

PSYCHIATRIC NEWS

NEWSPAPER OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Supreme Court To Decide Case on Group Homes

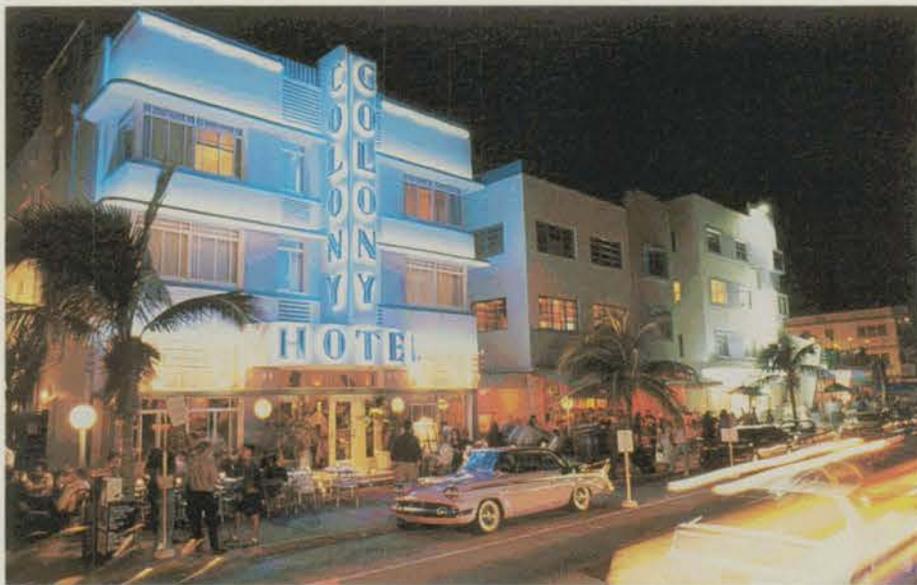
APA has joined a coalition of organizations asking the U.S. Supreme Court to rule that a local government violates the federal Fair Housing Act when it bars certain group homes from opening in neighborhoods zoned for single-family houses.

The case before the Court challenges a zoning decision by the city of Edmonds, Wash., to prohibit a group home for substance abusers from opening at its chosen site on the basis of a local ordinance that imposes a limit on the number of unrelated people allowed to reside in a single dwelling.

The amicus brief in the case of *City of Edmonds v. Washington State Building Code Council (No. 94-23)*—to which APA recently agreed to become a signatory—argues that the federal Fair Housing Act's provisions regarding discrimination against people with handicaps requires that local governments make "reasonable accommodation" to comply with the act. The legislation's stated intent was "to end the unnecessary exclusion of persons with handicaps from the American mainstream."

Edmonds officials acted on an exemption in the law's wording, however, that allows localities to enforce laws "regarding the maximum number of occupants permitted to occupy a dwelling." Zoning laws on the books in Edmonds impose a limit of five unrelated individu-

See "Group Home," page 26



The Miami Beach Convention Center, site of APA's 1995 annual meeting later this month, is only a short distance from the chic nightlife of South Beach and its Art Deco District. The annual meeting runs from May 20 to May 25.

APA Trustees Approve Manual For Primary Care Physicians

APA's Board of Trustees approved in March the first primary care version of the *DSM-IV* for publication by the American Psychiatric Press Inc. (APPI). The approval came after a lengthy discussion about the manual's purpose and potential uses.

The *DSM-IV* primary care diagnostic manual will be published in September and is designed to improve communication between psychiatrists and primary care physicians and increase recognition of mental disorders in primary care settings.

It also will enhance the role of psychiatrists in training primary care physicians, according to former APA president John McIntyre, M.D., who reviewed the document with Area 2 Trustee Harvey Bluestone, M.D., and recommended its approval for publication. McIntyre told *Psychiatric News* that he has a longstanding interest in the practice of psychiatry in primary care settings, and consultation-liaison psychiatry is a major thrust of his department at the University of Rochester Medical Center in New York.

"This document accomplishes the three goals outlined by the Joint Reference Committee well and represents an enormous benefit to the field," McIntyre told the Board.

He emphasized that the manual is primarily an educational tool that can facilitate psychiatrists' involvement in primary care education, "which is essential in so many ways to our role."

Studies show that primary care physicians often do not detect mental illnesses in their patients. "By increasing the recognition of mental illnesses, patients will benefit," McIntyre said.

APA former president Paul Jay Fink, M.D., opposed publishing the primary care document. "It will only encourage the competition by giving them a stronger basis for making diagnoses and to begin treatment. Primary

care physicians in managed care companies do not refer to specialists under most circumstances and have no incentives to do so."

He added in an interview with *Psychiatric News* that family physicians tend to prescribe medications and refer to psychologists and other nonphysician mental health providers for psychotherapy (see story on page 11). "A mental health professional and a family physician do not equal a psychiatrist."

McIntyre responded, "Paul Fink's comments are very important and have been mentioned and discussed extensively in other settings as we moved into the development of the document."

See "Manual," page 28

HHS Considers Reorganizing Structure

The Clinton Administration has challenged the Department of Health and Human Services (HHS) to examine its programs and look for new ways of doing business, according to a March internal memo obtained from Secretary Donna Shalala's office.

One option HHS is exploring is to create a new organization combining the expertise of the Substance Abuse and Mental Health Services Administration (SAMHSA), Health Care Financing Administration (HCFA), and Health Resources and Services Administration (HRSA) and preserve their separate missions, according to Shalala's memo.

Shalala told HHS employees, "Our goal is to provide better service to our customers at a lower cost to taxpayers. We will also be using this process to redefine the mission of HHS now that the Social Security Administration is becoming independent."

"The goal would be to strengthen health, mental health, [and] substance abuse prevention and treatment services through better coordination at the federal, state, and community levels."

She denied reports of a plan to place both HRSA and SAMHSA in HCFA and described the options to be presented to President Clinton as not yet final.

HHS officials held a "Reinventing Government II constituency meeting" last month to discuss the proposed merger. Jay Cutler, director of APA's Division of Government Relations, represented APA. He told *Psychiatric News*, "We are concerned about the demise of a federal agency with a Presiden-

See "HHS," page 20

Early Career Psychiatrists to Get Representation in APA Governance

APA's Board of Trustees voted in March to endorse officially a five-year pilot program that would encourage early career psychiatrists to participate in the Assembly and Area Councils.

APA's Council on Medical Education and Career Development defines early career psychiatrists as "active physician members of APA who are not residents serving in an approved training program, but who are under 40 years of age or are within the first five years of professional practice after residency and fellowship training programs."

At its December 1994 meeting, the Board voted to allocate \$28,452 in the 1995 budget for early career psychiatrists. In formally approving the pilot program in March, the Board asked the Assembly to prepare and approve specific procedures to bring early career psychiatrists into the structure of the Assembly and Area Councils.

As outlined, the program calls for one representative and deputy representative to

be chosen by each Area Council from those early career psychiatrists nominated by the Area's district branches. In the first year, each Area Council will choose a representative for a one-year term and a deputy representative to serve one year as deputy and the second year as representative. In subsequent years, each Area Council will choose a deputy representative to serve one year as deputy and one year as representative.

A memorandum distributed at the March Board meeting enumerated a number of ideas that emerged from discussions in the Joint Reference Committee, Assembly Executive Committee, and the Assembly Committee on Planning. Among them:

- Include all early career psychiatrists in Association-wide networking efforts.
- Assist early career psychiatrists in networking with each other, and link them with specialty field mentors and appropriate others.

See "Early Career," page 28



MANAGED CARE HOTLINE

APA wants to hear from you about managed care—its failures as well as its successes. APA seeks descriptions of specific patient problems, such as access to care, in addition to problems relating to the structure of

1-800-343-4671

managed care systems (such as review criteria and process procedures). Also sought are descriptions of successful managed care systems and practices and situations in which patients have been served well. The information will allow APA to document and challenge inappropriate managed care review trends and make recommendations about practices that work. Call weekdays 9 a.m. to 5 p.m. Eastern time. You may also use it to obtain Medicare reimbursement information.

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Board Takes Action on Campaigning Violations

At its meeting on March 26 the Board of Trustees accepted a finding by the Elections Committee that a serious violation of election guidelines had occurred in the campaign for president-elect. The Board of Trustees, after considerable and considered discussion, further voted to implement the recommendation of the Elections Committee that notice of the violation be printed in *Psychiatric News*. Subsequently the Board was asked to reconsider its decision and to review if proper procedure had been observed. The Board did assure itself that proper procedure was followed and reaffirmed its decision by a significant majority. You will find publication of the notice immediately following and after that a very forthcoming response from Lawrence Kline, M.D. Dr. Kline's response should satisfactorily bring this issue to a close and allow the Association to go forward in a spirit of collegiality, mutual respect, and professional values.

Jerry Wiener, M.D.
APA President

Statement of the Elections Committee:

The Elections Committee received reports of possible violations of the APA election guidelines during the 1995 election. The committee, in accordance with the election guidelines, investigated these potential deviations, and found that there were approximately nine actual violations. Again in accordance with the election guidelines, the committee reported the results of its inquiries to the Board and recommended that a notice of these violations be published in *Psychiatric News*. The Board approved the committee's recommendation.

The most serious violation that the Elections Committee reported to the Board occurred in a letter sent to 5,000 members by Dr. Lawrence Kline in his role as acting president of the American Association of Private Practice Psychiatrists (AAPPP) on the letterhead of that organization. Despite Dr. Kline's claim to the contrary, the Elections Committee determined and the Board of Trustees concurred that Dr. Kline's letter was a campaign letter in support of Dr. Harold Eist, candidate for President-Elect, and as such, it violated several APA election guidelines. In an effort to protect the integrity of the election process and to deter this sort of campaigning in the future, the Elections Committee recommended, and the Board approved, publication of the notice of these violations in *Psychiatric News*.

The other violations that occurred during the 1995 election were as follows:

- One violation of Section II.A.6.b: Letters must be produced by the person signing the letter. The body of the letter may be produced in any fashion . . . only by the person signing the letter. . . .
- One violation of Section II.B.I: National, Area, and district branch officers. . . shall not use their official APA/Area/DB titles. . . to endorse or support any candidate. Officers may refer to their organizational titles in their letters, but may not sign letters over their titles.
- Seven violations of Section II.A.6.a: Letters. . . are to have individual salutations by name (no "dear colleague," "dear member," "dear friend," etc.)

The Elections Committee wishes to remind all APA members that the Board of Trustees has affirmed that APA elections be conducted under a set of guidelines that prescribe members' and candidates' election-related activities. The guidelines, though imperfect, attempt to provide candidates and their supporters with ways in which to campaign equitably. A summary of the guidelines is published each year in *Psychiatric News* prior to the election; the full guidelines are included in the Operations Manual of the Board of Trustees, and copies are available from the staff liaison to the Elections Committee, Carol Lewis (202-682-6063). Any member wishing to support a candidate should read the guidelines before doing so.

Response of Lawrence Y. Kline, M.D.:

We all must adhere to our election guidelines. At the time I wrote the letter in question, I did not believe that I was violating them. For the past 20 years I have been an active and enthusiastic campaigner for local and national legislative and regulatory initiatives that seek to protect patients' access to appropriate psychiatric treatment. At the time I wrote the letter, I simply viewed it as part of these continuing efforts.

I apologize for any infraction I may have committed. I accept the Board's call for compliance and urge all members to do the same.

AAMC President To Present Convocation Lecture

Jordan J. Cohen, M.D., president of the Association of American Medical Colleges, will present the William C. Menninger Memorial Lecture at the Convocation of Fellows at APA's annual meeting in Miami later this month.

The AAMC, founded in 1876, represents all 125 U.S. medical schools, 400 major teaching hospitals, and more than 90 academic and research societies.

The Convocation will be held Monday, May 22, at the Miami Beach Convention Center.

Cohen came to the AAMC in April 1994 from the State University of New York at Stony Brook, where he was dean of the medical school, president of the medical staff, and director of the University Medical Center. Among his numerous accomplishments there was the launching of an innovative model curriculum emphasizing the changing role of medicine in modern society.

A medical educator for more than 30 years, Cohen has held positions on the medical faculties of Harvard, Brown, and Tufts universities. He has written on medical education, residency training, and the physician workforce. His chief areas of research are acid-base metabolism and renal physiology.

Cohen has contributed his leadership abilities to virtually every aspect of academic medicine. He chaired the Accreditation Council for Graduate Medical Education from 1993 to 1994. He is a former chair of the American Board of Internal Medicine and former president of the Association of Program Directors of Internal Medicine. At the American College of Physicians, he served as vice chair of its Board of Regents and chair of the Education Policy Committee. He was awarded a mastership from the college in 1993.

Cohen began his association with the AAMC as a member of the Council of Deans in 1988 and chair of the Generalist Physician Task Force.

In 1994 Cohen was named a member of the National Academy of Sciences' Institute of Medicine.



Jordan J. Cohen, M.D., will present the Convocation lecture on Monday, May 22, at 8 p.m.

In This Issue

IHS APPROPRIATIONS

4 APA testifies before a House subcommittee that increased Indian Health Service appropriations is a strategic investment.

ANNUAL MEETING

6 While in Miami, you can dance to the sound of the Psychodynamics—psychiatry's only rock group—and raise funds for charity.

FROM THE PRESIDENT 3
HISTORY NOTES 22

CONTRACT WITH CHILDREN

8 APA's Board of Trustees counters the Republican "Contract With America" with a "Contract With America's Children."

BYLAWS AMENDMENT

10 APA's Board of Trustees votes to approve an amendment to the APA Bylaws to alter the procedure for a referendum.

PROFILES IN PRACTICE 9

AIDS PROJECT

13 APA's AIDS Education Project won a government contract to expand education and training in psychiatric aspects of HIV illness.

NEW EDITOR IN CHIEF

14 Neuroscientist and psychiatrist Floyd Bloom, M.D., has been named editor in chief of *Science* magazine.

LETTERS TO THE EDITOR 12

TV VIOLENCE

16 APA and other members of the Citizens' Task Force on TV Violence explore strategies with Attorney General Reno.

FEAR AND HEART ATTACK

24 Can extreme fear trigger heart attacks in normal people? Two studies come to opposite conclusions.

MEDIA WATCH 17

Psychiatry Rises to the Challenge

By Jerry Wiener, M.D.
APA President



So far as my term as president is concerned, this definitely feels like the beginning of the end; transition time is upon us, and I feel at the same time both

the tug of reminiscence and the excitement of the upcoming Miami meeting.

As I write this, we and the nation are one week post-Oklahoma City and its nightmare of revenge and retaliation gone totally amok. We share with everyone the horror and monstrousness of the murder and destruction there, but as psychiatrists—at least I speak for myself—we have a particular relationship to such events; first, because we try to understand the origins, motives, and mental structures within which such behavior can occur (not, by the way, either to make pathology of it or provide some *DSM-IV* "defense" for it) and, second, because we have a responsibility to make our knowledge and services available to the survivors and families of the victims. I am pleased and proud to recognize the Oklahoma district branch and the area psychiatric community for their immediate response and provision of much-needed and valuable first-aid assistance (see the next issue of *Psychiatric News*).

It is coincidental that APA and the American Red Cross are in the process of drawing up an agreement and guidelines for the participation of psychiatry and psychiatric expertise at times of disaster—both natural and all-too-often of human manufacture. This agreement will provide a readiness and organizational structure within which psychiatry can respond.

New Administrator at APA

Dr. Melvin Sabshin has announced agreement with Robert Trachtenberg to join APA in the new position of chief operating officer, filling the administrative vacancy left by the resignation last year of Dr. Carolyn Robinowitz. Bob Trachtenberg is an experienced and tested senior administrator who has held many key positions over the course of a very successful career, and we are fortunate to have him join us and join the management team led by Dr. Sabshin.

Psychoanalytic Institutes

The weekend of April 22 and 23 I was privileged to give the luncheon address at the 50th anniversary celebration of my psychoanalytic alma mater, the Columbia Psychoanalytic Center for Training and Research in New York City. The Columbia program is distinguished in many ways, but in particular it was the first and still one of only a few analytic programs to become part of an academic department of psychiatry.

For most of its history, the training programs and institutes of the American Psychoanalytic Association have remained separate and autonomous of academic medical centers, and for a while this was a source

of independence, self-control, autonomy, and some strengths. It also provided the American Psychoanalytic with both an accrediting and certifying *raison d'être* and therefore also a source of great resistance to being taken over, swallowed up, digested, absorbed, and all the other things academic centers are projected to do (although the Columbia, Emory, and Downstate programs seem in reasonably good health). However, since the requirement of a link between analytic training and the M.D. degree was eliminated in the late 1980's, the links between organized psychiatry and its counterpart in psychoanalysis seem destined for increasing distance and eventual severance. This is, or should be, a source of concern for both parties in what has been a long-standing and mutually productive and enriching relationship.

My hope is that new relationships can begin to emerge and develop between academic departments of psychiatry and analytically trained psychiatrist faculty. These should include postresidency educational programs, which will permit and support the valuable contributions of psychoanalytic theory and practice to remain an important part of psychiatry.

