rapid thought, grandiose notions such as intentions to start a new religion, poor sleep, and then over-familiarity with strangers. She was hospitalized and responded to treatment with lithium. Diagnosed with bipolar disorder, she was stable on valproic acid until age 63. At this point her husband felt that her cognition was below her baseline, and she was seen at the Memory and Aging Center. There, she was found to have very mild executive dysfunction and verbal memory impairment; she received a diagnosis of mild cognitive impairment. Two years later, her affect had become strange and she became disinhibited. By age 68 she had ALS and was wheelchair-bound.

Late-onset OCD and a C9orf72 mutation. At age 60, Ms. A began to display rigid, obsessive-compulsive behaviors, including checking email compulsively and obsessively organizing household items. A community physician diagnosed OCD. Then, over the next 2 years, she became increasingly apathetic and withdrawn. Her judgment deteriorated, her empathy diminished, and she became disinhibited. Some of her behaviors included personal postings on an Internet sex site, losing money in an on-line scam, and making inappropriate remarks in public.

Pointers for psychiatrists in evaluating patients who might have bvFTD
With current information about bvFTD, how might one approach the psychiatric evaluation of a patient like Chad? The Table provides some important points to help the psychiatrist when evaluating patients with suspected bvFTD.

Conclusion
Early identification of bvFTD allows patients to have time to put their affairs in order and to participate in planning for their own future care. In addition, an accurate diagnosis is extremely helpful to family members who often are befuddled by the changes in their loved ones’ behaviors and who also may be facing extremely difficult social, financial, and/or legal predicaments.

Among mental health professionals, psychiatrists are the most intensively trained in the diagnosis of discrete, well-described medical/neurological conditions that might be masquerading as primary psychiatric disorders. When it comes to bvFTD, psychiatrists have an especially important role in the early identification of patients who may have this disorder.

References
Anti-NMDA Receptor Encephalitis: Diagnostic Issues for Psychiatrists

James S. Brown Jr, MD, MPH, MS
Assistant Clinical (Adjunct) Professor of Psychiatry, VCU [Virginia Commonwealth University] School of Medicine, Department of Psychiatry, Richmond, VA

The condition known as anti-N-methyl-D-aspartate receptor (NMDAR) encephalitis was first reported in 2005 but not identified as a diagnostic entity until 2007.1 At that time, 12 female patients were identified; they ranged in age from 14 to 44 years. All presented with various psychiatric and neurological symptoms, including personality and behavioral changes, paranoia, agitation, confusion, catatonia, autonomic instability, dyskinetic movements, seizures, hypoventilation requiring mechanical ventilation, hyperthermia (less often hypothermia), and coma.

All 12 patients had serum/cerebrospinal fluid (CSF) antibodies to the NR1 subunit of the NMDAR. Moreover, 11 had ovarian teratomas, of which 5 were examined and found to have nervous tissue expressing NR2 subunits that reacted with patient antibodies. The teratoma was removed in 8 patients, followed by immunotherapy that resulted in improvement of symptoms or full recovery. Two of three patients who did not have the tumor resected died.

Anti-NMDAR encephalitis is recognized as an autoimmune disorder in which IgG autoantibodies are directed against the NR1 subunit of the NMDAR. Binding of the antibodies to NMDARs induces internalization of the receptors in synapses, which is a mechanism that agrees with the glutamate hypothesis of schizophrenia in which NMDAR antagonists cause psychiatric symptoms. The condition can present as a paraneoplastic syndrome that is often but not always associated with ovarian teratoma. However, in many patients no tumor can be found. A general definition of “paraneoplastic syndrome” is one that is caused by cancer but not by direct invasion so that most are the result of hormones, cytokines, and immune responses from or as a result of the tumor.2

Hundreds of cases of anti-NMDAR encephalitis have been reported, and many patients—possibly up to 40%—are initially hospitalized on psychiatric units.3 Some patients may present with psychiatric symptoms without neurological involvement, and there may not be any differences in demographics, psychiatric symptoms, or outcomes compared with patients who have neurological symptoms. In Dalmau’s original case series, 77% of cases were initially seen by psychiatrists and 23% by neurologists.4 Because of the significant morbidity and mortality associated with NMDAR encephalitis, it is essential that psychiatrists in all settings but especially in inpatient, emergency, and consultation-liaison roles be acquainted with the presentation and diagnosis of the condition.

Recognizing anti-NMDAR encephalitis
Most cases of anti-NMDAR encephalitis occur in young women, although ages range from 2 months to 85 years. Prodromal symptoms are common (more than 75% of patients) and usually appear as a viral syndrome with headache, fever, and respiratory and gastrointestinal symptoms. The initial psychiatric symptoms may include prominent visual and auditory hallucinations through the joint providership of CME Outfitters, LLC, and Psychiatric Times. CME Outfitters, LLC, is accredited by the ACCME to provide continuing medical education for physicians.

CME Outfitters designates this enduring material for a maximum of 1.5 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Note to Nurse Practitioners and Physician Assistants: ANCCP and AANPA accept certificates of participation for educational activities certified for AMA PRA Category 1 Credit™.

DISCLOSURE DECLARATION
It is the policy of CME Outfitters, LLC, to ensure independence, balance, objectivity, and scientific rigor and integrity in all of their CME/CE activities. Faculty must disclose to the participants any relationships with commercial companies whose products or devices may be mentioned in faculty presentations, or with the commercial supporter of this CME/CE activity. CME Outfitters, LLC, has evaluated, identified, and attempted to resolve any potential conflicts of interest through rigorous content validation procedure, use of evidence-based data/research, and a multidisciplinary peer-review process.

Questions about this activity? Call us at 877.CME.PROS (877.263.7767)
Anti-NMDA Receptor Encephalitis: Diagnostic Issues for Psychiatrists

Continued from page 29

tions, paranoia, delusions, agitation, memory loss, depression, and eating disorders (Table 1).

The condition usually progresses to include serious neurological symptoms such as seizures, abnormal movements, autonomic instability, and hypoventilation. Seizures may include any type but especially generalized tonic-clonic or partial complex. Dyskinesias may be of any type but include orofacial, complex extremity, abdominal and pelvic movements, abnormal postures, and rigidity. A frequent pattern seen in case reports is admission to a psychiatric unit followed by transfer to an ICU after the onset of serious neurological symptoms. At this point, treatment usually requires a multidisciplinary approach.

Similar symptoms may be observed in children, although the youngest may have less apparent psychiatric symptoms and more prominent abnormalities of sleep, speech, and/or gait that progress to motor abnormalities, dyskinesias, and seizures. Tumors are found less often in pediatric cases. In older patients (older than 45 years), behavioral changes, seizures, and cognitive problems are frequent; males represent a greater proportion of cases than in younger groups; and fewer have an identifiable tumor compared with younger patients. Tumors, especially in older patients, can include not only ovarian tumors but also carcinomas and tumors of the breast, lung, and thymus as well as melanocytic nevi. In male cases, fewer tumors are found but have included schwannoma and mediastinal and testicular teratomas.

Misdiagnosis

Psychiatric misdiagnosis can occur before the onset of neurological symptoms. Early diagnoses have included schizophrenia, schizoaffective disorder, bipolar disorder, depression, conversion disorder, and anorexia nervosa (Table 2). However, most cases of schizophrenia, new-onset psychosis, and depression do not involve anti-NMDAR antibodies. Although most patients with anti-NMDAR encephalitis have no prior psychiatric histories, some do—including schizophrenia and autism, or positive family histories of mental illness. In cases of anti-NMDAR encephalitis in adults with preexisting autism or intellectual disability, initial presentations may be mistaken for new-onset primary psychosis or medication effects.

One case report describes a young woman with a 7-year history of schizophrenia who received a diagnosis of anti-NMDAR encephalitis, although the relationship of her prior schizophrenia to the newly diagnosed encephalitis could not be discerned. In another case report, a young woman with a 14-year history of neuropsychiatric symptoms presented as an outpatient with symptoms of word-finding difficulties, later diagnosed as anti-NMDAR encephalitis.

Anti-NMDAR encephalitis can occur during pregnancy and can resemble postpartum depression and neuroleptic malignant syndrome (NMS). Many symptoms of NMS (rigidity, hyperthermia, elevated serum creatine kinase, rhabdomyolysis) may also occur in anti-NMDAR encephalitis. Testing for anti-NMDAR antibodies should therefore be considered in any patient with acute-onset psychiatric symptoms who has neurological or autonomic abnormalities, including rigidity and altered consciousness. (See Sansing and colleagues’ for an in-depth discussion of differential diagnoses for anti-NMDAR encephalitis, NMS, and serotonin syndromes.)

Presenting symptoms

Psychiatrically and neuropsychiatrically, the differential diagnosis is quite broad (Table 2 and Table 3). A key factor for recognizing this disorder is that it often follows a pattern of syndrome development. In about 70% of cases, prodromal symptoms develop, including headache, fever, and gastrointestinal and upper respiratory tract symptoms. Usually within 2 weeks, psychiatric symptoms emerge, which often leads to psychiatric assessment. These symptoms may include anxiety, insomnia, delusions, mania and paranoia, possibly social withdrawal, and stereotypical behaviors. Short-term memory loss occurs as does disrupted language.

The condition progresses to decreased responsiveness with agitation, catatonia, abnormal movements, and autonomic instability and “storms,” as well as hypoventilation that may require ventilation. Seizures including status epilepticus can occur at any stage, can overlap with abnormal movements, and can decrease over the course of the illness.

The diagnosis is often made on the presence of neurological impairment, including abnormal movements, speech problems, rigidity, and altered consciousness as indications of something other than primary psychiatric disorders, although these are not universal. Drug screening and medication history may help rule out intoxication. Encephalitis from other causes including infections and autoimmune responses can be assessed with basic laboratory screenings, metabolic testing, immunological testing, MRI findings, and response to treatments such as thiamine and corticosteroids. Once anti-NMDAR encephalitis is diagnosed, care of the patient usually involves psychiatric consultation on ICU, surgery, medical, and/or neurological units.

Very small and even microscopic tumors can cause anti-NMDAR encephalitis, and the condition can occur as a complication of herpes simplex encephalitis. Initial laboratory studies can be normal, electroencephalograms (EEGs) can show non-specific slowing, and CSF analysis may show only lymphocytic pleocytosis. Confirmation of the diagnosis is based on positivity of the serum or, more importantly, the CSF for antibodies to the GluN1 NMDA receptor subunit. Serum testing alone may result in false positive or negative results.

Treatment

Following tumor resection, if a tumor is found, treatment often begins with first-line immunotherapy (corticosteroids, plasma exchange, intravenous im-

<table>
<thead>
<tr>
<th>Table 1 – Symptoms reported in NMDAR encephalitis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychiatric</strong></td>
</tr>
<tr>
<td>Hallucinations</td>
</tr>
<tr>
<td>Delusions</td>
</tr>
<tr>
<td>Agitation</td>
</tr>
<tr>
<td>Confusion</td>
</tr>
<tr>
<td>Labile mood, mania</td>
</tr>
<tr>
<td>Insomnia</td>
</tr>
<tr>
<td>Depression</td>
</tr>
<tr>
<td>Eating disorders</td>
</tr>
<tr>
<td>Panic attacks</td>
</tr>
<tr>
<td>Irritability</td>
</tr>
<tr>
<td>Cognitive decline</td>
</tr>
<tr>
<td>Sexual disinhibition</td>
</tr>
<tr>
<td>Aggression</td>
</tr>
<tr>
<td>Suicidal ideation</td>
</tr>
</tbody>
</table>

NMDAR, N-methyl-D-aspartate receptor.
munoglobulin). Second-line immunotherapy (rituximab, cyclophosphamide) may become necessary and increases the likelihood of better outcome.

Psychiatric management includes psychotropic medications, although the response can be poor especially before a precise diagnosis is made. Irritability toward caregivers and family is often reported, and suicidal ideation with severe agitation and aggression can occur. ECT has been used successfully in some cases of catatonia but is not well studied and not always successful. Some treatment recommendations include atypical antipsychotics for behavioral symptoms, valproic acid for mood dysregulation, and benzodiazepines for catatonia. Medically induced coma has sometimes been required in the most psychologically severe cases.

Recovery depends on many factors, but Dalmau’s original case series remains a general guide: 75% of patients recovered, although some still had mild residual deficits, and 25% had poor outcomes with severe residual deficits or died. Because anti-NMDAR encephalitis is potentially curable, early diagnosis and treatment including tumor removal and immunotherapy are key to best outcomes. Antipsychotic medications can help control psychotic symptoms; however, be aware that, especially before diagnosis, rigidity and autonomic instability from anti-NMDAR encephalitis can be mistaken for NMS, and antipsychotic medications can cause NMS in these patients.

Improvement of psychiatric and neurological symptoms during treatment can be observed within days—in some cases hours—after tumor resection, but full recovery may be a slow process, perhaps taking several months, with possible relapses. Most neurological symptoms may improve, but executive functions and severe psychiatric symptoms, including suicidality and aggression, can persist for many months, possibly requiring inpatient psychiatric treatment. Lengthy outpatient psychiatric treatment with antipsychotic medication may be necessary. Recurrences caused by recurring tumors have also been reported.

Much remains to be learned about the various presentations of anti-NMDAR encephalitis. A case report, for example, described an adolescent who presented to an outpatient service and received a diagnosis of atypical anorexia nervosa without secondary amenorrhea. She was treated as an outpatient until 3 weeks later when she was admitted with a seizure. On day 23 of hospitalization, hallucinations developed that did not respond to antipsychotic medications. They were initially diagnosed as dissociative because the neurological workup was mostly non-specific. The diagnosis of anti-NMDAR encephalitis was confirmed 36 days after admission.