The Washington Front

To shift to the national scene here in Washington, D.C., we are active and engaged on a number of fronts: concern about the protection of benefits for mental illness in the state Medicaid waivers, concern for psychiatric services to children and adolescents in various block grant proposals, opposition to psychologist prescribing initiatives at the state and national (DOD) level (the more you know about this program, the more outrageous, wasteful, and shameful it becomes), the rapidly emerging battle over reduction in Medicare benefits in ways that will especially disadvantage mental illness, tort reform (in trouble in the Senate as of this writing), and the battle (another battle) over establishing appropriate liability and accountability for medical decision making by managed care and other payment intermediaries.

Once you begin to touch base and become involved in these various issues, very quickly your plate becomes full and your cup runneth over—so kudos and regards are due for the members and staff involved in APA's Joint Commission on Government Relations and the Division of Government Relations, because it is they who really work on our behalf to make sure that disadvantageous and discriminatory policies do not prevail in Congress and the Administration, and now increasingly at the state level. The Board of Trustees has increased support to the Division of Government Relations to strengthen our ability to work together with district branches on important state initiatives.

Whatever our diversities and differences, we need now to stay the course together as a strong and unified profession with a consistent core set of goals and values, and in that we will prevail.

APA
Psychiatry & The Arts
Special Exhibit

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- Luiz Cruz Azaceta □
- Melvin Edwards □
- Teresita Fernández □
- Julio Galan □
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SCIOS NOVA

Exhibit #1423

Sunday, May 21 -
Wednesday, May 24, 1995

Miami Beach
Convention Center

Graciela Iturbide
"Señora de las iguanas" (detail)
Mexico, 1979
Courtesy of Sandra Berler Gallery



PASS THE BOARDS!

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APA Supports More Funds For IHS

The Congressional budget axe may fall next on the Indian Health Service (IHS), the federal agency that provides direct medical, mental health, and substance abuse services to about 1.4 million American Indians and Alaska Natives.

APA's Assembly Recorder R. Dale Walker, M.D., an expert on American Indian mental health and substance abuse issues, testified before the House Subcommittee on Interior and Related Agencies in March that at a minimum President Clinton's proposed \$98 million budget increase for IHS should be retained.

The President's FY 1996 budget for IHS is \$2.3 billion, a 4.5 percent increase over FY 1995. This includes a request for \$38.7 million for mental health and social services and \$96 million for substance abuse services, which is an increase of \$2.3 million and \$4.6

"Not one full-time psychiatrist is assigned to work in any of the IHS addictions programs throughout the country."

million, respectively, over FY 1995 levels.

Walker, a Cherokee Indian and associate chief for addictions at Seattle Veterans Affairs Medical Center, urged House subcommittee chair Ralph Regula (R-Ohio) to consider the proposed increase a "strategic investment to prevent the problems from getting worse."

He explained, "American Indians don't have access to adequate mental health care, medications, and substance abuse services. It is clear that if treatment was given to people with mental illness, they would improve and recover, which would in turn increase Indian productivity and self-sufficiency."

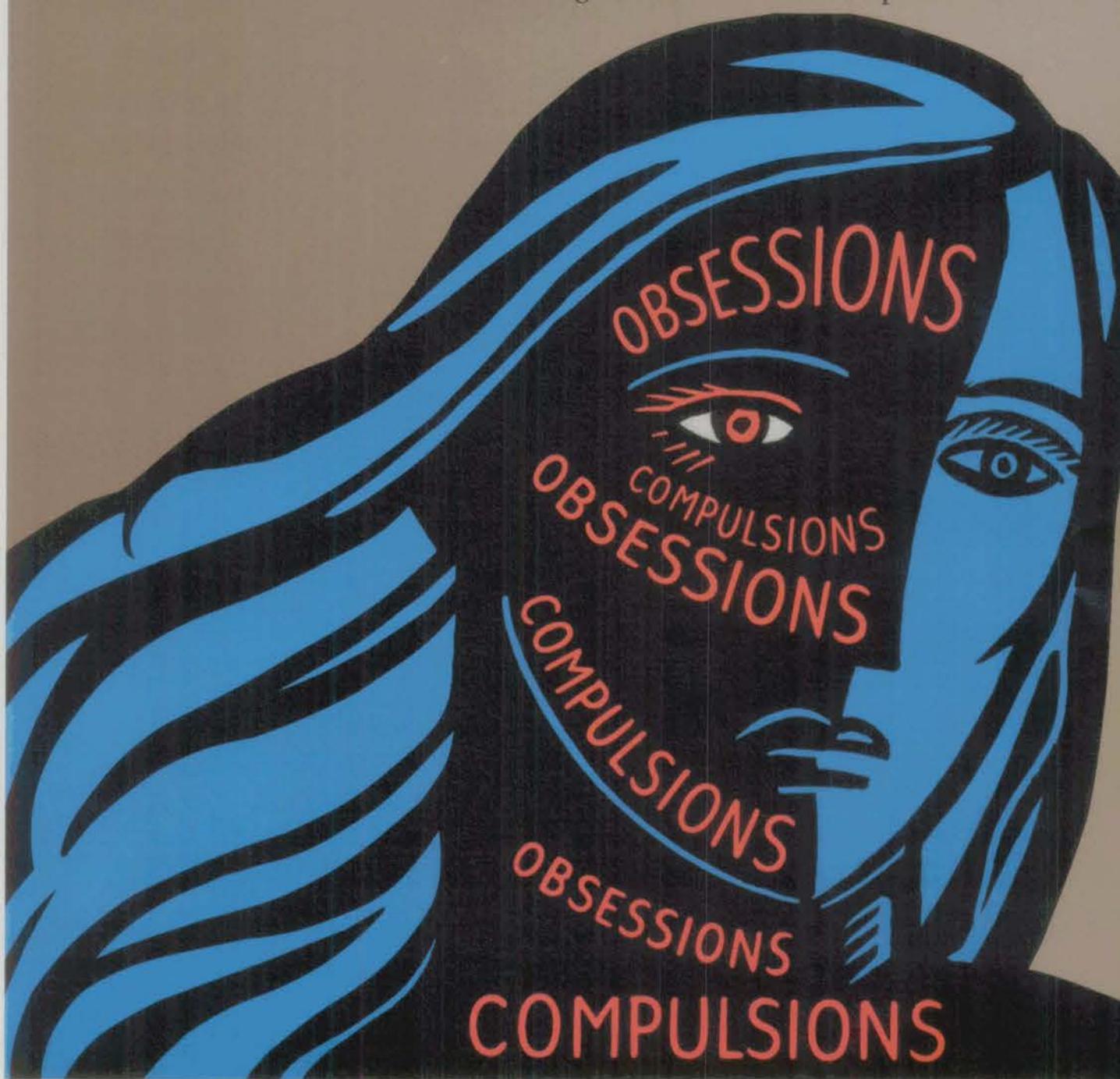
In addition, APA "strongly supports the President's proposed increase in funding for urban Indian health," which is \$2.4 million more than last year's budget, for a total of \$26 million. Walker noted that urban In-

See "Walker," page 30



R. Dale Walker, M.D., testified before a Congressional committee about the Indian Health Service budget. "The need for community-based suicide intervention and prevention programs is very great. . . ."

Introducing a selective serotonin reuptake inhibitor for O



LUVOX™ (fluvoxamine maleate) Tablets

Brief Summary (For full Prescribing Information refer to package insert.)

INDICATIONS AND USAGE

LUVOX Tablets are indicated for the treatment of obsessions and compulsions in patients with Obsessive Compulsive Disorder (OCD), as defined in the DSM-IV. The obsessions or compulsions cause marked distress, are time-consuming, or significantly interfere with social or occupational functioning. The efficacy of LUVOX Tablets was established in two 10-week trials with obsessive compulsive patients with the diagnosis of Obsessive Compulsive Disorder as defined in DSM-IV. Obsessive Compulsive Disorder is characterized by recurrent and persistent ideas, thoughts, impulses or images (obsessions) that are ego-syntonic and/or repetitive, purposeful, and intentional behaviors (compulsions) that are recognized by the patient as excessive or unreasonable. The effectiveness of LUVOX Tablets for long-term use, i.e., for more than 10 weeks, has not been systematically evaluated in placebo-controlled trials. Therefore, the physician who elects to use LUVOX Tablets for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient.

CONTRAINDICATIONS

Coadministration of tricyclic antidepressants with LUVOX Tablets is contraindicated (see WARNINGS and PRECAUTIONS). LUVOX Tablets are contraindicated in patients with a history of hypersensitivity to fluvoxamine maleate.

WARNINGS

Potential for interaction with Monoamine Oxidase Inhibitors. In patients receiving another serotonin reuptake inhibitor drug in combination with monoamine oxidase inhibitors (MAOI), there have been reports of serious, sometimes fatal, reactions including hyperthermia, rigidity, myoclonus, autonomic instability with possible rapid fluctuations of vital signs, and mental status changes that include extreme agitation progressing to delirium and coma. These reactions have also been reported in patients who have discontinued that drug and have been started on a MAOI. Some cases presented with features resembling neuroleptic malignant syndrome. Therefore, it is recommended that LUVOX Tablets not be used in combination with a MAOI, or within 14 days of discontinuing treatment with a MAOI. After stopping LUVOX Tablets, at least 2 weeks should be allowed before starting a MAOI.

Other Potentially Important Drug Interactions

(Also see PRECAUTIONS - Drug Interactions) **Benzodiazepines:** Benzodiazepines metabolized by hepatic oxidation (e.g., alprazolam, midazolam, triazolam, etc.) should be used with caution because the clearance of these drugs is likely to be reduced by fluvoxamine. The clearance of benzodiazepines metabolized by glucosylation (e.g., lorazepam, oxazepam, temazepam) is unlikely to be affected by fluvoxamine. **Alprazolam:** When fluvoxamine maleate (100 mg qd) and alprazolam (1 mg qd) were co-administered to steady state, plasma concentrations and other pharmacokinetic parameters (AUC, C_{max}, T_{1/2}) of alprazolam were approximately twice those observed when alprazolam was administered alone; oral clearance was reduced by about 50%. The elevated plasma alprazolam concentrations resulted in decreased psychomotor performance and memory. This interaction, which has not been investigated using higher doses of fluvoxamine, may be more pronounced if a 300 mg daily dose is co-administered, particularly since fluvoxamine exhibits non-linear pharmacokinetics over the dosage range 100-300 mg. If alprazolam is co-administered with LUVOX Tablets, the initial alprazolam dosage should be at least halved and titration to the lowest effective dose is recommended. No dosage adjustment is required for LUVOX Tablets. **Diazepam:** The co-administration of LUVOX Tablets and diazepam is generally not advisable. Because fluvoxamine reduces the clearance of both diazepam and its active metabolite, desmethyldiazepam, there is a strong likelihood of substantial accumulation of both species during chronic co-administration. Evidence supporting the conclusion that it is advisable to co-administer fluvoxamine and diazepam is derived from a study in which healthy volunteers taking 150 mg/day of fluvoxamine were administered a single oral dose of 10 mg of diazepam. In these subjects (n=8), the clearance of diazepam was reduced by 65% and that of desmethyldiazepam to a level that was too low to measure over the course of the 2 week long study. It is likely that this experience significantly underestimates the degree of accumulation that might occur with repeated diazepam administration. However, as noted with alprazolam, the effect of fluvoxamine may even be more pronounced when it is administered at higher doses. Accordingly, diazepam and fluvoxamine should not routinely be co-administered. **Potential Terfenadine and Astemizole Interactions:** Terfenadine and astemizole are both metabolized by the cytochrome P450B4 isoenzyme, and it has been demonstrated that terfenadine, a potent inhibitor of B4, blocks the metabolism of terfenadine and astemizole, resulting in increased plasma concentrations of parent drug. Increased plasma concentrations of parent drug, increased plasma concentrations of fluvoxamine in combination with diazepam, a drug that is known to be metabolized by the B4 isoenzyme. Although it has not been definitively demonstrated that fluvoxamine is a potent B4 inhibitor, it is likely to be, given the substantial inhibition of fluvoxamine with alprazolam. Consequently, it is recommended that fluvoxamine not be used in combination with other terfenadine or astemizole. (See CONTRAINDICATIONS and PRECAUTIONS). **Theophylline:** The effect of steady-state fluvoxamine (50 mg bid) on the pharmacokinetics of a single dose of theophylline (325 mg in 442 mg aminophylline) was evaluated in 12 healthy non-smoking, male volunteers. The clearance of theophylline was decreased approximately 24%. Therefore, if theophylline is co-administered with fluvoxamine tablets, its dose should be reduced to one third of the usual daily maintenance dose and plasma concentrations of theophylline should be monitored. No dosage adjustment is required for LUVOX Tablets. **Warfarin:** When fluvoxamine maleate (50 mg bid) was administered concomitantly with warfarin for two weeks, warfarin plasma concentrations increased by 98% and prothrombin times were prolonged. The patients receiving oral anticoagulants and LUVOX Tablets should have their prothrombin time monitored and their anticoagulant dose adjusted accordingly. No dosage adjustment is required for LUVOX Tablets.

PRECAUTIONS

General

Activation of Mania/Hypomania: During premarketing studies involving primarily depressed patients, hypomania or mania occurred in approximately 1% of patients treated with fluvoxamine. Activation of mania/hypomania has also been reported in a small proportion of patients with major affective disorder who were treated with other marketed antidepressants. As with all antidepressants, LUVOX Tablets should be used cautiously in patients with a history of mania. **Seizures:** During premarketing studies, seizures were reported in 0.2% of fluvoxamine-treated patients. LUVOX Tablets should be used cautiously in patients with a history of seizures. It should be discontinued in any patient who develops seizures. **Suicide:** The possibility of a suicide attempt is inherent in patients with depressive symptoms, whether these occur in primary depression or in association with another primary disorder such as OCD. Close supervision of high risk patients should accompany initial drug therapy. Prescriptions for LUVOX Tablets should be written for the smallest quantity of tablets consistent with good patient management in order to reduce the risk of overdose. **Use in Patients with Concomitant Illness:** Closely monitored clinical experience with LUVOX Tablets in patients with concomitant systemic illness is limited. Caution is advised in adminis-

ing LUVOX Tablets to patients with diseases or conditions that could affect hemodynamic responses or metabolism. LUVOX Tablets have not been evaluated or approved for use in patients with a recent history of myocardial infarction or unstable heart disease. Patients with these diagnoses were systematically excluded from clinical studies during the product's premarketing testing. Evaluation of the electrocardiogram for patients with depression or OCD who participated in premarketing studies revealed no differences between fluvoxamine and placebo in the emergence of clinically important ECG changes. In patients with first degree heart block, fluvoxamine decreased by approximately 30%. LUVOX Tablets should be slowly titrated in patients with low dysfunction during the initiation of treatment.

Information for Patients: Physicians are advised to discuss the following issues with patients for whom they prescribe LUVOX Tablets: **Interference with Driving or Motor Performance:** Since any psychoactive drug may impair judgment, thinking, or motor skills, patients should be cautioned about operating hazardous machinery, including automobiles, until they are certain that LUVOX Tablets therapy does not adversely affect their ability to engage in such activities. **Pregnancy:** Patients should be advised to notify their physicians if they become pregnant or intend to become pregnant during therapy with LUVOX Tablets. **Nursing Mothers:** Patients receiving LUVOX Tablets should be advised to notify their physicians if they are taking, or plan to take, any prescription or over-the-counter drugs, since there is a potential for clinically important drug-drug interactions. **Alcohol:** As with other psychotropic medications, patients should be advised to avoid alcohol while taking LUVOX Tablets. **Allergic Reactions:** Patients should be advised to notify their physicians if they develop a rash, hives, or a related allergic phenomenon during therapy with LUVOX Tablets.

Laboratory Tests

There are no specific laboratory tests recommended.