No tumor was found, but near-baseline functioning was achieved with immunotherapy after 10 months. The case is atypical because most patients with anti-NMDAR encephalitis do not have an identifiable eating disorder.

**Conclusion**

Future research on anti-NMDAR encephalitis will contribute to our knowledge of psychosis, autoimmunity, and glutamatergic function; although the extent to which the condition applies to specific conditions such as schizophrenia remains unknown. However, the recognition of anti-NMDAR encephalitis has already led to further research that contributed to the discovery of other autoimmune synaptic encephalitides. And, the elucidation of anti-NMDAR encephalitis has led to new approaches to the diagnosis of catatonia, movement abnormalities, memory problems, seizures, and limbic encephalitis.

**Table 3 – Neurological differential diagnosis**

- Viral encephalitis
- Other infectious encephalitis
- Cerebral vasculitis
- Autoimmune encephalitis
- Encephalitis lethargica
- Tardive dyskinesia
- Seizures
- Neuroleptic malignant syndrome
- Serotonin syndrome
- Metabolic encephalopathy
- Wernicke encephalopathy
- Hashimoto encephalopathy
- Intoxication (drugs, medications)

and she has been having problems in school because of unusual memory loss. At home, she seems lethargic during the day but is unable to sleep at night. Her family reports that Jenny has become irritable, which is out of character for her. They brought her to the ED after she was found wandering confused in the yard.

An uncle has bipolar disorder, and the family is concerned she may have the same condition. She has a temperature of 106°F, but baseline blood work and physical and neurological examination results are normal. A brain CT scan is unremarkable. Psychiatric assessment finds symptoms consistent with mild depression, but she is alert and oriented. There are no findings that support admission. Antibiotics are prescribed, and the patient is discharged.

A few days later she returns to the ED after becoming agitated and paranoid and experiencing auditory hallucinations. She is admitted to the psychiatric unit, where she exhibits bizarre behavior including giggling, echolalia, and posturing. She has frequent cycling leg movements and believes that staff members are plotting against her and that her food is poisoned. She is hyperkinetic, screaming, hallucinating, and sexually disinhibited. Antipsychotic medications do not seem effective, and prominent orofacial dyskinetic movements develop.

She experiences altered mental status followed by a generalized tonic-clonic seizure, although she has no history of seizures. An EEG shows nonspecific slowing, and a leukoencephalopathy is noted in the CSF. She does not return to her previous level of consciousness, autonomic instability develops, and she is transferred to the ICU.

In the ICU she requires sedation and mechanical ventilation. Subsequent EEGs reveal only nonspecific slowing, and a brain MRI scan shows nonspecific small hyperintensities. During an extensive work-up, anti-NMDA receptor antibodies are found in her CSF. CT scanning of the chest, abdomen, and pelvis reveals a small right ovarian mass. The tumor is surgically resected and diagnosed as a teratoma.

Three days after the operation, she starts to improve significantly and is extubated. She receives first-line immunotherapy before discharge to a rehabilitation unit. Several months later, her neurological and psychiatric examinations are normal and she returns to academic study.

**References**

Our work matters

Los Angeles County has immediate openings with Antelope Valley, Correctional Health Services, Juvenile Hall and Probation Camps, and directly operated programs. This is your chance to join a nationally recognized mental health agency and work in a professionally rewarding, diverse, and exciting environment. The County is filled with opportunities for professional development and growth, including new full-time and part-time psychiatrist positions.

- Competitive starting salaries and benefits
- Potential bonuses up to $30,000 a year
- Up to 24 hours /wk for outside employment

“I picked DMH because it gave me the opportunity to work with a wide variety of patient populations and overall makes my career very fulfilling. It's a great place to continue to learn, with a very nurturing environment. Come join us!”

Carlos Contreras, M.D.
Mental Health Psychiatrist

Better Work-Life Balance.
Better Salary.

Psychiatrists now have 12,000+ more reasons (hint: it's dollars) to join the California Correctional Health Care Services team. We've increased salaries for Psychiatrists by 5% department-wide in 2017 with additional increases scheduled for 2018 and 2019!

Plus, working within a California Department of Corrections and Rehabilitation facility, you'll experience the positive work-life balance you crave — whether it's the flexibility of 4/10 shifts or a 40-hour workweek. And with the clinical assistance of our Positive Behavioral Support Team, you'll finally find the career you deserve.

Board Certified Psychiatrists: $256,488 - $308,184
Board Eligible Psychiatrists: $249,900 - $299,496

Take the first step toward better work-life balance and a better salary, contact LaTeesa Phillips at (916) 691-4818 or LaTeesa.Phillips@cdcr.ca.gov. You may also apply online at www.ChangingPrisonHealthCare.org.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY
WWW.AACAP.ORG

AACAP's 64th Annual Meeting
October 23-28, 2017 ● Washington, DC
Washington Marriott Wardman Park and the Omni Shoreham Hotel

Join us in Washington, DC for AACAP's 64th Annual Meeting! With important ongoing changes in the field such as integrated care, wellness, excessive use of electronics, gun violence, the effects of '13 Reasons Why,' new challenges with children of illegal immigrants and LGBT communities, and updated research in complementary medicine and psychopharmacology, mental healthcare professionals can’t afford to miss this Annual Meeting!

For more information and to register visit: www.aacap.org/AnnualMeeting2017

2018 Psychopharmacology Update Institute
Cutting-Edge Psychopharmacology: Fad vs. Fact?
January 26-27, 2018 ● Brooklyn, NY
New York Marriott at the Brooklyn Bridge

Laurence L. Greenhill, MD, and Jeremy Veenstra-VandeWeele, MD, Co-Chairs

This Institute links newly published findings on the treatment of aggression and violence, substance use disorders, disruptive mood dysregulation disorder, bipolar disorder, tics and obsessive-compulsive disorder, autism, attention-deficit/ hyperactivity disorder, pharmacogenomics, and anxiety disorders, with practical implementations in treating youth with these disorders and determining whether treatments are fad vs. fact.

Visit www.aacap.org/psychopharm-2018 for more information! Registration will open in early September.

For information about all of AACAP's meetings and to register, visit www.aacap.org, email meetings@aacap.org, or call 202.966.7300, ext. 2006.
Central New York Psychiatric Center (CNYPC) recognizes that our employees are our greatest resource. We are seeking motivated psychiatrists to help promote hope, resilience, and recovery within a culture of safety that employs a team approach. CNYPC is a dynamic organization that provides comprehensive forensic mental health services through a continuum of care at its inpatient setting, located in Central New York, and in the Correctional System throughout New York State. CNYPC is fully accredited by The Joint Commission.

Benefits:
- Psychiatrist Loan Repayment Program offering up to $150,000 over 5 years.
- Competitive salaries.
- Flexible work schedules. Private practice permitted.
- Tele-psychiatry positions available.
- Optional paid on-call duty at the hospital.
- Opportunities for academic affiliation with SUNY Upstate, Division of Forensic Psychiatry.
- Generous benefits and retirement package.
- Relocation assistance.
- Robust continuing medical education opportunities
- Positions in proximity to: Utica, Albany, NYC, Buffalo, Rochester, Elmira, Glens Falls, and Syracuse.

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

---

EMERGENCY PSYCHIATRIST - Greenville, SC

Greenville Health System (GHS) seeks an Emergency Psychiatrist as faculty in the Department of Emergency Medicine, Division of Emergency Psychiatry. Successful candidates should be prepared to shape the future of Emergency Psychiatry at GHS and contribute to the academic output of the department.

GHS is the largest healthcare provider in South Carolina and serves as the tertiary referral center for the entire Upstate region. As an integral system component, the Department of Emergency Medicine provides care in 6 Emergency Departments and 5 urgent care centers.

Our program offers:
- Division leadership that is dual trained in Emergency Medicine and Psychiatry
- Dedicated Psychiatric Area within the ED
- Team of psychiatric social workers and advanced practice providers with mental health training
- Inpatient child and adult psychiatric units located on campus
- Five Community Hospital Emergency Departments
- Level 1 Trauma Center
- Dedicated Pediatric Emergency Department within the Children’s Hospital
- Accredited 3-year Emergency Medicine Residency Program and 4-year Psychiatry Residency

Faculty within the newly developed Emergency Psychiatry Division within the Department of Emergency Medicine enjoy a flexible work schedule, highly competitive salary, generous benefits, and additional incentives based on clinical, operational, and academic productivity.

Greenville, South Carolina is a beautiful place to live and work. It is one of the fastest growing areas in the country, and is ideally situated near beautiful mountains, beaches and lakes. We enjoy a diverse and thriving economy, excellent quality of life, and wonderful cultural and educational opportunities.

“Public Service Loan Forgiveness (PSLF) Program Qualified Employer”

Qualified candidates should submit a letter of interest and CV to Senior In-house Physician Recruiter, Kendra Hall, at khal@ghs.org.
Ph: 800-772-6987.
GHS does not offer sponsorship at this time.
EOE

---

HELP BUILD A GATEWAY FOR BETTER HEALTH

When you join Northwest Permanente, P.C., you’ll have the chance to practice in an environment that offers ample opportunity to pursue – and achieve – your personal and professional dreams. You’ll benefit from a comprehensive network of support services and a talented team of colleagues who share your passion for medicine and patient care. We invite you to consider these opportunities with our physician-managed, multi-specialty group of over 1,500 physicians and clinicians who care for over 570,000 members throughout Oregon and Southwest Washington.

BC/BE PSYCHIATRISTS - Pacific Northwest

We are seeking BC/BE Adult Psychiatrists to staff our facilities throughout the Portland metro area and Salem, Oregon as well as in Longview-Kelso and Vancouver, Washington. The positions include direct clinical work with outpatients, consultations occurring in our ERs and require compatibility with physicians in the primary care setting. Candidates should have experience in medication consultation, crisis intervention, evidence-based psychiatric treatments and psychiatric consultations.

We offer excellent benefits:
- $25,000 sign-on bonus*
- $125,000 loan assistance program for medical education*
- Professional liability coverage
- Generous pension program
- Sabbatical leave, education leave and more
- Competitive salary and benefit package

* inquire for details

To apply, please visit our Web site at: http://nwp.kpphysiciancareers.com.
For more information, call Laura at (503) 813-3862 or email Laura.A.Russell@kp.org.

EEO/AA employer M/F/D/V.

nwp.kpphysiciancareers.com
Outpatient Adult Psychiatrists

Minnesota

Share your expertise in an environment that supports new treatments and innovation while embracing a strong work-life balance.

HealthPartners is a dynamic multi-specialty medical group practice headquartered in the Twin Cities of Minneapolis/St. Paul, Minnesota. Our Behavioral Health group has a large outpatient practice with 21 adult psychiatrists, 4 child psychiatrists, 7 clinical nurse specialists and 60 therapists. Each has special interests and expertise, but also practice as generalists to provide outstanding clinical care to our diverse patient population via integrated outpatient services with our primary care and specialty clinics.

We have exciting practice opportunities for outpatient adult psychiatrists, and provide:

- 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 call requirements (by pager/phone) covering outpatient practice
- 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
- An organizational commitment to a sustainable medical practice with EHR, documentation efficiency work group, extensive billing and coding support, integrated services and telemedicine

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,” which exists to inspire constant improvement and lasting success. We achieve this by partnering with patients and families in everything from care decisions to service and facility design. As we work together as a unified team, we engage patients, families and the community, and put them at the center of everything we do.

To learn more and apply, visit us online at healthpartners.com/careers, or email your CV and cover letter to lori.m.faker@healthpartners.com.

COME HOME TO SOUTHERN CENTRAL CALIFORNIA

Adult, Child and Addiction Medicine Psychiatrists - Kern County, CA

Competitive Salary and Excellent Benefits plus GENEROUS BONUS

In addition to a picturesque location in Southern Central California’s recreational heartland, Kaiser SCPMG is proud to offer its physicians:

- An organization that has served the communities of Southern California for more than 60 years
- Stability during times of change in health care nationwide
- A physician-led practice that equally emphasizes professional autonomy and cross-specialty collaboration
- An environment that promotes excellent service to patients
- Comprehensive administrative support
- A fully implemented electronic medical record system
- Partnership eligibility after 3 years

MEDICAL EDUCATION LOAN REPAYMENT PROGRAM

The Program offers up to $170,000.

For consideration or to apply, please visit our website at http://scpmpgphysiciancareers.com. For questions or additional information, please contact Kathy Uchida at 877-959-4745 or email Kathy.C.Uchida@kp.org.

You’ll love coming home to Southern Central California

http://scpmpgphysiciancareers.com

We are an AAP/EEO employer
NATIONWIDE

THE 1ST CHOICE IN PSYCHIATRIC RECRUITMENT
Visit our website www.fcspsy.com
Over 400 permanent searches nationwide.
800-783-9152

ALASKA

Alaska Psychiatric Institute (API), Anchorage, AK

API Seeks: Psychiatrist
The Facility: 80 bed, acute care, psychiatric hospital
Specialty/Focus: Inpatient, Adult
Compensation: $250k starting salary for 37.5 Full-Time equivalent hours.
Paid On Call: No Alaska income tax, No Anchorage sales tax
10 days CME time/year
4 weeks’ vacation + 11 paid holidays/year
Medical, Dental, Visual plans
Permanent Fund Dividend
Geography: Anchorage pop ~350,000.
Alaskan pop ~ 700,000 residents
Lifestyle/Culture: World-class hunting & fishing, Running, Biking, Skiing, Skijoring, Dog Mushing, Birding, Rafting, Adventure trekking, Museum, opera, fine dining, arts community, and a vibrant craft brewing industry.