Drug Interactions

Potential Interactions with Drugs that Inhibit or are Metabolized by Cytochrome P450 Isozymes: Multiple hepatic cytochrome P450 isozymes are involved in the oxidative biotransformation of a large number of structurally different drugs and endogenous compounds. The available knowledge of the relationship of fluvoxamine and the CYP450 enzyme system has been obtained mostly from pharmacokinetic interaction studies conducted in healthy volunteers, preliminary *in vitro* data are also available. Based on a listing of substantial interactions of fluvoxamine with certain of these drugs (see later parts of this section), **WARNINGS for details) and listed in also data for the B4 isoenzyme, it appears that fluvoxamine inhibits the following isoenzymes that are known to be involved in the clearance of the listed drugs: 3A2 - Warfarin, Theophylline, Propafenone, ICY - Venlafaxine, B4 - Alprazolam. *In vitro* data suggest that fluvoxamine is a relatively weak inhibitor of the B6 isoenzyme. None of the drugs studied for drug interactions significantly affected the pharmacokinetics of fluvoxamine. However, the metabolism of fluvoxamine has not been fully characterized and the effects of potent inhibitors of B6, such as quinolone, or of B4A such as tricyclic antidepressants, on fluvoxamine metabolism have not been studied. A clinically significant fluvoxamine interaction is possible with drugs having a narrow therapeutic ratio such as terfenadine or astemizole, warfarin, theophylline, diazepam and phenytoin. If LUVOX Tablets are to be administered together with a drug that is eliminated via oxidative metabolism and has a narrow therapeutic dose, plasma levels and/or pharmacodynamic effects of the latter drug should be monitored closely, at least until steady-state conditions are reached. (See WARNINGS - Active Drug: Fluvoxamine Maleate Inhibitor. See WARNINGS - Alprazolam. See WARNINGS - Diazepam. See WARNINGS - General. See WARNINGS - Laboratory Tests.) On average, both terfenadine alone and terfenadine with fluvoxamine produced substantial decrements in cognitive functioning; however, the co-administration of fluvoxamine and terfenadine did not produce larger decrements compared to terfenadine alone. **Alcohol:** As with other serotonergic drugs, alcohol may enhance the effects of fluvoxamine and, therefore, the combination should be used with caution. **Serotonin:** There have been reports with the co-administration of fluvoxamine maleate and **Agitation:** Agitation may enhance the serotonergic effects of fluvoxamine, and the combination should, therefore, be used with caution. **Serious warning reported with the co-administration of fluvoxamine maleate and typhloquin:** Co-administration of fluvoxamine maleate and typhloquin has been reported in patients taking fluvoxamine and diazepam. **Serious drug-drug interaction:** Patients should be closely monitored when fluvoxamine maleate and diazepam are used concomitantly. **Alcohol:** Steady state 40 mg doses of alcohol (and administration in one study and intravenous in the other) and multiple dosing with fluvoxamine maleate (50 mg bid) resulted in a 40% increase in the pharmacokinetics of the other. **Tricyclic Antidepressants (TCA):** Significantly increased plasma TCA levels have been reported with the co-administration of fluvoxamine maleate and amitriptyline, nortriptyline, or imipramine. Caution is indicated with the co-administration of LUVOX Tablets and **Clozapine:** Elevated clozapine plasma levels and symptoms of toxicity have been reported with the co-administration of fluvoxamine maleate and clozapine. **Mefenorex:** Significantly increased methadone plasma levels (and also) have been reported when fluvoxamine maleate was administered to patients receiving oral methadone treatment, with symptoms of opioid intoxication in one patient. **Opioid withdrawal symptoms:** were reported following fluvoxamine maleate discontinuation in one patient. **Other Drugs:** **Theophylline:** See WARNINGS. **Propafenone and Other Antiarrhythmics:** Co-administration of fluvoxamine maleate 100 mg per day (n=12) in normal volunteers resulted in a mean free-half increase (range 2 to 17) in minimum propafenone plasma concentrations. In this study, a slight potentiation of the propafenone-induced reduction in heart rate and reduction in the average diastolic pressure. The case of bradycardia and hypotension and case of orthostatic hypotension have been reported with the co-administration of fluvoxamine and metoprolol. If propafenone or metoprolol is co-administered with LUVOX Tablets, a reduction in the initial beta-blocker dose and/or maintenance dose should be considered. **Warfarin:** See WARNINGS. **Diazepam:** Administration of fluvoxamine maleate 100 mg for 14 days (n=4) did not significantly affect the pharmacokinetics of a 1.25 mg single intravenous dose of diazepam. **Diazepam:** Body fluids has been reported with administration of fluvoxamine maleate and diazepam. **Effects of Smoking on Fluvoxamine Metabolism:** Smokers had a 25% increase in the metabolic clearance compared to non-smokers. **Electroconvulsive Therapy (ECT):** There are no clinical studies establishing the benefits or risks of combined use of fluvoxamine maleate.**

Cardiogenesis, Mutagenesis, Impairment of Fertility

Cardiogenesis: There is no evidence of cardiotoxicity, mutagenicity or impairment of fertility with fluvoxamine maleate. **Cardiogenesis:** There was no evidence of cardiotoxicity in rats treated orally with fluvoxamine maleate for 30 months or hamsters treated orally with fluvoxamine maleate (female) or 24 (male) months. The daily doses in the high dose groups in these studies were increased over the course of the study from a minimum of 1/6 to a maximum of 240 mg/kg in rats, and from a minimum of 135 mg/kg to a maximum of 740 mg/kg in hamsters. The maximum dose of 240 mg/kg (equivalent to 4 times the maximum human daily dose on a mg/m² basis). **Mutagenesis:** No evidence of mutagenic potential was observed in a mouse micronucleus test, an *in vitro* chromosome aberration test, or the Ames microbial mutagen test with or without metabolic activation. **Impairment of Fertility:** In fer-

Psychiatrists Debate Precision of Geriatric Psychiatry

Does geriatric psychiatry medicalize normal conditions of aging?

Geriatric psychiatry made news in the April edition of *Atlantic Monthly* and in a controversial discussion of the subject by psychiatrist Keith Ablow, M.D., who writes a regular column for the *Washington Post*.

The *Atlantic Monthly* article, "Overselling Depression to the Old Folks," and Ablow's piece in the March 7 edition of the *Washington Post*, "Forcing Elderly Patients to Face Reality: Some Psychiatric Treatment May Not Be in the Best Interest of the Patient," both question the growth of a field that treats as disease certain conditions long considered endemic to the aging process.

Ablow, who is acting medical director of Heritage Health Systems in Somerville, Mass., also asserted that growth in the field of geriatric psychiatry stems, in part, from economic incentives related to the fact that Medicare does not manage reimbursement for clinical services as strictly as do private insurers.

To geriatric psychiatrists such as Ira Katz, M.D., of the section on geriatric psychiatry at the University of Pennsylvania, the two articles are glaring and disturbing evidence of a lack of familiarity with advances made in recognizing and treating psychiatric illness in the elderly.

"The reason for the recent growth of interest in the field of geriatric psychiatry is the aging of our population together with increasing research evidence that psychiatric treatment of older adults is effective," Katz wrote in a letter to the editor responding to Ablow's article.

"For example, findings from ongoing NIMH-supported Clinical Research Centers at the University of Pittsburgh, Duke University, and the University of Pennsylvania demonstrate that late-life depression is a treatable illness that amplifies the pain, disability, and health care costs associated with other general medical conditions that are common in the elderly. Moreover, findings from NIMH-supported research at New York University demonstrate that mental health services that support caregivers of patients with Alzheimer's disease can significantly delay the need for nursing home placement."

Katz's letter was joined by a letter to the editor from APA Medical Director Melvin Sabshin, M.D., who also refuted Ablow's comments.

"The baseless assertion that the primary motivation for innovation in geriatric psychiatry research and treatment is financial is completely contradicted by Medicare's miserably low payment for 45-50 minutes of a psychiatrist's face-to-face time," wrote Sabshin. "... If anything, Medicare and Medicaid payment rules should be seen as a disincentive to provide medically necessary care."

But to Ablow, who extended his criticisms in an interview with *Psychiatric News*,

See "Geriatric Psychiatry," page 18

Resignation

Kenneth R. Jones, M.D., of Victorville, Calif., resigned from the American Psychiatric Association, the California Psychiatric Association, and the Southern California Psychiatric Society during the course of an ethics investigation.

New
LUVOX™
fluvoxamine maleate 50 mg & 100 mg COATED TABLETS

TARGETED TREATMENT FOR OBSESSIONS AND COMPULSIONS THAT IMPRISON PATIENTS' MINDS

PROVEN EFFECTIVE IN IMPROVING OCD SYMPTOMS¹

- LUVOX™ Tablets produced significantly greater improvement than placebo in two 10-week, double-blind, multicenter studies in patients with moderate to severe OCD.¹ Effectiveness not established beyond 10 weeks in controlled trials.

RAPIDLY ACHIEVES STEADY-STATE BLOOD LEVELS...SHORT HALF-LIFE¹

	LUVOX™ Tablets ¹	Anafranil®2**	Prozac®3,4†
Drug class	SSRI	Tricyclic	SSRI
Active metabolite	None known	Yes	Yes
Half-life			
Parent compound	15.6 hours	32 hours	4-6 days
Active metabolite	—	69 hours	4-16 days
Time to steady-state plasma concentration	7 days	7-14 days	30 days
Protein binding	80%	97%	94.5%

In vitro activity does not necessarily imply clinical effect.

FAVORABLE SAFETY PROFILE

- Low incidence of agitation (2% vs 1% for placebo)¹
- No clinically significant changes in ECG or blood pressure.¹ (Not studied in patients with myocardial infarction or unstable heart disease.)
- The most commonly observed adverse events likely to be drug-related, compared to placebo, were somnolence 22% vs 8%, insomnia 21% vs 10%, nervousness 12% vs 5%, nausea 40% vs 14%, abnormal ejaculation 8% vs 1%, asthenia 14% vs 6%, dry mouth 14% vs 10%, dizziness 11% vs 6%, constipation 10% vs 8%.¹
- Concomitant use of LUVOX™ Tablets and monoamine oxidase inhibitors is not recommended.¹

Please see brief summary of prescribing information below.

* Anafranil (clomipramine HCl) is a registered trademark of Basell Pharmaceuticals, Division of CIBA-GEIGY Corporation.
† Prozac (fluoxetine HCl) is a registered trademark of Dista Products Company, Division of Eli Lilly and Company.

made and female rats, up to 80 mg/kg/day orally of fluvoxamine maleate, approximately 2 times the maximum human daily dose on a mg/m² basis) had no effect on mating performance, duration of gestation, or pregnancy rate.

Toxicity - **Pre-treatment Category C:** In toxicity studies in rats and rabbits, daily oral doses of fluvoxamine maleate of up to 80 and 40 mg/kg, respectively (approximately 2 times the maximum human daily dose on a mg/m² basis) caused no fetal malformations. However, in other reproduction studies in which pregnant rats were dosed through weaning there was (1) an increase in pup mortality of both sexes at 80 mg/kg and above but not at 20 mg/kg, and (2) decreases in postnatal weights (seen at 160 but not at 80 mg/kg) and survival (seen at all doses; lowest dose tested - 5 mg/kg). (Doses of 5, 20, 80, and 160 mg/kg are approximately 1/5, 2, and 4 times the maximum human daily dose on a mg/m² basis.) While the results of a crossfostering study implied that at least some of these results likely are secondary to maternal toxicity, the role of a direct drug effect on the fetuses or pups could not be ruled out. There are no adequate and well-controlled studies in pregnant women. Fluvoxamine maleate should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Lactation and Delivery: Effect of fluvoxamine on lactation and delivery in humans is unknown.

Drug Interactions: In many other drugs, fluvoxamine is secreted in human breast milk. The decision of whether to discontinue nursing or to discontinue the drug should take into account the risk for serious adverse effects from exposure to fluvoxamine in the nursing infant as well as the potential benefits of LUVOX™ Tablets therapy to the mother.

Contraindications: Concomitant use of LUVOX Tablets in individuals below 18 years of age have not been established.

Warnings: In many other drugs, fluvoxamine is secreted in human breast milk. The decision of whether to discontinue nursing or to discontinue the drug should take into account the risk for serious adverse effects from exposure to fluvoxamine in the nursing infant as well as the potential benefits of LUVOX™ Tablets therapy to the mother.

Adverse Reactions: In many other drugs, fluvoxamine is secreted in human breast milk. The decision of whether to discontinue nursing or to discontinue the drug should take into account the risk for serious adverse effects from exposure to fluvoxamine in the nursing infant as well as the potential benefits of LUVOX™ Tablets therapy to the mother.

Controlled Trials: In many other drugs, fluvoxamine is secreted in human breast milk. The decision of whether to discontinue nursing or to discontinue the drug should take into account the risk for serious adverse effects from exposure to fluvoxamine in the nursing infant as well as the potential benefits of LUVOX™ Tablets therapy to the mother.

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16 vs. 2%; Vomiting (5 vs. 2); Flatulence (4 vs. 3); Tooth Disorder (3 vs. 1); Dysphagia (2 vs. 1). **NERVOUS SYSTEM:** Somnolence (22 vs. 8); Insomnia (21 vs. 10); Dry Mouth (14 vs. 10); Nervousness (12 vs. 5); Dizziness (11 vs. 6); Inertia (5 vs. 1); Anxiety (5 vs. 3); Vasodilatation* (3 vs. 1); Hypertonic (2 vs. 1); Agitation (2 vs. 1); Increased Libido (2 vs. 1); Depression (2 vs. 1); CNS Stimulation (2 vs. 1). **RESPIRATORY SYSTEM:** Upper Respiratory Infection (9 vs. 5); Dyspnea (2 vs. 1); Toux (2 vs. 0). **SKIN:** Sweating (7 vs. 3). **SPECIAL SENSES:** Taste Perversion (3 vs. 1); Amblyopia* (3 vs. 2). **UROGENITAL:** Abnormal Ejaculation* (8 vs. 1); Urinary Frequency (3 vs. 2); Impotence* (2 vs. 1); Anorgasmia (2 vs. 0); Urinary Incontinence (1 vs. 0).

* Events for which fluvoxamine maleate incidence was equal to or less than placebo are not listed in the table above, but include the following: abdominal pain, abnormal dreams, appetite increase, back pain, chest pain, constipation, dyspareunia, fever, infection, leg cramps, migraine, myalgia, pain, parosmia, pharyngitis, postural hypotension, pruritus, rash, rhinitis, throat and larynx. * Includes "hothotache," "sooth extraction and abscess," and "caries." * Mostly feeling warm, hot, or flushed. * Mostly "blurred vision." * Mostly "delayed ejaculation." * Incidence based on number of male patients.

Other Events Observed During the Pre-marketing Evaluation of LUVOX Tablets: During pre-marketing clinical trials conducted in North America and Europe, multiple doses of fluvoxamine maleate were administered for a combined total of 2737 patient exposures in patients suffering OCD or Major Depressive Disorder. Unwanted events associated with this exposure were recorded by clinical investigators using descriptive terminology of their own choosing. Consequently, it is not possible to provide a meaningful estimate of the proportion of individuals experiencing adverse events without first grouping similar types of unwanted events into a limited (i.e., rational) number of standardized event categories. In the tabulations which follow, a standard COSTART-based Dictionary terminology has been used to classify reported adverse events. If the COSTART term for an event was so general as to be uninformative, it was replaced with a more informative term. The frequencies presented, therefore, represent the proportion of the 2737 patient exposures to multiple doses of fluvoxamine maleate who experienced an event of the type cited on at least one occasion while receiving fluvoxamine maleate. All reported events are included in the list below, with the following exceptions: 1) those events already listed in Table 2, which tabulates incidence rates of common adverse experiences in placebo-controlled OCD and depression clinical trials, are included; 2) those events for which a drug cause was considered remote (i.e., respiratory, gastrointestinal carcinoma, herpes simplex, herpes zoster, application site reaction, and unintended pregnancy) are omitted; and 3) events which were reported in only one patient and judged to not be potentially serious are not included. It is important to emphasize that, although the events reported did occur during treatment with fluvoxamine maleate, a causal relationship to fluvoxamine maleate has not been established. Events are further classified within body system categories and enumerated in order of decreasing frequency using the following definitions: frequent adverse events are defined as those occurring on one or more occasions in at least 1/100 patients; infrequent adverse events are those occurring between 1/100 and 1/1000 patients; and rare adverse events are those occurring in less than 1/1000 patients. **Body as a Whole:** Frequent: accidental injury, edema; Infrequent: allergic reaction, neck pain, neck rigidity, overdose, photosensitivity reaction, suicide attempt; Rare: eye, pelvic pain, sudden death. **Cardiovascular System:** Frequent: hypertension, hypotension, syncope, tachycardia; Infrequent: angina pectoris, bradycardia, cerebrovascular disease, cold extremities, conduction delay, heart failure, myocardial infarction, palp, pulse irregular, ST segment changes; Rare: AV block, cerebrovascular accident, coronary artery disease, embolus, pericarditis, phlebitis, pulmonary infarction, supraventricular arrhythmias. **Digestive System:** Frequent: altered liver transaminase; Infrequent: colitis, eructation, esophagitis, gastritis, gastroenteritis, gastrointestinal hemorrhage, gastrointestinal ulcer, gingivitis, glossitis, hemorroids, melena, rectal hemorrhage, stomatitis; Rare: biliary pain, cholelithiasis, cholelithiasis, fecal incontinence, hemorrhoids, intestinal obstruction, jaundice. **Endocrine System:** Infrequent: hypothyroidism; Rare: galactorrhea. **Hemic and Lymphatic Systems:** Infrequent: anemia, ecchymosis, leukocytosis, lymphadenopathy, thrombocytopenia; Rare: leukopenia, purpura. **Metabolic and Nutritional Systems:** Frequent: edema, weight gain, weight loss; Infrequent: dehydration, hypercholesterolemia; Rare: diabetes mellitus, hypoglycemia, hypokalemia, hypophosphatemia, hypocalcemia, lactic acid dehydrogenase increased. **Musculoskeletal System:** Infrequent: arthralgia, arthritis, bursitis, generalized muscle spasm, myasthenia, tetanus contractus, tenosynovitis; Rare: arthrosis, myopathy, pathological fracture. **Nervous System:** Frequent: amnesia, apathy, hyperreflexia, hypokinesia, mood reaction, myoclonus, psychotic reaction; Infrequent: agoraphobia, akathisia, ataxia, CNS depression, delirium, delusion, depression, depersonalization, drug dependence, dyskinesia, dystonia, emotional lability, euphoria, extrapyramidal syndrome, gut unstylish, hallucinations, hemiparesis, hostility, hyperosmia, hyperostosis, hypochondria, hypotonia, incontinence, increased salivation, increased libido, nausea, paralysis, parosmia, reaction, phobia, psychosis, sleep disorder, stress, vertigo, vertigo; Rare: akinesia, coma, fibrillation, muscle atrophy, reflexes decreased, slurred speech, tremor, dystonia, torticollis, tremor, withdrawal syndrome. **Respiratory System:** Frequent: cough increased, sinusitis; Infrequent: asthma, bronchitis, epistaxis, hiccups, hyperventilation; Rare: apnea, congestion of upper airway, hemoptysis, laryngitis, laryngospasm, obstructive pulmonary disease, pneumonia. **Skin:** Infrequent: acne, alopecia, dry skin, urticaria, exfoliative dermatitis, furunculosis, seborrhea, skin discoloration, urticaria. **Special Senses:** Infrequent: accommodation abnormal, conjunctivitis, dryness, diplopia, dry eyes, ear pain, eye pain, mydriasis, otitis media, parosmia, photophobia, taste loss, visual field defect; Rare: corneal ulcer, retinal detachment. **Urogenital System:** Infrequent: anuria, breast pain, cystitis, delayed menstruation, dysuria, female lactation, hematuria, menorrhagia, metrorrhagia, nocturia, polyuria, premenstrual syndrome, urinary incontinence, urinary tract infection, urinary urgency, urethral impaction, vaginal hemorrhage, vaginitis; Rare: kidney calculus, hematuria, hematuria, hematuria. 1 Based on the number of female; 2 Based on the number of male.