Call Rose (907) 269-7150 Medical Staff Coordinator; to be connected with the Director of Psychiatry.

Outpatient Adult and Child Psychiatrists are needed for Stanislaus County Behavioral Health & Recovery Services, in the Central Valley less than two hours from San Francisco and Yosemite.

Recovery-oriented treatment provided in a multidisciplinary setting with friendly and dedicated staff members. Recently revised rates with full malpractice coverage and pension plan (PARS) as a Personal Service contractor with an income potential of over $325 K per year for adult psychiatrist and over $355 K per year for child psychiatrist 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.

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

STERLING CARE PSYCHIATRIC GROUP, INC is a physician-owned practice group located in Ventura County California. We are currently hiring psychiatrists to work in innovative programs throughout Ventura County Behavioral Health in Adult Services, Youth and Family Services and Quality Assurance. The ideal candidates are creative, energetic and comfortable working as part of a multidisciplinary team. Annual salary range is from $260,000 for board eligible to $353,600 for double boarded, bilingual child and adolescent psychiatrists. Generous benefits package includes performance bonus, health insurance, 401K with match, and up to 30 days of paid annual leave.

Please contact Celia Woods, M.D., 1911 Williams Drive, Oxnard, CA 93036. email celia.woods@ventura.org, phone (805) 485-5051, fax (805) 278-7945.

BC/BE CHILD PSYCHIATRIST NEEDED
In Beautiful Santa Cruz, CA

Welcome to the #1 place in California to live and the 3rd best place to live in the country! I am looking for a BC/BE child psychiatrist for a private practice located in Santa Cruz, CA, just about 1 hour south of San Francisco. The position is strictly outpatient without call. All administrative duties such as: scheduling, billing and coding are included. The position is $125 per hour. Your income is based on how many hours you choose to work. The practice is currently turning patients away and is booked through the end of 2017. The office is available Monday through Thursday after 5 pm and all day Friday through Sunday. Valid CA Medical License (in good standing) REQUIRED.

Please fax/email your curriculum vitae to 831-477-9908/office@drsdass.com. Full Time can be discussed.

www.psychiatrictimes.com

August 2017

QUALITY OF PRACTICE. QUALITY OF LIFE.

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

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

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

For inquires, contact Robert A. Friedman, M.D. at: (858) 279-1223, ext. 412; or Email: rfriedman@psycare.org.
Unique Opportunity in San Francisco

Growing outpatient practice focused on cutting-edge treatments such as IV ketamine in a warm, collegial environment. No experience with ketamine necessary - full training and ongoing education provided.

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:
Marcy Sesma Lopez (442) 265-1605
marcysesma@co.imperial.ca.us

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

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

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, Beverly 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@pcpasf.com
or visit us at www.pcpasf.com

Private Practice
Looking for the Freedom and Flexibility

Earn over $350K/Year

Choose your own hours
Clinical Freedom
Malpractice paid
H1 Visa Welcome

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

Comprehensive Psychiatric Services
Mansoor Zuberi, M.D.
(P) 925-944-9711  (F) 925-944-9709
dr.zuberi@gmail.com
www.psych-doctor.com

Multidisciplinary medical group looking for additional California licensed telepsychiatrists. Contact us at 661-840-9270 or inquire with CV at jobs@telehealthdocs.com.

Psychiatrist Position
J-1 Visa Opportunity in California

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

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

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

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

J-1 applicants welcome.

For additional information, please contact:
Marcy Sesma Lopez (442) 265-1605
marcysesma@co.imperial.ca.us

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

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

At the Southern California Permanente Medical Group (SCPMMG), we believe in giving every member of our community the opportunity to live a happy, healthy life. From the physicians we employ to the patients we serve, our mission is to provide a level of care and support that enables each of us to achieve our best.

BC/BE ADULT PSYCHIATRY OPPORTUNITIES
Openings in Fontana, California

Our SCPMMG Fontana location offers spectacular natural scenery and an exceptional climate. Ideally situated near Big Bear and Lake Arrowhead, you’re just a short trip away from amazing recreational activities such as hiking, skiing and watersports. We also provide an excellent salary/benefits package and stability in today’s rapidly changing health care environment.

Our physicians enjoy:
• 4 1/2 day work week (8-10 hours/day)
• Options for flexible schedules
• Education time (1/2 day)
• Academic teaching opportunity available through our Adult Residency Program
• Telepsychiatry - Fontana Medical Center
• Bonuses offered
• Research opportunities
• Team model - MA, LCSW, Psychologists
• Child and Adolescent Fellowship opens in the summer of 2017
• In clinic consult model available in the Chino/Grand facility (embedded in Primary Care)

If you believe in pursuing dreams, creating hope and driving progress, then you’re the very definition of a Permanente Physician.

For consideration, forward your CV to:
Kathy Uchida
Phone: 626-405-2653
Email: Kathy.C.Uchida@kp.org
http://scpmmgphysiciancareers.com

Kaiser Permanente
Southern California Permanente Medical Group

Qualify For A Free Subscription Online @ www.psychiatrictimes.com
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, to up to $500,000, for the industrious physician. Our generous benefit package includes almost 7 weeks paid time off per year. If you are creative and think outside the box, if you value diversity and cultural competency, if you like innovative programs that are patient driven, using a rehabilitative, rather than illness model, if you want more time to work with patients, to get the best results, then TBH is the company for you. To learn more about the specific job openings and salary and benefit packages, check out our website at: www.tbhcare.com or Email your letter of interest and CV to our company President, Gary A. Hayes, Ph.D. at: Dhayes3@tbhcare.com TBH is an equal opportunity employer.

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

- **San Bernardino, CA:**
  - Schedule: 16hrs per week.
  - Pay Rate: $172 per hour.
  - Benefits Eligible

- **Oakland, CA:**
  - Schedule: 24hrs per week.
  - Pay Rate: $156 per hour.
  - Benefits Eligible

- **Riverside, CA:**
  - Schedule: 24hrs per week.
  - Pay Rate: $156 per hour.
  - Benefits Eligible

- **Riverside, CA:**
  - Schedule: 9hrs per week.
  - Pay Rate: $200 per hour (IC Rate)

- **Ridgecrest/Bakersfield, CA:**
  - Schedule: 24hrs per week.
  - Pay Rate: $172 per hour. Benefits eligible

- **Oakland, CA:**
  - Schedule: 16hrs per week.
  - Pay Rate: $156 per hour.
  - Benefits Eligible

- **Oakland, CA:**
  - Schedule: 24hrs per week.
  - Pay Rate: $156 per hour.
  - Benefits Eligible

- **Modesto, CA:**
  - Schedule: 24hrs per week.
  - Pay Rate: $172 per hour. Benefits Eligible.

- **For additional listings, please visit:**
  - www.telecarecorp.com/physician-jobs/
  - You will work as part of a multidisciplinary team. The staff is all very friendly and it is a supportive working environment.

Please email your resume to tlcrecruiting@telecarecorp.com

**Payscale:**

- $246,900 - $323,000 annually

- 7 weeks of annual leave

- Full benefits & retirement

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

As the largest public health care system in northern California, we offer comprehensive healthcare resources to a large and diverse patient population. Psychiatrists are part of a robust team of staff that work in collaboration with other medical specialties to provide integrated health care to patients. Psychiatrists are eligible for numerous benefits including 7 weeks of annual leave, 1 week of educational leave, 12 holidays, $4500 educational funds, health benefits, life insurance and CalPERS retirement plan.

If you are interested in working in a dynamic and collegial work environment, please submit a CV and letter of interest directly to:

- **Dr. Tiffany Ho,**
  - Behavioral Health Medical Director:
  - tiffany.ho@hs.scgov.org
  - (408) 885-5767

The County of Santa Clara is an Equal Opportunity Employer

Office spaces available for Adult or Child Psychiatrist, Psychologist, F/T/PT. Solo practitioner set up, Fee/ Rent all inclusive (admin. support, billing, patient resources).

No cap on income. We are located in San Diego. Contact: Office: (619) 258-6730 or kchristiansen.horizon@gmail.com. Paul Liederer MD @ (619) 871-9250

Our competitive rates can help you promote physician products and services like these:

- Medical transcription
- Practice management
- Medical billing
- Equipment and supplies
- Legal services

For details call (203) 523-7026

Receive $200 PER HOUR average. Seeking board-eligible psychiatrist for part-time outpatient private practice in Apple Valley, CA (45 minute drive from Redlands/San Bernardino area). Please contact Janet Rhodes at Fax: 760-946-1215.

Aligned Telehealth, Inc. is a National Behavioral Health Hospitalist and Telemedicine Company.

Aligned is working in conjunction with a world class organization known for its clinical excellence in the Sacramento area.

We need a Full-time on site Psychiatric NP or PA for a 30 bed Psych unit.

**RELOCATION ASSISTANCE AVAILABLE.**

**Scope of job:**

You will round about 8 patients a day and will need to cover the whole census one weekend a month

**Compensation for position is $150,000.00, plus Bonus and excellent benefits for a mid-level NP/PA with experience in Psych care.**

Relocation assistance available.

- *Hours of work: Full-Time/weekdays.
  - M-F 8am-5pm
  - *Required Certification:*
  - *Must be Nurse Practitioner or Physician Assistant*
  - *CA NP/PA Medical License*
  - *DEA*
  - *Two years Psychiatric experience in the past four years is a must*

Please call Sandra at 818-584-1785 and email your current cv to squirlliams@alignedth.com to be considered immediately

**COLORADO**

SPECIALTY PRAC TICE OPPORTUNITY

Specialty private practice in adult ADHD in highly desirable area of Denver, Colorado, seeking practitioner to buy in and ultimately acquire practice. Patients pay cash at time of service. Practice is full with waiting list. Part-time nurse practitioner is also full. Contact DodsonADHD@gmail.com

**CONNECTICUT**

GERIATRIC PSYCHIATRY MEDICAL DIRECTOR – Seeking Geriatric Psychiatrist for a brand new 15-bed Geriatric Psychiatry Unit to open in Bristol Hospital, Bristol, CT, in early January 2018. Offering competitive salary/relocation/bonus/comprehensive array of benefits. Ideal location in central CT: only 19 miles from Hartford; 30 miles from New Haven; and only 2 hours from NYC and Boston.

Please call Terry Good at 804-684-5661 or email: terry.good@horizonhealthcare.com; Fax: 1-804-684-5663, EOE

Meridian Behavioral Healthcare, Inc. is a CARF accredited community mental healthcare facility located in the heart of Florida. Currently, we have full time position Staff Psychiatrist position available with an excellent salary and benefits package.

Looking for someone who can work with a flexible schedule – preferably Adult and Child, with the mixure of inpatient and outpatient to be discussed. Meridian has been a part of the lives of thousands since 1972; providing a safety net for those in crisis. Since then, Meridian has expanded to 16 sites across Central Florida, touching over 22,000 lives through over 325,000 direct care visits a year. Gainesville is home to the University of Florida and serves as the cultural, educational and commercial center for the north central Florida region.

For more information, contact:

Logan Anglin, Vice President – Staffing/Recruiting @ (352)-374-5600 x8294 or email confidential C.V. to logan_anglin@mbhi.org

MBH is an Equal Opportunity Employer and a Drug-Free Workplace. Please visit our website: www.mbhi.org

**FLORIDA**

Horizon Behavioral Health, PC is seeking a full-time psychiatrist to treat patients of all ages. With offices in Savannah, Hinesville and Rincon Georgia, HBH is a multi-specialty behavioral health private practice specializing in the treatment of ADHD, Depression and other mental health disorders. We offer a flexible 40-hour work week with no call or weekend duties, competitive salary, and benefits package. Wiling to consider J-1 and H1b Visa sponsorship.

Interested parties please send CV to kchristiansen.horizon@gmail.com.

Horizon Health in partnership with Upson Regional Medical Center, in Thomaston, GA, has a great opportunity for a Medical Director for a new, 18-bed Geriatric inpatient psychiatric program. Practice in a fully staffed program with excellent clinical team, dedicated marketing support and outstanding resources from the nation’s largest psychiatric contract management company. Thomaston is within 60 miles of three of Georgia’s major cities: Atlanta, Macon, and Columbus, 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. Excellent compensation! For more information contact:

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

EOE.
ICLASSIFIEDS

ILLINOIS

FORENSIC CLINICAL SERVICES CIRCUIT COURT OF COOK COUNTY

FORENSIC PSYCHIATRIST
Full-time/Part-Time position available for BC/BE Psychiatrist with the Cook County Circuit Court in Chicago, Illinois. Perform evaluations of adult offenders in a large, urban, court setting. Competitive salary with excellent benefits.

Forensic Clinical Services Department has the distinction of being the nation’s first adult psychiatric court clinic (established in 1914) and provides comprehensive mental health evaluations for the Circuit Court of Cook County which includes Chicago and the surrounding suburbs. This agency of the court is a unique and highly specialized facility with forensically-trained, Board-Certified Psychiatrists, Forensic Psychologists, and Social Workers. The department processes a high volume of cases which ensures a broad exposure to varying degrees of clinical pathology rarely seen in other settings. Additionally, this position provides good opportunity for teaching/training of psychiatry residents and medical students with the prospect of faculty appointment at a large, University Department of Psychiatry in Chicago.