Non-US Postmarketing Reports: Voluntary reports of adverse events in patients taking LUVOX Tablets that have been received since market introduction and are of unknown causal relationship to LUVOX Tablets are: toxic epidermal necrolysis, Stevens-Johnson syndrome, Heschl-Scheerlin purpura, larynx angioedema, pruritus, agranulocytosis, neutropenia, aplastic anemia, myofasciitis reaction, hypochondria, acute renal failure, and severe disease with fever when fluvoxamine was administered with antipsychotic medication.

CAUTION: Federal law prohibits dispensing without prescription.

2E1252 Rev 12/94

References: 1. Data on file, Solvay Pharmaceuticals. 2. PER® 476 rd. Montreal, NJ. Medical Economics Data, 1993:671-675. 3. Prozac prescribing information, 5/94. 4. Siles PE. Fluoxetine: a five-year review. *Chil Ther*. 1993;15:216-241.

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The Upjohn Company
Kalamazoo, MI 49001, USA

You're Invited to a Psychodynamic Party

Local Miami Charity to Benefit From Annual Meeting Party

Psychiatrists may have always marched to the beat of their own drummer, but now they can also dance to the beat of their own rock group.

The Psychodynamics—believed to be the world's only all-psychiatrist rock 'n' roll band—will be playing at APA's annual meeting on Tuesday, May 23, from 9 p.m. to mid-



night in the Fontaine Room of the Fontainebleau Hilton in Miami Beach. While admission is free, party goers are invited to make a donation to benefit the Miami Rescue Mission. This charitable organization provides food and other necessities to the homeless and poor in the Miami area.

The party—which has become a social staple at APA's annual meetings—is being partially funded by Solvay Pharmaceuticals. The Medical University of South Carolina, home to some of the band's members, is also underwriting some of the expenses.

The Psychodynamics was begun about five years ago, when Al Santos, M.D., and George Arana, M.D., at the Medical University of South Carolina, discovered that some of the psychiatry department's faculty had musical talent; some had even had earlier careers as professional musicians. The known musicians gathered with their equipment in Arana's basement and auditioned other interested psychiatrists to form the Psychodynamics.

That same basement was the scene for the band's early gigs, and after garnering enthusiastic response, it emerged to perform at Charleston charity events, university parties, and the Charleston-based Spoleto Arts Festival. The group went on to develop three solid hours of dance music and brought their show to APA's annual meetings in New Orleans, Washington, D.C., San Francisco, and Philadelphia.

"Much to our surprise," said Santos, "during the Philadelphia party a faculty member from the School of Music at the University of the Arts in Philadelphia was impressed with our commercial potential and helped us raise funds, rehearse, and record the first four cuts for an upcoming CD release. The proceeds from the CD will go to mental health charity organizations."

In addition to drummer Santos, the current members of the band are John Rob-

erts, M.D., who does the lead vocals; Bruce Lydiard, M.D., Ph.D., vocals and keyboards; Glenn Horres, M.D., vocals and bass guitar; Mark Beale, M.D., and James McKinney, M.D., electric guitar; Tim Brewerton, M.D., acoustic guitar; and Joseph Zealberg, M.D., percussion. Arana is the group's coproducer.

Some band members are on sabbatical, and Santos praised them for their energy and enthusiasm that led to the band's earlier success. They are Bryon Adinoff, Dave Nixon, Bert Hutto, Sue Pickrel, Robin Barrineau-Welsh, and Jill Afrin (all M.D.'s).

The Miami Rescue Mission will also receive any leftover food from APA functions at the annual meeting. APA participates in a national program called Network for the Needy, sponsored by the Professional Convention Management Association. As a member of this network, APA arranges for the untouched leftover food from all APA functions to be donated to local charities.



The Psychodynamics, the only all-psychiatrist rock 'n' roll band, will be playing at APA's annual meeting on Tuesday, May 23, from 9 p.m. to midnight in the Fontaine Room of the Fontainebleau Hilton in Miami Beach.

Early Career Members To Meet in Miami

APA's Committee of Early Career Psychiatrists will be hosting a forum, reception, and dinner for early career psychiatrists and graduate residents on Tuesday, May 23, from 6:30 p.m. to 9:30 p.m. at Victor's Restaurant in Miami Beach.

The restaurant is located at 2340 S.W. 32nd Avenue.

Early career psychiatrists—those who are under 40 years of age or are in the first five years of professional practice after residency training—are invited to share their questions and concerns with the committee and network with other early career psychiatrists.

This event is supported by an educational grant from Janssen Pharmaceutica.

FIRST LINE FOR DEPRESSION

EFFEXOR[®] Tablets
VENLAFAXINE HCl



A Serotonin and Norepinephrine Reuptake Inhibitor

"Investigations of the action mechanisms of antidepressants have provided support for the importance of [serotonin and norepinephrine] interactions in the pathophysiology of depression."

—reported in Kalus et al¹

Pharmacologic activity

Compound	Uptake Inhibition		Receptor Affinities		
	NE	5HT	Muscarinic	Histaminergic	Adrenergic
TCA ^s ^{2,3}	✓	✓*	✓	✓	✓
SSRI ^s ⁴		✓			
EFFEXOR ¹	✓	✓			

✓ = strong affinity.

NE = norepinephrine; 5HT = serotonin; TCA = tricyclic antidepressant; SSRI = selective serotonin reuptake inhibitor.

The clinical significance of these *in vitro* data is unknown.

*Serotonin reuptake inhibition varies among TCAs.

- Like SSRIs and TCAs, EFFEXOR is a weak inhibitor of dopamine reuptake
- As with SSRIs, anticholinergic-like side effects may occur with EFFEXOR
- EFFEXOR is a structurally novel antidepressant, and is chemically unrelated to any other available antidepressant⁵

New York Governor Criticized for Proposing Community MH Cuts

A budget proposal by New York Governor George Pataki to cut nearly \$50 million from state aid to community mental health programs has generated widespread criticism.

As a state senator in 1994, Pataki supported the mental health program that would be hardest hit by his new budget, a fact not overlooked by his critics. In its lead editorial for March 22, the *New York Times* accused Pataki of breaking a promise and engaging in "a fiscally expedient flip-flop."

The program at issue is the 1994 Community Reinvestment Act (CRA), which was designed to provide community alternatives to New York's extensive, costly, and outmoded network of psychiatric hospitals.

"The interesting thing about the Community Reinvestment Act is that it passed unanimously in both houses of the state legislature, something almost unheard of," observed D.J. Jaffe, a spokesperson

for the Alliance for the Mentally Ill of New York State and the New York City chapter of Friends and Advocates of the Mentally Ill.

Under CRA, money saved from mental hospital closures was slated for treatment and housing in the community. Some funding was starting to go to that purpose, said Jaffe, but would be sharply curtailed if the Governor's budget becomes law.

New York is highest nationwide on per capita spending for mental health, according to the National Association of State Mental Health Program Directors, a statistic that Pataki's supporters have noted in defense of the Governor's budget.

According to the New York State Office of Mental Health (OMH) fiscal 1995-96 budget summary released in February by then Acting Commissioner William Morris, Ph.D., the bulk of the proposed cuts would come in local aid reductions. The proposal was

slated to go into effect April 1 but at press time was running into trouble.

A high-ranking OMH official who agreed to comment only on condition of anonymity said the Pataki budget appears to undermine the intent of the CRA and could portend an alarming abandonment of com-

munity. The proposed reduction would certainly have an impact by decreasing available community resources and, if it represents the first of a series of further reductions in this critically important reinvestment process, is an alarming signal."

One of the harshest directives in the pro-

"The sad part of it is, the more they abandon community-based treatment, the more untreated people there are in the streets, and the more the communities resist community-based services."

munity alternatives to high-cost hospitalization.

"The reinvestment legislation was really a landmark piece of legislation that, for the first time, established a legal requirement that money freed up by deinstitutionalization follow the patient into the community," the official said. "It required for the first time that money be used to create alternative mental health resources in the

posed budget would cap Medicaid funding of inpatient care at 60 days a year regardless of need, said Jaffe. "They are cutting real programs in exchange for the myth of things to come," he asserted.

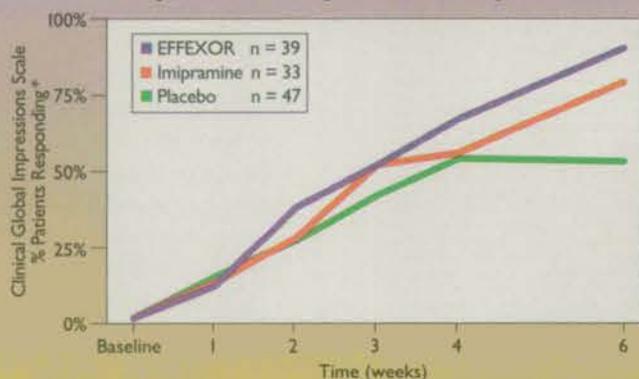
Pataki's defenders point to the state's \$3 billion budget deficit and contend he is merely facing harsh fiscal realities. They note that over the last two years expendi-

See "New York," page 18

EXPAND YOUR TREATMENT POSSIBILITIES

An effective first-line therapy for depressed patients

Response in depressed outpatients⁶



No significant difference between EFFEXOR and imipramine was observed. Significant difference ($P < 0.05$); venlafaxine and imipramine > placebo at week 6.

*Response to treatment was defined as CGI improvement score of 1 (very much improved) or 2 (much improved).

In one randomized, double-blind, placebo-controlled study of depressed patients initiated/maintained on venlafaxine or imipramine at 75 mg to 225 mg daily in divided doses (observed cases at week 6).⁶

The effectiveness of EFFEXOR in long-term use (>6 weeks) has not been systematically evaluated in controlled trials.

EFFEXOR is contraindicated in patients taking monoamine oxidase inhibitors (MAOIs). EFFEXOR should not be used in combination with an MAOI or within at least 14 days of discontinuing treatment with an MAOI because of potential for serious adverse reactions. Based on the half-life of EFFEXOR, at least 7 days should be allowed after stopping EFFEXOR before starting an MAOI.

Treatment with EFFEXOR is associated with sustained increases in blood pressure (BP) in some patients. These appear to be dose dependent and were seen at an incidence of >5% at dosages above 200 mg/day. Regular monitoring of BP is recommended.

As with any psychotropic drug, EFFEXOR may impair judgment, thinking, or motor skills, and patients should be advised to exercise caution until they have adapted to therapy.

The most common adverse events reported in EFFEXOR clinical trials (incidence >10% and $\geq 2x$ that of placebo) were: nausea, somnolence, dry mouth, dizziness, constipation, nervousness, sweating, asthenia, abnormal ejaculation/orgasm, and anorexia.¹

Please see brief summary of prescribing information on last page of this advertisement.

EFFEXOR[®] Tablets
VENLAFAXINE HCl
 25 mg, 37.5 mg, 50 mg, 75 mg, and 100 mg

APA 'Contract' Focuses on Rights of America's Children

Echoing the G.O.P.'s 10-point "Contract With America," APA's Board of Trustees voted in March to sign on to a 10-point "Contract With America's Children."

The contract focuses on defending the health and well-being of children. David Pruitt, M.D., who chairs the Council on Children, Adolescents, and Their Families, asked the Board to sign onto the council's contract. The text is below.

- 1. Children First:** We promise to consider children's needs and well-being first and foremost in evaluating health and welfare reforms, or any other national policy.
- 2. Healthy Children:** We promise to ensure that all children get the basics they need to grow up healthy.
- 3. Capable Children:** We promise all children the chance to realize their potential, and we expect all parents to join in the

promise by becoming active partners in their child's education.

- 4. Safe Children:** We promise to reduce the exposure of children to violence—on television, on our streets, and in our homes—and to educate the public about the risks of firearms.
- 5. Families Together:** We promise to support marriage, help families stay together, and help young people understand the responsibility of parenting.
- 6. Working Families:** We promise to help working families stay out of poverty.
- 7. Fair Chance:** We promise to support a family's efforts to get ahead by making sure that continuing education and job training are available to people of all means.
- 8. Value Youth:** We promise to provide young people with places to go and things to do that will help them become responsible members of our society.

EFFEXOR Tablets
VENLAFAXINE HCl
25 mg, 37.5 mg, 50 mg, 75 mg, and 100 mg

Brief Summary

See package insert for full prescribing information.

Clinical Pharmacology: The antidepressant action of venlafaxine is believed to be associated with potentiation of neurotransmitter activity in the CNS. In preclinical studies, venlafaxine and its active metabolite, O-desmethylvenlafaxine (ODV), were potent inhibitors of neuronal serotonin and norepinephrine reuptake and weak inhibitors of dopamine reuptake. Venlafaxine and ODV have no significant affinity for muscarinic, histaminergic, or α -1 adrenergic receptors *in vitro*. Pharmacologic activity at these receptors is hypothesized to be associated with the various anti-cholinergic, sedative, and cardiovascular effects seen with other psychotropic drugs. Venlafaxine and ODV do not possess monoamine oxidase (MAO) inhibitory activity.

Indications and Usage: Effexor is indicated for the treatment of depression. **Contraindications:** Contraindicated in patients with known hypersensitivity. Concomitant use in patients taking monoamine oxidase inhibitors (MAOIs) is contraindicated (see "Warnings"). **Warnings:** POTENTIAL FOR INTERACTION WITH MONOAMINE OXIDASE INHIBITORS (MAOIs)—Adverse reactions, some serious, have been reported when venlafaxine therapy is initiated soon after discontinuation of an MAOI and when an MAOI is initiated soon after discontinuation of venlafaxine. Reactions have included tremor, myoclonus, diaphoresis, nausea, vomiting, flushing, dizziness, hyperthermia with features resembling neuroleptic malignant syndrome, seizures, and death. Given these reactions as well as the serious, sometimes fatal interactions reported with concomitant or immediately consecutive administration of MAOIs and other antidepressants with pharmacological properties similar to Effexor, do not use Effexor in combination with an MAOI or within at least 14 days of discontinuing MAOI treatment. Allow at least 7 days after stopping Effexor before starting an MAOI. Hyperthermia, rigidity, myoclonus, autonomic instability, mental status changes including extreme agitation progressing to delirium and coma, and features resembling neuroleptic malignant syndrome have been reported with concomitant selective serotonin reuptake inhibitor/MAOI therapy. Severe hyperthermia and seizures, sometimes fatal, have been reported with concomitant tricyclic antidepressants/MAOI therapy.

SUSTAINED HYPERTENSION—Effexor treatment is associated with dose-related sustained increases in supine diastolic blood pressure. Regular monitoring of blood pressure is recommended, and, when appropriate, consider dose reduction or discontinuation. **Precautions:** GENERAL—Anxiety and Insomnia: Anxiety, nervousness, and insomnia have been reported in short-term studies. **Changes in Appetite/Weight:** Anorexia has been reported in short-term studies, and a dose-dependent weight loss has been reported in patients taking Effexor for several weeks. **Activation of Mania/Hypomania:** Hypomania or mania has been reported, as with all antidepressants, use cautiously in patients with a history of mania. **Seizures:** Seizures were reported in premarketing testing (0.26%). Use cautiously in patients with a history of seizures. Discontinue in any patient who develops seizures. **Suicide:** The possibility of suicide attempt is inherent in depression and may persist until significant remission occurs. Closely supervise high-risk patients during initial drug therapy. Write Effexor prescriptions for the smallest quantity consistent with good patient management to reduce risk of overdose.