Please mail, fax, or email your CV with a Cover Letter providing a brief description of your interest in the position to the attention of Mathew S. Markos, M.D., Director, Forensic Clinical Services; 773-674-6123 or Fax your CV to 773-674-5113; Email: Mathew.markos@cookcountyil.gov

SOUTHERN IL – SMALL TOWN, BIG OPPORTUNITY – Week on/Week Off if desired - Seeking Psychiatrist for a hospitalist position on a 30-bed Adult Psychiatric Unit in Harrisburg. Competitive employment package which includes sign-on bonus, student loan repayment plan, relocation, additional income for outpatient; or open to discussing practice opportunity for a more entrepreneurial physician. Enjoy a wonderful, laidback quality of life in a very welcoming community. Harrisburg is 24 miles from Marion, IL; 39 miles from Carbondale; and 62 miles from Evansville, IN. HI/11 available here.

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

KENTUCKY

ADDITIONS PSYCHIATRIST

Come to the Greater Cincinnati area! With a population of over 2 million people, major league sports teams (Reds, Bengals), world-class cultural venues (theater, arena concerts, ballet, opera, symphony), and dining choices galore, it’s an upscale urban area that’s hard to beat.

New, state-of-the-art 200-bed dedicated psychiatric hospital in Northern Kentucky is seeking an innovative additions specialist. Influence this 50-bed unit to make it one of the best in the U.S. FT salary is top-of-range with full benefits and option to have an adjunct outpatient practice. PsychPros, Inc. is conducting the search and is a national executive search firm dedicated exclusively to job placements for psychiatrists and behavioral healthcare professionals since 1995. If you want to make a difference in treatments, find out more about this opportunity!

For information, contact President Holly Dorna, 24/7, at 513-703-8021 (private cell) or e-mail Holly@psychpros.com.

MARYLAND

PSYCHIATRIST

AmerCare Services, Inc. is pleased to announce a new relationship and an excellent position in western Maryland. The opportunity is an inpatient setting, Monday – Friday (40 hours) with no weekend, evening or holiday coverage. On call is a possible option. The compensation is $210.00 to $230.00 per hour. For confidential consideration call 610-695-8521 or email: KGallagher@AmCareServices.com or Fax: 610-695-9041.

SEND YOUR AD NOW TO: CAREERS@PSYCHIATRICTIMES.COM

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

INDIANA

EVANSVILLE, IN – Not Too Large, Not too Small; Great Quality of Life – Medical Director position available on a 12-bed Adult Inpatient Psychiatric Unit in the St. Vincent’s Medical Center – an impressive hospital system in so. IN. Hospital is flexible on the compensation package: employment with benefits; or for those more entrepreneurial minded, an independent contractor arrangement. Full-time or Part-time available. Join an outstanding behavioral team.

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

Geriatric Psychiatry Faculty Opportunity

DEPARTMENT OF PSYCHIATRY, UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE, BALTIMORE

The University of Maryland School of Medicine, Department of Psychiatry, is seeking a full-time faculty psychiatrist in the Geriatric Psychiatry Division. Positions carry full-time faculty appointments at the University of Maryland School of Medicine and offer exciting opportunities for clinical care, teaching and research. Candidates must be ABPN certified or eligible. Academic rank and salary are commensurate with experience.

Send letter of introduction and CV to: William T. Regenold, M.D.C.M., Director, Division of Geriatric Psychiatry, Department of Psychiatry, University of Maryland, Baltimore, preferably by email: wregenold@som.umaryland.edu or by mail: University of Maryland Medical Center, Box #351 Room S12A09, 22 South Greene Street, Baltimore, MD 21201.

The University of Maryland, Baltimore is an equal Opportunity/Affirmative Action Employer. Minorities, women, individuals with disabilities, and protected veterans are encouraged to apply.

MICHIGAN

SPARROW

Psychiatry Opportunity with Sparrow Medical Group

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

Learn more about this 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

MINNESOTA

Telepsychiatry Position/Onsite Once or Twice Per Month

Seeking psychiatrist in Minnesotan (or South Dakota) who can provide telepsychiatry for 12-bed inpatient Geropsychiatric Unit in Bemidji, MN and be available to visit the program two days per month for clinical/part-time administrative work.

For more information, please call Terry B. Good, at 804-684-5661; or email: terry.good@horizonhealth.com; Fax: 1-804-684-5663; EOE

MISSOURI

Compass Health operates facilities /clinics in forty-nine counties in rural Missouri and Louisiana where psychiatry services are needed.

OUTPATIENT PSYCHIATRISTS

Immediate full-time positions available in the Compass Health system throughout Missouri and Central and Northern Louisiana (specific locations and openings are at www.compasshealthlhome.org. Please specify acceptable locations on your C.V.)

M.D. or equivalent professional degree, Missouri or Louisiana license eligibility, and Board Certification/Board Eligibility in Psychiatry are required

Comprehensive benefits package and contract

Please submit CV to: crigg@compasshn.org
Fax: 417-532-6606 EOE

NEW JERSEY

POSITIONS IN NORTHER NJ – Englewood: Additional Psychiatrist needed on 12-bed geropsych unit and 9-bed adult unit for inpatient and consultation liaison work in Englewood Hospital. Contract work available for Attending Psychiatrist- or can offer employment w/benefits if preferred. Bayonne: Additional Psychiatrist needed to do inpatient work on adult psy unit and consults in Bayonne Hospital. Offering employment w/benefits. Jersey City: Seeking additional Psychiatrist for outpatient position (adult and C/A) with some call responsibilities for inpatient adult psy unit. Please contact Terry B. Good at 804-684-5661.

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

300 sq ft office suite available. Join Existing Doctor and Dentist Suite contains three rooms. Piscataway NJ

Contact Mayur Patel (732) 735-0542
NEW YORK

Presbyterian Healthcare Services is a locally owned, not-for-profit organization based in Albuquerque, New Mexico. The Presbyterian Medical Group employs more than 700 primary care and specialty providers. We are seeking a Psychiatric Hospitalist to join our team. The Presbyterian Behavioral Medicine Program is a full-service psychiatry department with 2 adult units, 1 child/adolescent inpatient unit, a multidisciplinary outpatient clinic, intensive outpatient treatment, emergency and consultative services and behavioral medicine services embedded in primary care. We have been proudly providing care to New Mexicans since 1908. This is an employed position with competitive salary, comprehensive benefits and relocation assistance.

Contact Susan Camenisch at 505-923-8718 or scamenich@phs.org

NEW MEXICO

NYACK – “ART & SOUL ON THE HUDSON” – Inpatient Psychiatry position on a 26-bed Adult Inpatient Psychiatric Unit in the Nyack Hospital—highly accredited hospital with A ranking for safety. Associate Medical Director position available. Offering salaried position with benefits. Top-notch behavioral health team; great location. 30 miles from NYC.

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

OSWEGO, NY – Lovely College Town on Lake Ontario – An easy drive to the Adirondacks: 40 miles from Syracuse. Two positions available: Seeking an additional Psychiatrist to work on a 28-bed adult inpatient psychiatric unit in the Oswego Hospital. Also, seeking a Psychiatrist to work in the hospital’s outpatient clinics. Work with a great group of people: very flexible hospital. Offering salaried position with benefits.

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

Unique Opportunity in Manhattan

Growing outpatient practice focused on cutting-edge treatments such as IV ketamine in a warm, collegial environment. No experience with ketamine necessary - full training and ongoing education provided. 3-5 days/wk and flexibility to maintain your own private practice. Generous base salary + bonus, paid vacation, retirement plan and medical benefits. BC/BE and NY license required.

Fax/email CV: 609-228-5959 pfrischtak@ktcpartnership.com

Psychiatry: NY Psychiatrist, part-time, also; Practice for Sale, Adult, Child, S.A. Established, multidisciplinary practice serving Northern Westchester and Putnam Counties, nearby CT. (914) 669-5526

PSYCHIATRISTS & PSYCH NURSE PRACTITIONERS

CONSULTATION SERVICES IN LONG TERM CARE (NH, SNF)

NEW YORK CITY & WESTCHESTER COUNTY

Part Time / Full Time / Per diem / Locums Tenens

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

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

Montefiore Mount Vernon Hospital (MVH) is a 176-bed, community-based teaching hospital that has been serving the medical needs of the community and region since its founding in 1891. Montefiore Mount Vernon Hospital provides inpatient, critical care and ambulatory services. The Hospital is part of Montefiore Health System, a premier academic medical center and the University Hospital system for Albert Einstein College of Medicine. Montefiore Mount Vernon Hospital is a New York State-designated Stroke Center and HIV/AIDS Center, and it is home to the Beale Chronic Wound Treatment and Hyperbaric Center and the Montefiore School of Nursing.

We are currently looking for a FT Unit Psychiatrist. The Psychiatry Inpatient Unit has 22 beds and services mostly Adult patients. This position in Monday - Friday 9a - 5p with one night working until 6pm. No weekend or weeknight. On Call is required for this position. The Psychiatrist will be responsible for seeing all new patients in a timely manner, consulting with other multidisciplinary teams and conducting family meetings. This individual will also assist in the ED as needed and on the medical floor.

We also have moonlighting opportunities available.

Qualifications: Must have a current Physician license in NYS. Must have completed a residency program and be Board Certified, Board eligible applicants are welcome. Experience working in a psychiatric unit preferred. Must have graduated from an accredited medical school.

Please contact: Roshielle Robertson at ROROBERT@montefiore.org

STAFFING & EXECUTIVE SEARCH

ADDICTIONS PSYCHIATRIST

Come to the Greater Cincinnati area! With a population of over 2 million people, major league sports teams (Reds, Bengals), world-class cultural venues (theater, arena concerts, ballet, opera, symphony), and dining choices galore, it’s an upscale urban area that’s hard to beat.

New, state-of-the-art 200-bed dedicated psychiatric hospital in Northern Kentucky is seeking an innovative additions specialist. Influence this 50-bed unit to make it one of the best in the U.S. FT salary is top-of-range with full benefits and option to have an adjunct outpatient practice. PsychPros, Inc. is conducting the search and is a national executive search firm dedicated exclusively to job placements for psychiatrists and behavioral healthcare professionals since 1995. If you want to make a difference in additions treatment, find out more about this opportunity!

For information, contact President Holly Dorma, 24/7, at 513-703-8021 (private cell) or e-mail Holly@psychpros.com .
OREGON

Morrison Child & Family Services, a large, dynamic, non-profit agency, is seeking a Medical Director to lead their excellent Psychiatric Services Team and provide leadership in various clinical settings including outpatient services, day treatment and specialty residential programs. We are the largest provider of children’s mental health services in the Portland metro area. Funding sources include state and county juvenile justice organizations, federal state and county contracts for many specialty services. Must be Board Certified or Board eligible in Child and Adolescent Psychiatry, and eligible for licensure in Oregon.

Learn more about us at: http://www.morrisonkids.org/
View Medical Director posting MD-471 http://www.morrisonkids.org/careers/openpositions/

Pennsylvania

CRISIS SERVICE POSITION - DARBY, PA – Suburb of Philadelphia – Horizon Health, in partnership with Mercy Catholic Medical Center, is seeking a Psychiatrist for the night shift on the hospital’s Crisis Service (5pm to 8am shift). Offering salaried positions with benefits. Please contact Terry B. Good, Horizon Health, at 804-684-5661.

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

PSYCHIATRISTS
AmeriCare Services is pleased to announce excellent psychiatry positions in Eastern and Western Pennsylvania. The opportunities are inpatient settings, Monday – Friday with no call, weekends, evenings or holidays. The compensation is $200.00 - $215.00 per hour.

For confidential consideration call 610-695-8521 or email: KGallagher@AmCareServices.com or Fax: 610-695-9041

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 compen-
Applicants must submit a cover letter and resume to hr.mail@mch1.org. The Penn State Milton S. Hershey Medical Center is committed to affirmative action, equal opportunity and the diversity of its workforce. Equal Opportunity Employer – M/W/N/D.

Inpatient Psychiatrist
LECOM Health Millcreek
Community Hospital
Erie, Pennsylvania

Currently looking for Board-Certified Psychiatrists to provide support as Attending Psychiatrists for the large and growing inpatient Behavioral Health Units of a community hospital located in Erie, Pennsylvania.

Ideal candidates will be board certified and possess a medical license with experience in Psychiatry.

Requirements of Inpatient Psychiatrist
• Provide clinical support and care to patients admitted to our Behavioral Health Units.
• Oversee, evaluate and mentor Resident Psychiatrists.
• Examine, evaluate, diagnose, and treat psychiatric disorders.
• Advise on problems related to mental health and prevention of mental disorders.
• Reasonable call responsibilities.

ESSENTIALS
Job Type: Full-time
Compensation
• Base salary negotiable based on experience and qualifications. Tenure-track positions are possible.
• Benefits that include participation in a 403B retirement plan with generous employer match, health care, paid time off, and more.
• Job Type: Full-time

For more information, please visit: www.psychiatristtimes.com

We offer a competitive salary and benefit package, including life, health and disability insurance; an excellent deferred compensation and participation in the Virginia retirement program; and a generous leave package.

RACS participates in the National Health Services Corps (NHSC Score 16). Eligible candidates may be able to apply for Federal Student Loan forgiveness.

TO APPLY: Applicants must submit a completed Rockbridge Area Community Services Board employment application, detailed resume, salary history, and cover letter outlining his or her interest in and qualifications for this position.

For Now

Apply by sending cover letter and resume to hr.mail@mch1.org

www.psychiatristtimes.com

QUALIFICATIONS
• Board certified Psychiatry
• Experience in Psychiatry
• Computer skills required.

We invite you to join a team of dedicated physicians and loyal staff who are committed to promoting a life of possibilities for all Virginians.