Use in Patients with Concomitant Illness: Clinical experience with Effexor in patients with concomitant systemic illness is limited. Use cautiously in patients with diseases or conditions that could affect metabolism or hemodynamic responses. In patients with renal impairment (GFR=10-70 mL/min) or liver cirrhosis, clearance of venlafaxine and its active metabolite were decreased, resulting in prolonged elimination half-lives. A lower dose may be necessary; use with caution in such patients. **INFORMATION FOR PATIENTS—**Clinical studies revealed no clinically significant impairment of psychomotor, cognitive, or complex behavior performance. However, caution patients about operating hazardous machinery, including automobiles, until they are reasonably sure that Effexor does not adversely affect their ability to engage in such activities. Tell patients to 1) notify their physician if they become pregnant or intend to become pregnant during therapy, or if they are nursing; 2) inform physicians about other medications they are taking or plan to take; 3) avoid alcohol while taking Effexor; 4) notify their physicians if they develop a rash, hives, or related allergic phenomena. **DRUG INTERACTIONS—Cimetidine:** Use caution when administering Effexor with cimetidine to patients with pre-existing hypertension or hepatic dysfunction, and the elderly. **Drugs Inhibiting Cytochrome P₂U₂ Metabolism:** *In vitro*, venlafaxine is metabolized to its active metabolite, O-desmethylvenlafaxine (ODV), via cytochrome P₂U₂. Therefore drugs inhibiting this isoenzyme could potentially increase plasma concentrations of venlafaxine and decrease concentrations of ODV. **Drugs Metabolized by Cytochrome P₂U₂:** *In vitro*, venlafaxine is a relatively weak inhibitor of this isoenzyme; clinical significance is unknown. **Monoamine Oxidase Inhibitors:** See "Contraindications and Warnings." **CNS-Active Drugs:** Use of venlafaxine with CNS-active drugs has not been systematically evaluated; therefore, use caution when administering Effexor with such drugs.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY—Carcinogenesis: In 18-month studies, there was no evidence of carcinogenicity in mice given 120 mg/kg/day [16 times the maximum recommended human dose (MRHD)]. In 24-month studies, there was no evidence of carcinogenicity in rats given 120 mg/kg/day. **Mutagenicity:** In male rats receiving 200 times (on a mg/kg basis) the MRHD, chromosomal aberrations were found in the bone marrow *in vivo*. **Impairment of Fertility:** No impaired reproductive function was found in rats given 8 times (mg/kg) the MRHD. **PREGNANCY—Teratogenic Effects—Pregnancy Category C:** Reproduction studies in rats given 11 times, and rabbits given 12 times the MRHD (on a mg/kg basis) revealed no malformations of offspring. However, in rats given 10 times the MRHD, there was a decrease in pup weight, increase in stillborn pups, and an increase in pup deaths during the first 5 days of lactation when dosing began during pregnancy and continued until weaning. There are no adequate and well-controlled studies in pregnant women; use Effexor during pregnancy only if clearly needed. **LABOR, DELIVERY, NURSING—**The effect on labor and delivery in humans is unknown. It is also not known whether Effexor or its metabolites are excreted in human milk; exercise caution when administering to a nursing woman. **PEDIATRIC USE—**Safety and effectiveness in children (<18 years) have not been established. **GERIATRIC USE—**In clinical trials, 12% of Effexor-treated patients were \geq 65 years of age. Overall differences in efficacy or safety in the elderly have not been demonstrated, however, greater sensitivity of older patients should not be ruled out.

Adverse Reactions: ASSOCIATED WITH DISCONTINUATION OF TREATMENT—Nineteen percent (537/2897) of Effexor patients in clinical trials discontinued treatment due to an adverse event. The more common events (\geq 1% associated with discontinuation and considered to be drug-related) included: somnolence, insomnia, dizziness, nervousness, dry mouth, anxiety, nausea, abnormal ejaculation (male), headache, asthenia, and sweating. **INCIDENCE IN CONTROLLED TRIALS—Commonly Observed Adverse Events in Controlled Clinical Trials:** The most commonly observed adverse events associated with the use of Effexor (incidence of 5% or greater and incidence for Effexor at least twice that for placebo) are: asthenia (12% vs. 6%), sweating (12% vs. 3%), nausea (37% vs. 11%), constipation (15% vs. 7%), anorexia (11% vs. 2%), vomiting (6% vs. 2%), somnolence (23% vs. 9%), dry mouth (22% vs. 11%), dizziness (19% vs. 7%), nervousness (13% vs. 6%), anxiety (6% vs. 3%), tremor (5% vs. 1%), blurred vision (6% vs. 2%), abnormal ejaculation/orgasm male (12% vs. <1%), and male impotence (6% vs. <1%).

9. Community Responsibility: We promise to do our part in our own communities to support all children's healthy development.

10. Leadership Accountability: We promise to hold our elected leaders accountable for their responsibilities to safeguard the future of America's children.

CDF Statement

In a related action, the Board also approved signing onto a statement from the Children's Defense Fund (CDF), titled "Statement for Children."

Although the Board ultimately approved signing onto the statement, there was considerable controversy over what some members viewed as the statement's unrealistically idealistic nature.

The CDF has organized a coalition of child advocacy organizations to pressure legislators to consider the impact of current federal legislative proposals on children. At the time of the March Board meeting, the CDF was circulating the statement with the goal of getting 200 to 300 organizations to offer endorsements prior to sending a copy

to every governor and member of Congress.

The statement says, in part, that a safety net developed over 50 years to protect "young and other vulnerable Americans" is in jeopardy as a result of recent federal legislative action. A particularly controversial part of the statement criticized the concept of a balanced budget amendment, stating that approving such an amendment would be tantamount to abandoning the federal commitment to children and middle income and poor families with children. APA President Jerry Wiener, M.D., suggested that the balanced budget amendment, while problematic, represented a sober attempt to deal with a ballooning deficit and did not deserve blanket condemnation.

The CDF statement was finally approved with one Trustee opposing.

Board Votes to Continue Funding Capitation Study

The APA Board of Trustees voted last month to provide further funding for a study on capitation by the actuarial firm Milliman and Robertson, adding \$25,000 to a \$30,000 allocation the Board approved in December.

When the study is completed, "it will help our members to understand what they're buying when they sign on to a capitation agreement that can vary from 50 cents per patient per month to \$5 per patient per month," said former APA president Paul Jay Fink, M.D., who also chairs APA's Council on Economic Affairs.

HMO's make most of their profit in mental health services "by reducing the capitation in mental health to almost zero," Fink said. The completed Milliman and Robertson study will provide an important negotiating tool for psychiatrists confronting such unreasonable capitation schedules under managed care, Fink said.

APA's initial \$30,000 allocation covered development of capitation standards for the commercial market, excluding Medicaid and Medicare populations. The additional funding expands the study to the Medicaid and Medicare populations. The study will look at a model based on set payments per patient per month for various scenarios of service, explained APA Secretary Steven Sharfstein, M.D.

The criteria on which the firm is basing the study were determined by APA as those necessary for a satisfactory level of mental health services, said Fink. Some members had expressed concern about standards that Milliman and Robertson developed independently assuming extremely meager psychiatric benefits.

An interim summary of the data provided by Milliman and Robertson since the December meeting will be available shortly, said Fink.

New Psychoanalytic Postgraduate Program

The department of psychiatry and behavioral sciences at George Washington University Medical Center in Washington, D.C., is offering a two-year postgraduate program in psychoanalytic psychotherapy for psychiatrists.

The program, which begins in September, will offer advanced training in the theory and technique of psychoanalytic psychiatry and will include weekly seminars and weekly individual supervision.

Further information and applications are available by calling (202) 994-4081.

Adverse Events Occurring at an Incidence of 1% or More Among Effexor-Treated Patients: The following occurred in 4- to 8-week placebo-controlled trials, with doses of 75 to 375 mg/day, at a frequency of 1% or more. This includes patients with at least one episode of an event at some time during treatment. **Body as a Whole:** headache, asthenia, infection, chills, chest pain, trauma. **Cardiovascular:** vasodilatation, increased blood pressure/hypertension, tachycardia, postural hypotension. **Dermatological:** sweating, rash, pruritus. **Gastrointestinal:** nausea, constipation, anorexia, diarrhea, vomiting, dyspepsia, flatulence. **Metabolic:** weight loss. **Nervous System:** somnolence, dry mouth, dizziness, insomnia, nervousness, anxiety, tremor, abnormal dreams, hyperthermia, paresthesia, libido decreased, agitation, confusion, thinking abnormal, depersonalization, depression, urinary retention, twitching. **Respiration:** yawn. **Special Senses:** blurred vision, taste perversion, tinnitus, mydriasis. **Urogenital System:** abnormal ejaculation/orgasm, impotence, urinary frequency, urination impaired, orgasm disturbance, menstrual disorder. Studies indicate a dose dependency for some of the more common adverse events associated with Effexor use. There also was evidence of adaptation to some adverse events with continued Effexor therapy over a 6-week period.

Vital Sign Changes: In clinical trials, Effexor was associated with a mean increase in pulse rate of about 3 beats/min; and a dose-dependent increase in mean diastolic blood pressure of 0.7 to 2.5 mmHg.

Laboratory Changes: During clinical trials, only serum cholesterol exhibited statistically significant differences from placebo (increases of 3 mg/dL from baseline); clinical significance is unknown. **ECG Changes:** Only heart rate exhibited a statistically significant difference, with mean increases of 4 beats per minute from baseline.

OTHER EVENTS OBSERVED DURING THE PREMARKETING EVALUATION OF EFFEXOR—During premarketing assessment, multiple doses of Effexor were administered to 2,181 patients, and the following adverse events were reported. Note: "frequent" = events occurring in at least 1/100 patients; "infrequent" = 1/100 to 1/1,000 patients; "rare" = less than 1/1,000 patients. Events are classified within body system categories and enumerated in order of decreasing frequency using the definitions above. It is important to emphasize that although the events occurred during Effexor treatment, they were not necessarily caused by it.

Body as a Whole - Frequent: accidental injury, malaise, neck pain; **Infrequent:** abdomen enlarged, allergic reaction, cyst, face edema, generalized edema, hangover effect, hernia, intentional injury, moniliasis, neck rigidity, overdose, chest pain substernal, pelvic pain, photosensitivity reaction, suicide attempt; **Rare:** appendicitis, body odor, carcinoma, cellulitis, halitosis, ulcer, withdrawal syndrome. **Cardiovascular system - Frequent:** migraine; **Infrequent:** angina pectoris, extrasystoles, hypotension, peripheral vascular disorder (mainly cold feet and/or cold hands), syncope, thrombophlebitis; **Rare:** arrhythmia, first-degree atrioventricular block, bradycardia, bundle branch block, mitral valve disorder, mucocutaneous hemorrhage, sinus bradycardia, varicose vein. **Digestive system - Frequent:** dysphagia, eructation; **Infrequent:** colitis, tongue edema, esophagitis, gastritis, gastroenteritis, gingivitis, glossitis, rectal hemorrhage, hemorrhoids, melena, stomatitis, stomach ulcer, mouth ulceration; **Rare:** cheilitis, cholecystitis, cholelithiasis, hematemesis, gum hemorrhage, hepatitis, ileitis, jaundice, oral moniliasis, intestinal obstruction, proctitis, increased salivation, soft stools, tongue discoloration, esophageal ulcer, peptic ulcer syndrome. **Endocrine system - Rare:** goiter, hyperthyroidism, hypothyroidism. **Hemic and lymphatic system - Frequent:** ecchymosis; **Infrequent:** anemia, leukocytosis, leukopenia, lymphadenopathy, lymphocytosis, thrombocytopenia, thrombocytopenia, WBC abnormal; **Rare:** basophilia, cyanosis, eosinophilia, erythrocytes abnormal. **Metabolic and nutritional - Frequent:** peripheral edema, weight gain; **Infrequent:** alkaline phosphatase increased, creatinine increased, diabetes mellitus, edema, glycosuria, hypercholesterolemia, hyperglycemia, hyperlipemia, hyperuricemia, hypoglycemia, hypokalemia, SGOT increased, thirst; **Rare:** alcohol intolerance, bilirubinemia, BUN increased, gout, hemochromatosis, hyperkalemia, hyperphosphatemia, hypoglycemic reaction, hyponatremia, hypophosphatemia, hypoproteinemia, SGPT increased, uremia.

Musculoskeletal system - Infrequent: arthritis, arthrosis, bone pain, bone spurs, bursitis, joint disorder, myasthenia, tenosynovitis; **Rare:** osteoporosis. **Nervous system - Frequent:** emotional lability, trismus, vertigo; **Infrequent:** apathy, ataxia, circumoral paresthesia, CNS stimulation, euphoria, hallucinations, hostility, hyperesthesia, hyperkinesia, hypertonia, hypotonia, incoordination, libido increased, myoclonus, neuralgia, neuropathy, paranoid reaction, psychosis, psychotic depression, sleep disturbance, abnormal speech, stupor, torticollis; **Rare:** akathisia, akinesia, alcohol abuse, aphasia, bradykinesia, cerebrovascular accident, loss of consciousness, delusions, dementia, dystonia, hypokinesia, neuritis, nystagmus, reflexes increased. **Respiratory system - Frequent:** bronchitis, dyspnea; **Infrequent:** asthma, chest congestion, epistaxis, hyperventilation, laryngismus, laryngitis, pneumonia, voice alteration; **Rare:** atelectasis, hemoptysis, hypoxia, pleurisy, pulmonary embolus, sleep apnea, sputum increased. **Skin and appendages - Frequent:** acne, alopecia, brittle nails, contact dermatitis, dry skin, herpes simplex, herpes zoster, maculopapular rash, urticaria; **Rare:** skin atrophy, exfoliative dermatitis, fungal dermatitis, lichenoid dermatitis, hair discoloration, eczema, furunculosis, hirsutism, skin hyper trophy, leukoderma, psoriasis, pustular rash, vesiculobullous rash. **Special senses - Frequent:** abnormal vision, ear pain; **Infrequent:** cataract, conjunctivitis, corneal lesion, diplopia, dry eyes, exophthalmos, eye pain, otitis media, parosmia, photophobia, subconjunctival hemorrhage, taste loss, visual field defect; **Rare:** blepharitis, chromatopsia, conjunctival edema, deafness, glaucoma, hyperacusis, keratitis, labyrinthitis, miosis, papilledema, decreased pupillary reflex, scleritis. **Urogenital system - Frequent:** anorgasmia, dysuria, hematuria, metrorrhagia; **Infrequent:** amenorrhea, kidney calculus, cystitis, leukorrhea, menorrhagia, nocturia, bladder pain, breast pain, kidney pain, polyuria, prostatitis, pyelonephritis, pyuria, urinary incontinence, urinary urgency, uterine fibroids enlarged; **Rare:** uterine hemorrhage, vaginal hemorrhage, vaginal moniliasis; **Rare:** abortion, breast engorgement, breast enlargement, calcium crystalluria, female lactation, hypomenorrhea, menopause, prolonged erection, uterine spasm* (*Based on the number of male or female patients as appropriate).

Drug Abuse and Dependence: CONTROLLED SUBSTANCE CLASS—Effexor is not a controlled substance. In a retrospective survey of new events occurring during taper or following discontinuation, the following occurred at an incidence of \geq 5%, with incidence for Effexor at least twice that for placebo: asthenia, dizziness, headache, insomnia, nausea, and nervousness. Taper the dose gradually and monitor the patient. Evaluate patients carefully for history of drug abuse and observe such patients closely for signs of Effexor misuse or abuse (e.g. development of tolerance, increments of dose, drug-seeking behavior).

Dosage and Administration: The recommended starting dose is 75mg/day in 2 or 3 divided doses, taken with food. If needed, dose increments of up to 75mg/day should be made at intervals of no less than 4 days. Maximum recommended dose, for use in severely depressed patients, is 375mg/day, in 3 divided doses. When discontinuing Effexor after more than 1 week of therapy, the dose should be tapered to minimize the risk of discontinuation symptoms.

SWITCHING PATIENTS TO OR FROM A MONOAMINE OXIDASE INHIBITOR At least 14 days should elapse between discontinuation of an MAOI and initiation of therapy with Effexor. In addition, at least 7 days should be allowed after stopping Effexor before starting an MAOI (see "Contraindications" and "Warnings"). Please consult full prescribing information for detailed dosing instructions.

This brief summary is based on CI 4193-2, issued May 23, 1994.

References: 1. Kalus D, Asnis GM, van Praag HM. The role of serotonin in depression. *Psychiatric Annals*. 1989;19:348-353. 2. Preskorn SH, Burke M. Somatic therapy for major depressive disorder: selection of an antidepressant. *J Clin Psychiatry*. 1992;53(suppl):5-18. 3. Richelson E. Synaptic pharmacology of antidepressants: an update. *McLean Hosp J*. 1988;8:67-88. 4. *Physicians' Desk Reference*. 48th ed. Montvale, NJ: Medical Economics Co Inc; 1994. Prozac® 877-880; Zoloft® 2000-2003; Paxil® 2267-2270. 5. EFFEXOR® prescribing information, Wyeth-Ayerst Laboratories, Philadelphia, PA. 6. Data on file, Wyeth-Ayerst Laboratories.



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August 1994

Philadelphia Psychiatrists Want Their Freedom

By Mark Moran

Progressive Health Solutions is an endeavor by two Philadelphia psychiatrists to take managed care back from the managed care companies and do it right.

The failure of political efforts at national health system reform last year has made clear what some policy analysts have been saying all along: that the driving force behind changes in the health care delivery system is the marketplace.

It is the marketplace—where an ever-increasing demand for medical and health services is met by the diminishing ability or willingness of employers and insurance companies to pay for those services—that is causing the private practice of medicine to give way to larger organized structures. Those structures demand uniformity at the expense of autonomy, but promise to deliver quality with more efficient use of resources.

Can psychiatry adapt to this 21st century vision of group practice in organized systems of care?

Two Philadelphia psychiatrists, Richard Sobel, M.D., and Fred Baurer, M.D., are betting that it can—or at least that the profession has no choice but to try.

Like a number of psychiatrists in every region of the country, Sobel and Baurer have begun the effort to take back their practices from intrusive managed care companies by forming their own provider-owned mental health network.

Progressive Health Solutions—owned by Sobel and Baurer, six psychologists, and two social workers—will offer a full continuum of mental health and substance abuse services to populations throughout the five counties of greater Philadelphia and the Delaware Valley.

It is a venture, they say, in trying to take managed care away from the managed care companies and do it right.

PROFILES in practice

"We are 10 mental health providers who came together last year with the same concerns as we watched the HMO penetration in Philadelphia grow about as fast as anywhere in the country," Sobel told *Psychiatric News*. "Our choice seemed to be either to play catch up and try to get on provider panels and watch ever-decreasing fees, or try to form our own anchor group for larger managed care organizations and try to get contracts with local industry."

Negotiations with those managed care companies and local employers are ongoing. The group was negotiating with several managed care companies when *Psychiatric News* went to press, and Sobel said he believes that Progressive Health Solutions will be up and running before the year is out.

The group has already recruited a network of about 100 providers throughout the area, Sobel said, including 12 psychiatrists.

Baurer emphasized that the organization is an experiment to take on the task of managed care with a clinician's eye to quality, in place of the corporate eye to the bottom line.

"I'm not opposed to the idea that care can be managed," he said, "but I'm very much opposed to the way it is being done across the board, with a heavily corporate model. This group provides an experiment to see if [managing mental health services] can be done right."

"I think as clinicians we are in a much better position to try to take the task on with the objective of providing quality, because as clinicians we know what quality is," Baurer said.

"One of the things that is very important to me about this is that rather than feeling like an employee of a managed care company, what we are trying to do is take charge of the

situation," he said.

Sobel said the group will be pursuing both fee-for-service and capitated arrangements, although he added that as a start-up group, the owners have been advised to enter into capitation cautiously.

Hurdles of Capitation

The ability to manage costs within a budget, as in capitation, requires that a provider organization have a good idea of what its costs will be—something that can be difficult for a new organization.

"Until you have your system in place, capitation can be tricky," Sobel said. "You can't even estimate what your costs will be, so we have been advised to stick with fee-for-service initially."

But Sobel said the group's first priority will be to aim high for quality, not low for cost savings.

"We are trying to position ourselves for what we think will be a backlash against the 'Therapy 'R' Us' or 'McTherapy' trends," Sobel said. "We are a clinician group, so our bottom line is quality. . . . We may not always be the cheapest care, but we recognize the need to be cost-conscious."

Sobel and Baurer said they believe that they can persuade employers that higher quality care will be a better value in the long run.

Sobel said, "We want to be able to say to employers: 'You can hire bachelor-degree therapists, but do your employees really benefit? Are your employees really getting better with five visits or less?'"

"In the short run you can save money," Sobel said, but only at the expense of long-term value.

Sobel said Progressive Health Solutions will offer inpatient, outpatient, substance abuse, employee assistance, and worker's compensation services, while performing all quality

assurance and utilization review.

He also said he foresees the time when the organization will offer in-home services. "This is a wide open area," he noted. "It is a service for people with psychiatric illness but who for various reasons cannot get to their appointment, or where the major problem is what is happening in the home."

Both Sobel and Baurer say that this new model of care is no minor shift of wind and weather around of the furniture, but a veritable sea change in priorities as well as a significant upheaval in their own professional lives.

"It requires a real change in orientation," Baurer said. "There has always been a business side to practice, but to think about what employers are looking for and to think about how to market services require a whole new mindset and new skills."

"One of the things that I and other clinicians have to overcome is the idea that business is somehow tainted, that it denigrates our identity as clinicians," he added. "You have to take responsibility for asking the hard questions about cost-efficiency and what kind of care is necessary. . . . You can't blame someone else if you take responsibility for utilization review."

Whole New World

Each of the 10 owners has logged a lot of what Sobel calls "sweat equity."

This has meant expenditures of time, attending conferences to learn the ropes of administering an organized system of care, and negotiating with attorneys, consultants, and accountants.

It has also meant an investment of personal money to cover start-up costs.

It is a "hard transition," Sobel said, involving a lot of growing pains. And it is one that may be especially difficult for psychiatrists.

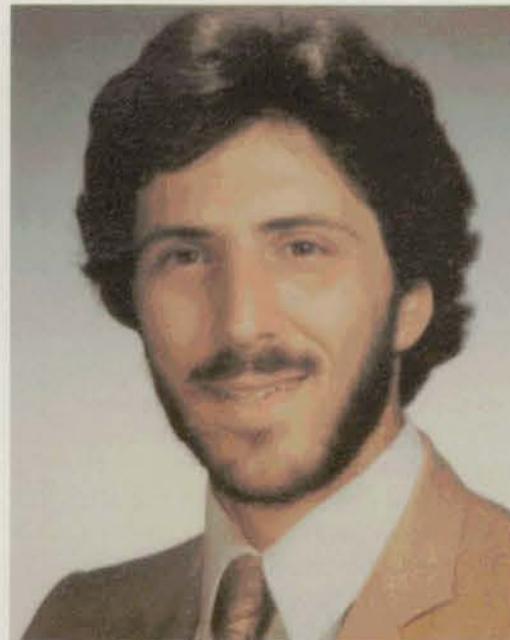
"People in our profession aren't trained with the idea of working in partnerships," he said. "You come into the field with certain expectations about what your professional life will be like, and then you have to change them."

See "Profiles," page 29



"I'm not opposed to the idea that care can be managed, but I'm very much opposed to the way it is being done across the board, with a heavily corporate model."

—Richard Sobel, M.D.



"I think as clinicians we are in a much better position to try to take the task on with the objective of providing quality, because as clinicians we know what quality is."

—Fred Baurer, M.D.

Board Approves Member Vote To Change Referendum Process

The Board of Trustees voted in March to approve an amendment to the APA Bylaws for presentation to the membership to alter rules that allow members to force an immediate referendum by a vote at the Annual Forum session of the Business Meeting.

The Business Meeting is held each year at the annual meeting.

The action to amend Chapter 12.2 of the Bylaws was the aftermath of an unsuccessful effort at last year's Business Meeting in Philadelphia to have APA hold an immediate referendum on the Association's abortion policy. Although the action failed, the Board of Trustees was concerned at the potential cost of such a special referendum, which would require printing and mailing ballots to all APA voting members.

The proposed amendment would require a vote on the next annual ballot in conjunction with APA's election.

The new provision reads: "Proposals about the affairs of the Association, and any old or new business, may be introduced and voted on by a two-thirds majority of the voting members present except to reverse an action of the Board or Assembly. To reverse an action of the Board or Assembly, a two-thirds majority of the voting members may call for a vote on the next annual ballot, and this shall require a mail ballot to be circu-

lated and reported prior to the fall meeting of the Assembly. In matters other than a Board or Assembly action, a simple majority of voting members present may initiate the referendum process as described in Chapter Seven, Section 6, of these Bylaws."

The proposed amendment must now be read and circulated at the Business Meeting to be held at the annual meeting later this month in Miami and will be placed on the 1996 APA ballot for a vote.

In other action, the Board

- voted to authorize APAs working with the American Academy of Child and Adolescent Psychiatry (AACAP) on membership recruitment. This pilot project would permit APA members to join AACAP for the first year for half the annual dues, and would permit AACAP members to join APA for the first year for half the annual dues, not applying to district branch dues. The offer would not apply to residents.

- voted to authorize APA membership in the National Leadership Coalition on AIDS. This action ratified an executive action taken by the president, speaker, and medical director to authorize APA membership in the coalition at a cost of \$500 a year in dues.

- voted to authorize the Office of Research to seek outside funding through the New York State Psychiatric Association for a grant from the New York State Department of Health. This action ratified an executive action taken by the president, speaker, and medical director for a project titled "Improving Quality of Care for Depression Through Clinical Practice Guidelines: A Patient and Clinician Targeted Approach."

- voted to change the way in which appointments and reappointments are made to the Board of Directors of the American Psychiatric Press Inc. (APPI). The changes had been proposed at the APPI board's last meeting in February. They permit the APA Board of Trustees to select a director from one of two nominees presented by APPI, although a sitting director eligible for reappointment may be presented as the only nominee. The APA Board of Trustees will

choose the APPI directors, when needed, at the Board of Trustees' spring meeting with the appointments effective until the close of the APA annual meeting the same year.

APA Library Director Takes New Post

APA Library and Archives Director William E. Baxter left APA May 5 to accept an appointment as head of special collections at the Smithsonian Institution in Washington, D.C.

In his more than a decade on the staff of the APA Library and Archives, six years of which he served as director, Baxter presided over the computerization of APA's archives and library services. Using private contributions, he established the Garfield and Helen W. Tourney Rare Books Room in March 1994. He also played a central role in organizing APA's 1994 sesquicentennial celebration.

In his new post he will be the chief librarian of the Smithsonian's collection of 40,000 rare books and manuscripts.

Position Statement Still in Works

APA's Board of Trustees voted in March to continue development of two draft papers on the Association's evolving position on psychotherapy.

Drafts of the papers were presented to the Board by Assembly Speaker Norman Clemens, M.D., on behalf of the Committee on the Practice of Psychotherapy. The Board voted to "receive" the drafts as "a work in progress for further consideration by the components of the Association."

The Board had asked Clemens to further refine an earlier position paper he circulated at the December Board meeting. At that time the Board voted to refer Clemens's paper to the Committee on the Practice of Psychotherapy, the Joint Reference Committee, and the Assembly Executive Committee.

Clemens said he had expected the position papers to serve as internal resource documents for members, not as an official position statement for general use.

But others, such as former APA president Paul Jay Fink, M.D., suggested that APA should develop both an internal, resource document and an official position statement.

Area 7 Trustee Robert George, M.D., a member of the Joint Commission on Government Relations (JCGR), said the documents lacked footnotes and specifics.

"The JCGR reviewed these for what the purposes were, and we had real concerns that there was not a clear document—it didn't show the footnotes, it didn't show the specifics, it didn't give enough detail to be useful for anything in a meaningful way outside of the organization," said George.

"Certainly there's a place for having something that speaks to the importance of psychotherapy, but to be done like a [scholarly] paper would be done."

The JCGR also recommended that APA develop "a one-page bulleted broadside for broad distribution using the key pieces as to why psychotherapy is important," said George.



Because of

* Doses above 6 mg/day were not shown to be more efficacious than lower doses and demonstrated an increase in extrapyramidal symptoms and other adverse effects. The safety of doses above 16 mg/day has not been evaluated in clinical trials.

† Antipsychotic activity is presumed to be mediated through a combination of dopamine D₂ and serotonin 5-HT₂ antagonism, although the exact mechanism of action is unknown.

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RESEARCH FOUNDATION

Psychologist Urges Colleagues to Collaborate With Primary Care Physicians

Such collaboration will not compensate for lack of medical training, rebuts APA official.

Greater collaboration between psychologists and family physicians, utilizing the biopsychosocial model first proposed by internist George Engel, M.D., is becoming both necessary and professionally advantageous to psychologists.

So says psychologist Susan H. McDaniel, Ph.D., in the article "Collaboration Between Psychologists and Family Physicians: Implementing the Biopsychosocial Model," in last month's edition of *Professional Psychology: Research and Practice*.

McDaniel's article was part of a special section titled "Psychological Consultation With Primary Care Physicians," which pointed out that primary care physicians are the major providers of mental and be-

havioral health services in the country, and that one-fourth of all health care visits in primary care are for mental health problems.

That trend is likely to continue, with managed care increasingly requiring patients to enter the health care system through their primary care physician, the journal notes.

The trend is prompting heated competition among mental health providers to become part of networks and organized systems of care. And last month APA Trustees approved the *DSM-IV Primary Care* manual, which some psychiatrists say will enhance collaboration with primary care physicians and increase referrals to psychiatrists. Others, however, say the manual may ultimately help the competition (see page 1).

Is the psychologists' move toward greater collaboration with primary care

physicians a competitive challenge to psychiatry?

Ronald Shellow, M.D., chair of APA's Joint Commission on Government Relations and chair of the AMA's Section Council on Psychiatry, said that psychologists' recognition of the medical model is laudable, but not unlikely to compensate for lack of medical training.

"I applaud this," Shellow told *Psychiatric News*, who added that he had not read the article by McDaniel. "They should be trying to get involved and learn the biopsychosocial model of illness. I'm gratified that after all these years of denigrating the medical model, they are coming around.

"I suspect their motives are economic, rather than professional," he added. "Psychiatrists have always had the biopsychosocial model, and we are at a distinct advantage in at least two ways," Shellow said. "The first is that we have gone to medical school and we

speak the same language as other physicians.

"The second is that the discipline of medical diagnosis and treatment is very different" from what psychologists know how to do, Shellow added.

"It is much better for internists and family physicians to consult with psychiatrists because it is an easier consultation," he said. "So while I would say it is important for psychologists to learn the biopsychosocial model, without the medical discipline they are at a distinct disadvantage."

McDaniel, in her article, noted some of the barriers to collaboration with primary care that the psychological profession must overcome.

"We must support the physician's relationship with the patient whenever possible and respect the continuity that is characteristic of the family physician's (and not the psychologist's) relationship with patients," she notes. "This approach, and a collaborative rather than authoritarian style, avoids inappropriate conflict over 'ownership' of the patient. In addition, we must offer the brief system interventions that make us at-

See "McDaniel," page 29

whole person is waiting to emerge.

A first choice to improve the positive and negative fragments of psychosis.

Statistically significant improvement of positive and negative symptoms

A first choice when considering EPS.

In clinical trials, extrapyramidal symptoms, while dose dependent, are comparable to placebo at recommended doses*

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The most common side effects reported in clinical trials (n = >2600) were insomnia, agitation, EPS, headache, anxiety, and rhinitis; less common were somnolence, dizziness, constipation, nausea, and tachycardia

RISPERDAL may induce orthostatic hypotension especially during the initial titration period. The risk of orthostatic hypotension and syncope may be minimized by adhering to the recommended initial titration regimen

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The only first-choice serotonin/dopamine antagonist (SDA).†

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Punishment?

Since psychotherapy is one activity in which psychiatrists engage, and since "counseling" is frequently used more or less synonymously, we have an interest in its use. For some time I have been smoldering from newspaper reports of counseling prescribed by one or another judge. When did counseling acquire a punitive significance?

What prompts this letter is an item in the March 30 *New York Times* headed "Army Says It Will Punish Nine Rangers." The nine were involved in the deaths of four officers who had been immersed too long in cold water as part of a supposedly supervised training operation. We are told that "punishment could range from counseling or letters of reprimand to removal from duty."

The details of the incident are complicated, including a rescue helicopter delayed for lack of fuel and a cable that broke and dropped a man 15 feet to the ground, but probably the human deficiencies can be

summed up as lack of training, poor judgment, or negligence. I wonder which of these three deficiencies can be helped by counseling.

John L. Simon, M.D.
New York, N.Y.

Videotaping Inevitable?

I believe Dr. Eli Einbinder's novel idea of videotaping short segments of some psychotherapy sessions (without sound?) is inevitable. Furthermore, given our sad litigious climate, I'm betting that many other disciplines and businesses will employ electronic "eavesdropping" to varying degrees as the number of lawsuits swells to grotesque proportions.

We're witnessing a sad state of affairs: Trust has vanished, so unfortunately such sophisticated protection as videotape documentation will become mandatory

(and its critics irrelevant).

"False memories" and accusations give us therapists reason to start planning for this installation pronto. Add on the age-old possibility of actual "assaults" and the indications for this "space-age remedy" become abundant.

To again reassure dissenters from this new insurance, Dr. Einbinder explains that there is no intent to record sessions, just to "check in" for brief, interspersed moments. Audio could be optional, as could an "alarm" or a "notification" component (to a secretary/witness or even to a security office?). Perhaps one trigger to activate the system could be one person arising from his or her seat in the therapy setting or a certain volume of sound or speed of movement.

I am among the many who feel grateful to Dr. Einbinder for his persistence in promoting this momentarily unpopular but eventually necessary innovation.

My cohorts and I have had some close scrapes with our judicial Big Brothers and

Psychiatric News invites readers to submit letters not more than 500 words long for possible publication; because of space constraints, shorter letters have a greater chance of being accepted for publication. Submission of a letter implies consent for publication unless otherwise indicated. All letters are subject to editing to meet style, clarity, and space requirements. Receipt of letters is not acknowledged.

nearly faced their "jury" (composed *not* of our peers). Have you yet?

J. Rich Lashley, M.D.
Columbia, S.C.

Abortion

In her letter to the editor in the January 20 issue, Dr. Patricia Wesley espouses that APA change its policy on abortion to one of "neutrality." I had understood that the policy was neutral on abortion. On this matter of individual moral and religious belief, it would be most inappropriate for APA to take a position for or against.

With respect to a quite distinct and separate issue, that of whether a woman may choose what shall happen with her own body and be free from intervention by the state's using its powers to enforce the beliefs of one segment of its citizens upon others, I believe it proper for APA to take a stand. For the state to restrict freedom of conscience is detrimental to the welfare and health of society—a plague upon democracy—and it is desirable that APA take a stand against it.

Jim Hood, M.D., Ph.D.
Camarillo, Calif.

This letter supports the sound professional, legal, and moral statement of APA's Board of Trustees on reproductive rights. The legal status of abortion has been affirmed by the U.S. Supreme Court. The professional contribution arises from our responsibility to provide relief of pain, physical and psychic, according to accepted standards. The current state of gynecological and psychiatric practice meets those standards. The debatable issue is on the question of morality, for morality is not necessarily a single standard.

Concepts of morality may and do vary from culture to culture, from nation to nation, and within nations according to variations in value systems. In our culture individual choice and responsibility have a very high value. Is the pain of an unwanted pregnancy less than the immediate extinction of an embryo or fetus that has no consciousness and no awareness of its existence? Is it a higher morality to insist that a female (for we are speaking not only of women but of teenage and sometimes pre-teen individuals) is a prisoner of her gender and must carry through a pregnancy that may be unplanned and unwanted and often the result of ignorance, impulsiveness, intimidation, force, submissiveness, or dependency seeking, to mention just a few factors?

What morality is it that gives mates the right to insist on females carrying through nine months of pregnancy and providing many years of care and support for the unwanted child? What morality justifies the deprivation experienced by an unwanted

See "Letters," page 23

1, 2, 3, 4 mg tablets

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Before prescribing, please consult complete prescribing information of which the following is a brief summary.

INDICATIONS AND USAGE: RISPERDAL® is indicated for the management of the manifestations of psychotic disorders.

CONTRAINDICATIONS: RISPERDAL® is contraindicated in patients with a known hypersensitivity to the product.

WARNINGS

Neuroleptic Malignant Syndrome (NMS)

A potentially fatal symptom complex sometimes referred to as Neuroleptic Malignant Syndrome (NMS) has been reported in association with antipsychotic drugs. If a patient requires antipsychotic drug treatment after recovery from NMS, the potential reintroduction of drug therapy should be carefully considered. The patient should be carefully monitored, since recurrences of NMS have been reported.

Tardive Dyskinesia

A syndrome of potentially irreversible, involuntary, dyskinetic movements may develop in patients treated with antipsychotic drugs. Although the prevalence of the syndrome appears to be highest among the elderly, especially elderly women, it is impossible to rely upon prevalence estimates to predict, at the inception of antipsychotic treatment, which patients are likely to develop the syndrome. If signs and symptoms of tardive dyskinesia appear in a patient on RISPERDAL®, drug discontinuation should be considered. However, some patients may require treatment with RISPERDAL® despite the presence of the syndrome.

Potential for Proarrhythmic Effects: Risperidone and/or 9-hydroxyrisperidone appears to lengthen the QT interval in some patients, although there is no average increase in treated patients, even at 12-16 mg/day, well above the recommended dose. Other drugs that prolong the QT interval have been associated with the occurrence of torsades de pointes, a life-threatening arrhythmia. Bradycardia, electrolyte imbalance, concomitant use with other drugs that prolong QT, or the presence of congenital prolongation in QT can increase the risk for occurrence of this arrhythmia.

PRECAUTIONS

Orthostatic Hypotension: RISPERDAL® may induce orthostatic hypotension associated with dizziness, tachycardia, and in some patients, syncope, especially during the initial dose-titration period, probably reflecting its alpha-adrenergic antagonistic properties. The risk of orthostatic hypotension and syncope may be minimized by limiting the initial dose to 1 mg BID in normal adults and 0.5 mg BID in the elderly and patients with renal or hepatic impairment (See DOSAGE AND ADMINISTRATION). A dose reduction should be considered if hypotension occurs. RISPERDAL® should be used with particular caution in patients with known cardiovascular disease (history of myocardial infarction or ischemia, heart failure, or conduction abnormalities), cerebrovascular disease, and conditions which would predispose patients to hypotension (dehydration, hypovolemia, and treatment with antihypertensive medications).

Seizures: RISPERDAL® should be used cautiously in patients with a history of seizures.

Hyperprolactinemia: As with other drugs that antagonize dopamine D₂ receptors, risperidone elevates prolactin levels and the elevation persists during chronic administration. Tissue culture experiments indicate that approximately one-third of human breast cancers are prolactin dependent in vitro, a factor of potential importance if the prescription of these drugs is contemplated in a patient with previously detected breast cancer. As is common with compounds which increase prolactin release, an increase in pituitary gland, mammary gland, and pancreatic islet cell hyperplasia and/or neoplasia was observed in the risperidone carcinogenicity studies conducted in mice and rats (See CARCINOGENESIS).

However, neither clinical studies nor epidemiologic studies conducted to date have shown an association between chronic administration of this class of drugs and tumorigenesis in humans; the available evidence is considered too limited to be conclusive at this time.

Potential for Cognitive and Motor Impairment: Somnolence was a commonly reported and dose-related adverse event associated with RISPERDAL® treatment. Since RISPERDAL® has the potential to impair judgment, thinking, or motor skills, patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that RISPERDAL® therapy does not affect them adversely.

Rare cases of priapism have been reported.

A single case of TTP was reported in a 28-year-old female patient receiving RISPERDAL®. The relationship to RISPERDAL® therapy is unknown.

Risperidone has an **antidromic effect** in animals; this effect may also occur in humans, and may mask signs and symptoms of overdose with certain drugs or of conditions such as intestinal obstruction, Ray's syndrome, and brain tumor. Caution is advised when prescribing for patients who will be exposed to **temperature extremes**.

The possibility of a **suicide attempt** is inherent in schizophrenia, and close supervision of high risk patients should accompany drug therapy. Prescriptions for RISPERDAL® should be written for the smallest quantity of tablets consistent with good patient management. In order to reduce the risk of overdose.

Clinical experience with RISPERDAL® in patients with certain **concomitant systemic illnesses** is limited. Caution is advisable in patients with diseases or conditions that could affect metabolism or hemodynamic responses. Because of the risks of orthostatic hypotension and QT prolongation, caution should be observed in cardiac patients (See WARNINGS and PRECAUTIONS).

In patients with severe renal impairment (creatinine clearance <30 mL/min/1.73 m²), or with severe hepatic impairment, a lower starting dose should be used. Patients should be advised of the risk of orthostatic hypotension, especially during the period of initial dose titration.

Patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that RISPERDAL® therapy does not affect them adversely. Tell patients to notify their physician if they become pregnant or intend to become pregnant during therapy; not to breast feed an infant; to inform their physicians if they are taking, or plan to take, any prescription or over-the-counter drugs; to avoid alcohol.

No specific laboratory tests are recommended.

The interactions of RISPERDAL® and other drugs have not been systematically evaluated. Caution should be used when taken in combination with other centrally acting drugs and alcohol.

RISPERDAL® may enhance the hypotensive effects of other therapeutic agents with this potential and it may antagonize the effects of levodopa and dopamine agonists.

Chronic administration of carbamazepine or clozapine with risperidone may increase the clearance of risperidone.

Risperidone is metabolized by cytochrome P₄₅₀2D₆, an enzyme that can be inhibited by a variety of psychotropic and other drugs. Analysis of clinical studies involving a modest number of poor metabolizers (n=70) does not suggest that poor and extensive metabolizers have different rates of adverse effects. No comparison of effectiveness in the two groups has been made. In vitro studies showed that drugs metabolized by the P₄₅₀2D₆ isozymes are only weak inhibitors of risperidone metabolism.

In vitro studies indicate that risperidone is a relatively weak inhibitor of cytochrome P₄₅₀3A₄, and is not expected to substantially inhibit the clearance of drugs that are metabolized by this enzymatic pathway. However, clinical data to confirm this expectation are not available.

Carcinogenicity studies: were conducted in Swiss albino mice and Wistar rats. Risperidone was administered in the diet at doses of 0.53, 2.5, and 10 mg/kg for 18 months to mice and for 25 months to rats. These doses are equivalent to 2.4, 9.4 and 37.5 times the maximum human dose (16 mg/day) on a mg/kg basis or 0.2, 0.75 and 3 times the maximum human dose (mice) or 0.4, 1.5, and 6 times the maximum human dose (rats) on a mg/m² basis. There were statistically significant increases in pituitary gland adenomas, endocrine pancreas adenomas and mammary gland adenocarcinomas. These neoplasms are considered to be prolactin-mediated. The relevance for human risk of the findings of prolactin-mediated endocrine tumors in rodents is unknown.

No evidence of mutagenic potential for risperidone was found.

Risperidone (0.16 to 5 mg/kg) was shown to impair mating, but not fertility, in Wistar rats in three reproductive studies at doses 0.1 to 3 times the maximum recommended human dose on a mg/m² basis. The effect appeared to be in females. In a subchronic study in Beagle dogs, sperm motility and concentration were decreased at doses 0.6 to 10 times the human dose on a mg/m² basis. Dose-related decreases were also noted in serum testosterone at the same doses. Serum testosterone and sperm parameters partially recovered but remained decreased after treatment was discontinued. No no-effect doses were noted in either rat or dog.

Pregnancy Category C: The teratogenic potential of risperidone was studied in Sprague-Dawley and Wistar rats and in New Zealand rabbits. The incidence of malformations was not increased compared to control in offspring of rats or rabbits given 0.4 to 6 times the human dose on a mg/m² basis. In three reproductive studies in rats there was an increase in pup deaths during the first 4 days of lactation at doses 0.1 to 3 times the human dose on a mg/m² basis. It is not known whether these deaths were due to a direct effect on the fetuses or pups or to effects on the dams. There was no no-effect dose for increased rat pup mortality. In one Segment III study, there was an increase in stillborn rat pups at a dose 1.5 times higher than the human dose on a mg/m² basis.

Placental transfer of risperidone occurs in rat pups. There are no adequate and well-controlled studies in pregnant women. However, there was one report of a case of agenesis of the corpus callosum in an infant exposed to risperidone in utero. The causal relationship to RISPERDAL® therapy is unknown.

RISPERDAL® should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

The effect on labor and delivery in humans is unknown.

It is not known whether or not risperidone is excreted in human milk. In animal studies, risperidone and 9-hydroxyrisperidone were excreted in breast milk. Therefore, women receiving RISPERDAL® should not breast feed.

Safety and effectiveness in children have not been established.

Clinical studies did not include sufficient numbers of patients aged 65 and over to determine whether they respond differently from younger patients. In general, a lower starting dose is recommended for an elderly patient, reflecting a decreased pharmacokinetic clearance in the elderly, as well as a greater frequency of decreased hepatic, renal, or cardiac function, and a greater tendency to postural hypotension (See CLINICAL PHARMACOLOGY and DOSAGE AND ADMINISTRATION).

ADVERSE REACTIONS

Associated with Discontinuation of Treatment

Approximately 9% percent (244/2607) of RISPERDAL® treated patients in phase 2-3 studies discontinued treatment due to an adverse event, compared with about 7% on placebo and 10% on active control drugs. The more common events (≥ 0.3%) associated with discontinuation and considered to be possibly or probably drug-related included: extrapyramidal symptoms, dizziness, hyperkinesia, somnolence, and nausea.

Suicide attempt was associated with discontinuation in 1.2% of RISPERDAL®-treated patients compared to 0.6% of placebo patients, but given the almost 40-fold greater exposure time in RISPERDAL® compared to placebo patients, it is unlikely that suicide attempt is a RISPERDAL®-related adverse event (See PRECAUTIONS).

Incidence in Controlled Trials

Commonly Observed Adverse Events in Controlled Clinical Trials: In two 6- to 8-week placebo-controlled trials, spontaneously-reported, treatment-emergent adverse events with an incidence of 5% or greater in at least one of the RISPERDAL® groups and at least twice that of placebo were: anxiety, somnolence, extrapyramidal symptoms, dizziness, constipation, nausea, dyspepsia, rhinitis, rash, and tachycardia.

Elicited adverse events in one of these two trials present at at least 5% and twice the rate of placebo were: increased dream activity, increased duration of sleep, accommodation disturbances, reduced salivation, micturition disturbances, diarrhea, weight gain, menorrhagia, diminished sexual desire, erectile dysfunction, ejaculatory dysfunction, and orgasmic dysfunction.

The following adverse events occurred at an incidence of 1% or more, and were at least as frequent among RISPERDAL®-treated patients treated at doses of ≤ 10 mg/day than among placebo-treated patients in the pooled results of two 6- to 8-week controlled trials. **Psychiatric Disorders:** insomnia, agitation, anxiety, somnolence, aggressive reaction. **Nervous System:** extrapyramidal symptoms¹, headache, dizziness. **Gastrointestinal System:** constipation, nausea, dyspepsia, vomiting, abdominal pain, salivary increased, toothache. **Respiratory System:** rhinitis, coughing, sinusitis, pharyngitis, dyspnea. **Body as a Whole:** back pain, chest pain, fever. **Dermatological:** rash, dry skin, seborrhea. **Infections:** upper respiratory. **Visual:** abnormal vision. **Musculo-Skeletal:** arthralgia. **Cardiovascular:** tachycardia.

¹ Includes tremor, dystonia, hypokinesia, hyperkinesia, muscle rigidity, oculogyric crisis, ataxia, abnormal gait, involuntary muscle contractions, hyporeflexia, and extrapyramidal disorders. Although the incidence of "extrapyramidal symptoms" does not appear to differ for the ≤ 10 mg/day group and placebo, the data for individual dose groups in fixed dose trials do suggest a dose/response relationship (See DOSE DEPENDENCY OF ADVERSE EVENTS).

Dose Dependency of Adverse Events: Data from two fixed dose trials provided evidence of dose-relatedness for extrapyramidal symptoms associated with risperidone treatment. Adverse event data elicited by a checklist for side effects from a large study comparing 5 fixed doses of RISPERDAL® (1, 4, 8, 12, and 16 mg/day) revealed a positive trend for the following adverse events: sleepiness, increased duration of sleep, accommodation disturbances, orthostatic dizziness, palpitations, weight gain, erectile dysfunction, ejaculatory dysfunction, orgasmic dysfunction, asthenia/lassitude/increased fatigability, and increased pigmentation.

Vital Sign Changes: RISPERDAL® is associated with orthostatic hypotension and tachycardia (See PRECAUTIONS).

Weight Changes: The proportions of RISPERDAL® and placebo-treated patients meeting a weight gain criterion of ≥ 7% of body weight were compared in a pool of 6- to 8-week placebo-controlled trials, revealing a statistically significantly greater incidence of weight gain for RISPERDAL® (18%) compared to placebo (9%).

Laboratory Changes: A between group comparison for 6- to 8-week placebo-controlled trials revealed no statistically significant RISPERDAL®/placebo differences in the proportions of patients experiencing potentially important changes in routine serum chemistry, hematology, or urinalysis parameters. Similarly, there were no RISPERDAL®/placebo differences in the incidence of discontinuations for changes in serum chemistry, hematology, or urinalysis. However, RISPERDAL® administration was associated with increases in serum prolactin (See PRECAUTIONS).

ECG Changes: The electrocardiograms of 8 out of 380 patients taking RISPERDAL® whose baseline QTc interval was less than 450 msec were observed to have QTc intervals greater than 450 msec during treatment (see WARNINGS). Changes of this type were not seen among about 120 placebo

patients, but were seen in patients receiving haloperidol (3/126).

Other Events Observed During the Pre-Marketing Evaluation of RISPERDAL®

During its premarketing assessment, multiple doses of RISPERDAL® were administered to 2607 patients in phase 2 and 3 studies and the following reactions were reported: (Note "frequent" are those occurring in at least 1/100 patients; "infrequent" are those occurring in 1/100 to 1/1000 patients; "rare" are those occurring in fewer than 1/1000 patients. It is important to emphasize that, although the events reported occurred during treatment with RISPERDAL®, they were not necessarily caused by it. **Psychiatric Disorders:** increased dream activity¹, diminished sexual desire¹, nervousness. **Infrequent:** impaired concentration, depression, apathy, catatonic reaction, euphoria, increased libido, amnesia. **Rare:** emotional lability, nightmares, delirium, withdrawal syndrome, yawning. **Central and Peripheral Nervous System Disorders:** Frequent: increased sleep duration¹. **Infrequent:** dysarthria, vertigo, stupor, paraesthesia, confusion. **Rare:** aphasia, cholinergic syndrome, hyposthesia, tongue paralysis, leg cramps, torticollis, hypotonia, coma, migraine, hyperreflexia, choreoathetosis. **Gastro-intestinal Disorders:** Frequent: anorexia, reduced salivation¹. **Infrequent:** flatulence, diarrhea, increased appetite, stomatitis, melena, dysphagia, hemorrhoids, gastritis. **Rare:** fecal incontinence, eructation, gastroesophageal reflux, gastroenteritis, esophagitis, tongue discoloration, cholelithiasis, tongue edema, diverticulitis, gingivitis, discolored feces, GI hemorrhage, hematemesis. **Body as a Whole/General Disorders:** Frequent: fatigue. **Infrequent:** edema, rigors, malaise, influenza-like symptoms. **Rare:** pallor, enlarged abdomen, allergic reaction, ascites, sarcoidosis, flushing. **Respiratory System Disorders:** Frequent: hyperventilation, bronchospasm, pneumonia, stridor. **Rare:** asthma, increased sputum, aspiration. **Skin and Appendage Disorders:** Frequent: increased pigmentation¹, photosensitivity¹. **Infrequent:** increased sweating, acne, decreased sweating, alopecia, hyperkeratosis, pruritus, skin exfoliation. **Rare:** bullous eruption, skin ulceration, aggravated psoriasis, furunculosis, verruca, dermatitis lichenoid, hypertrichosis, genital pruritus, urticaria. **Cardiovascular Disorders:** Frequent: palpitation, hypertension, hypotension, AV block, myocardial infarction. **Rare:** ventricular tachycardia, angina pectoris, premature atrial contractions, T wave inversions, ventricular extrasystoles, ST depression, myocarditis. **Vision Disorders:** Frequent: abnormal accommodation, xerophthalmia. **Rare:** diplopia, eye pain, blepharitis, photophobia, abnormal lacrimation. **Metabolic and Nutritional Disorders:** Frequent: hyponatremia, weight increase, creatine phosphokinase increase, thirst, weight decrease, diabetes mellitus. **Rare:** decreased serum iron, cachexia, dehydration, hypokalemia, hypoproteinemia, hyperphosphatemia, hypertriglyceridemia, hypuricemia, hypoglycemia. **Urinary System Disorders:** Frequent: polyuria/polydipsia¹. **Infrequent:** urinary incontinence, hematuria, dysuria. **Rare:** urinary retention, cystitis, renal insufficiency. **Musculo-skeletal System Disorders:** Frequent: myalgia. **Rare:** arthrosis, synostosis, bursitis, arthritis, skeletal pain. **Reproductive Disorders, Female:** Frequent: menorrhagia¹, organic dysfunction¹, dry vagina¹. **Infrequent:** nonpuerperal lactation, amenorrhea, female breast pain, leukorrhea, mastitis, dysmenorrhea, female perineal pain, intermenstrual bleeding, vaginal hemorrhage. **Liver and Biliary System Disorders:** Frequent: increased SGOT, increased SGPT. **Rare:** hepatic failure, cholestatic hepatitis, cholecystitis, cholelithiasis, hepatitis, hepatocellular damage. **Pleatlet, Bleeding and Clotting Disorders:** Frequent: epistaxis, purpura. **Rare:** hemorrhage, superficial phlebitis, thrombophlebitis, thrombocytopenia. **Hearing and Vestibular Disorders:** Frequent: tinnitus, hyperacusis, decreased hearing. **Red Blood Cell Disorders:** Frequent: anemia, hypochromic anemia. **Rare:** normocytic anemia. **Reproductive Disorders, Male:** Frequent: erectile dysfunction¹. **Infrequent:** ejaculation failure. **White Cell and Resistance Disorders:** Frequent: leukocytosis, lymphadenopathy, leucopenia, Pelger-Huet anomaly. **Endocrine Disorders:** Frequent: gynecomasia, male breast pain, anti-diuretic hormone disorder. **Special Senses:** Frequent: bitter taste.

¹ Incidence based on elicited reports.

Postintroduction Reports: Adverse events reported since market introduction which were temporally (but not necessarily causally) related to RISPERDAL® therapy, include the following: anaphylactic reaction, angioedema, atrial fibrillation, cerebrovascular disease, diabetes mellitus aggravated, hypothermia, intestinal obstruction, jaundice, mania, Parkinson's disease aggravated, pulmonary embolism, sudden death.

DRUG ABUSE AND DEPENDENCE

Controlled Substance Class: RISPERDAL® is not a controlled substance. Patients should be evaluated carefully for a history of drug abuse, and such patients should be observed closely for signs of RISPERDAL® misuse or abuse (e.g., development of tolerance, increases in dose, drug-seeking behavior).

DOSAGE AND ADMINISTRATION

Usual Initial Dose: RISPERDAL® (risperidone) should be administered on a BID schedule, generally beginning with 1 mg BID initially, with increases in increments of 1 mg BID on the second and third day, as tolerated, to a target dose of 3 mg BID by the third day. In some patients, slower titration may be medically appropriate. Further dosage adjustments, if indicated, should generally occur at intervals of not less than 1 week, since steady state for the active metabolite would not be achieved for approximately 1 week in the typical patient. When dosage adjustments are necessary, small dose increments/decrements of 1 mg BID are recommended.

Antipsychotic efficacy was demonstrated in a dose range of 4 to 16 mg/day in the clinical trials supporting effectiveness of RISPERDAL®, however, maximal effect was generally seen in a range of 4 to 6 mg/day. Doses above 6 mg/day were not demonstrated to be more efficacious than lower doses, were associated with more extrapyramidal symptoms and other adverse effects, and are not generally recommended. The safety of doses above 16 mg/day has not been evaluated in clinical trials. **Dosage in Special Populations:** The recommended initial dose is 0.5 mg BID in patients who are elderly or debilitated, patients with severe renal or hepatic impairment, and patients either predisposed to hypotension or for whom hypotension would pose a risk. Dosage increases in these patients should be in increments of no more than 0.5 mg BID. Increases to dosages above 1.5 mg BID should generally occur at intervals of at least 1 week. In some patients, slower titration may be medically appropriate.

Elderly or debilitated patients, and patients with renal impairment, may have less ability to eliminate RISPERDAL® than normal adults. Patients with impaired hepatic function may have increases in the free fraction of the risperidone, possibly resulting in an enhanced effect (See CLINICAL PHARMACOLOGY). Patients with a predisposition to hypotensive reactions or for whom such reactions would pose a particular risk likewise need to be titrated cautiously and carefully monitored (See PRECAUTIONS). **Switching from Other Antipsychotics:** There are no systematically collected data to specifically address switching from other antipsychotics to RISPERDAL®, or concerning concomitant administration with other antipsychotics. While immediate discontinuation of the previous antipsychotic treatment may be acceptable for some patients, more gradual discontinuation may be most appropriate for other patients. In all cases, the period of overlapping antipsychotic administration should be minimized. When switching patients from depot antipsychotics, if medically appropriate, initiate RISPERDAL® therapy in place of the next scheduled injection. The need for continuing existing EPS medication should be reevaluated periodically.

US Patent 4,804,663
August 1994, December 1994

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APA Wins Federal Contract for AIDS Education

Funds Will Allow APA to Educate More Psychiatrists on Mental Health Aspects of AIDS

The federal Center for Mental Health Services (CMHS) has awarded APA a three-year contract that will allow its AIDS Education Project to expand its education and training programs on the psychiatric aspects of HIV-related illnesses.

The AIDS Education Project recently completed the development of a curriculum on neuropsychiatric and psychosocial considerations in HIV disease and provided training for nearly 4,000 psychiatrists.

It also trained psychiatrists to return to their communities to serve as local resources on the mental health aspects of the

“Our goal is to see the curriculum being used by every psychiatric training program by the end of three years.”

AIDS epidemic and to train others on critical HIV-related issues.

The new contract, at \$150,000 for 1995 and an identical amount for each of two additional years if CMHS exercises its renewal options, builds on the project's earlier work. However, it provides 25 percent less money than the previous phase, pointed out project director Carol Svoboda.

As a result of the cutback, the project's staff and steering committee will no longer sponsor and conduct on-site training con-

ferences, but will coordinate education and training programs using the psychiatrists they have already trained throughout the U.S. The project plans to continue its popular AIDS education programs at APA's annual meeting and Institute on Psychiatric Services.

“We think we have found a way to get the most bang for the buck,” Svoboda said. “We will provide the technical assistance to help these people help themselves through the network of psychiatrists we've already trained in communities across the country and with the curriculum materials we've developed.”

The shift from providing direct education and training to coordinating these activities at the local level reflects the success of the project's early phase, said psychiatrist Melvyn Haas, M.D., associate director for medical affairs at CMHS.

Education on the mental health aspects of AIDS “has come a long way in the last few years,” he said in an interview. “The first contract [with APA] assured that psychiatrists in underserved and rural areas were given educational opportunities similar to those available in urban areas. There are now few areas of the country without this type of expertise.”

Cultivating Local Expertise

CMHS believes that future educational and training opportunities will be more successful if the psychiatrists attending them “identify with local experts,” Haas noted, “and when calls for assistance or visits become local rather than long distance.”

He added that the reason the new contract is for a funding level 25 percent below the previous project is the government's goal of expanding the education effort on mental health issues in AIDS and HIV to social workers and nurses. CMHS had previously awarded contracts to APA and the American Psychological Association, but some funding will now go the National Association of Social Workers and the American Nurses Association.

Under the new contract, the AIDS Education Project will establish a national network to link psychiatrists and mental health professionals with a host of AIDS-related resources, including referral sources, training programs, educational materials, community organizations with AIDS expertise, and lists of HIV-related projects undertaken by other mental health disciplines, she noted.

One of the earliest tasks for Svoboda and AIDS training coordinator John Andriote is to contact the approximately 2,500 psychiatrists who indicated on APA membership surveys that one of their clinical interests is AIDS and HIV.

“We plan to question them about their interest in serving as an AIDS resource at their facility or in their local community,” she said.

The AIDS project also will be expected to develop instructional materials that will make it easier for specific groups to adapt its two existing curricula—the AIDS Training Curriculum and HIV-Related Neuropsychiatric Complications and Treatments—to the unique requirements of their

community or facility. Psychiatry residency directors will, for example, be shown how to integrate the information into their training programs. Primary care providers will find a road map to learning about psychosocial and neuropsychiatric facets of HIV illness, and psychiatrists will find keys to making their clinical services more valuable to HIV-infected individuals and family or friends who are touched by the disease, Svoboda explained.

Emphasis on Residency Training

“A significant phase of the new contract will be a big push to get all psychiatry residency programs to incorporate the AIDS education curriculum into their training,” she pointed out. “We plan to enlist a select group of advisers who will help us turn our didactic curriculum into a format that will be more appropriate for use in residency training. We are thinking of ways to add clinical case discussions to our training format, for example.”

Once the expanded training materials have been developed, they will be tested for one year at four or five training sites and then evaluated for effectiveness and satisfaction.

“Our goal is to see the curriculum being used by every psychiatric training program by the end of three years,” she noted.

Psychiatrists who want to obtain additional information about the project or discuss joining the new network can contact the APA AIDS Program Office, 1400 K Street, N.W., Washington, D.C. 20005; (202) 682-6104. —K.H.

The Centers for Disease Control reported that 401,749 individuals had been diagnosed with AIDS in the U.S. as of June 1994, and 243,423 people had died of the disease.

Obsessive-Compulsive Disorder in Children and Adolescents

Saturday, May 20, 1995

7:00 pm—10:00 pm

**Miami Beach Convention Center
Rooms D128/D129, Level 1**

Accreditation: The American Psychiatric Association (APA) is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

The APA designates this continuing medical education activity for 3 credit hours of Category 1 of the Physician's Recognition Award of the American Medical Association and for the CME requirement of the APA.

Program Chairman/Moderator

JOHN S. MARCH, MD
Director of Child and Adolescent
Subspecialty Programs
Duke University Medical Center

Introduction and Diagnostic Issues

JOHN S. MARCH, MD

Neurobiology

PHILLIP B. CHAPPELL, MD
Assistant Professor of Child Psychiatry
Yale University Child Study Center

Comorbidity

JOHN WALKUP, MD
Assistant Professor
Director of Education and Training
Division of Child and Adolescent
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Behavioral Psychotherapy

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Psychopharmacology

MARK RIDDLE, MD
Director, Division of Child and
Adolescent Psychiatry
Johns Hopkins Medical Institution

This symposium is supported by an unrestricted educational grant from CoCensys Inc.

Bloom Named Editor in Chief of *Science* Magazine

Neuroscientist Floyd Bloom, M.D., chair of the department of neuropharmacology at the Scripps Research Institute in La Jolla, Calif., has been named editor in chief of *Science* magazine.

Bloom, one of the most widely published and cited neuroscientists, took the helm of what many consider the world's leading peer-reviewed general science magazine on May 1. He is the third psychiatrist to hold the position, according to Carolyn Martin of the American Association for the Advancement of Science (AAAS), which publishes the magazine.

The other psychiatrists were James McKeen Cattell, M.D., from 1895 to 1945, and Dael Wolfe, M.D., who was acting edi-

tor in chief for one year in 1955.

Despite his achievements, Bloom is humbled by his new position.

"My first move is to keep [the magazine] as good as it is before worrying how to make it different," he commented. "It is the winner's circle that all active scientists aspire to enter. It has very high criteria for what makes a paper a *Science* paper. We want to continue that courageous opportunity of detecting novel findings, perhaps findings that don't agree with current dogma. And that's true regardless of the field—whether it's astrophysics or psychoanalysis. We'd be pleased to have more papers dealing with social-behavioral subjects submitted."

While many journals accept 20 percent or more of papers submitted, *Science*, on average, accepts about 10 percent, Bloom observed.

"*Science* is a magazine for all of science," he commented. "It is the only weekly with the size of coverage it provides. Nearly 200,000 read it each week. There's a tremendous voice there for both the news of science and the science that's making the news."

As editor in chief, he will be dedicated to strengthening all of science, said Bloom. By so doing, *Science* cannot help but contribute to greater understanding of neuroscience and psychiatry, he said.

"I always viewed science from the perspective of what it could contribute to my understanding of neuroscience. The stronger all of science is, the stronger my role [as a neuroscientist] will be."

Bloom sees several key issues confronting neuroscience and psychiatry. "Right now the major clinical neuroscience problems we face are AIDS, Alzheimer's, and the addictive disorders," he asserted. "Those are built on the foundation of a major continuing health care problem arising from affective disorders and schizophrenia. When I then try to see where will neuroscience go to help solve those problems, it seems to me there's a major opportunity here to contribute to the world's health by focusing our efforts on these problems, by developing better animal models for these disorders, and by devising novel medications to treat them once they can be diagnosed. In my view the scientific contribution will come



Floyd Bloom, M.D.: "There's a tremendous voice there for both the news of science and the science that's making the news."

from earlier and earlier diagnosis of the people who are vulnerable to these diseases, and that may require new physical means to image the brain in its operations."

The interplay between technology and neuroscientific psychiatry is promising, said Bloom. "If we look back 10 years ago, PET [positron emission tomography] was barely making headway, and magnetic activity recording of the brain was not possible. One wonders what new physical principles engineers might develop to provide a finer grained picture of the brain in its operations."

One of the privileges of the editor-in-chief is the opportunity to shape the global scientific debate through the editorial column in the beginning of each issue of *Science*. "At the moment I'm in the open-eared, listening mode," said Bloom. While he will wield his own pen on many occasions, he will not hesitate to have guest editorials when he believes that someone else is better informed about a hot topic of the day, Bloom said.

In a discipline where public policy is often shaped by the skill with which scientists are able to make the public understand complex subject matter, Bloom has developed a reputation for making the complex comprehensible. His work has helped bridge the gap between biology and behavior, advancing the frontiers of psychiatry and neuroscience.

The recipient of many research awards, Bloom was responsible for the first demonstration of a brain synaptic action attributable to norepinephrine and the first mapping of pituitary and brain endorphin peptides.

Bloom brings more than three decades of neuroscience research and writing to the post. His curriculum vitae runs 69 pages, including 65 pages of publications. He has served and continues to serve on the editorial boards of a number of prestigious publications, including *Science*, *Biological Psychiatry*, and the *Journal of Pharmacology and Experimental Therapeutics*.

His selection capped a year-long search to replace retiring editor-in-chief Daniel Koshland Jr., Ph.D., a microbiologist. Koshland is returning to full-time research at the University of California at Berkeley.

With 143,000 subscribers, the magazine has the largest paid circulation of any scientific journal. It was founded in 1880 by Thomas Edison.

One of Bloom's first initiatives will be to create electronic access to *Science*. At present there is none, Bloom said. He envisions a subject-friendly data base that transcends the content of any single issue of the magazine. —R.B.K.

Anxiety Disorders: THE ROLE OF SEROTONIN

Sunday, May 21, 1995

Reception 7:00 pm - 7:30 pm, Program 7:30 pm - 10:00 pm
Doral Ocean Beach Resort, Mediterranean Room

Introduction

JOHN H. GREIST, MD

Distinguished Senior Scientist,
Dean Foundation for Health, Research, and Education
Clinical Professor of Psychiatry,
University of Wisconsin Medical School

Program Chair

Serotonin Receptor Specificity in Anxiety Disorders

IRWIN LUCKI, PhD

Associate Professor,
Departments of Psychiatry and Pharmacology,
University of Pennsylvania

OCD:

Where the Serotonin Selectivity Story Begins

TERESA A. PIGOTT, MD

Associate Professor, Georgetown University
Medical Center
Departments of Psychiatry and Pharmacology,
Georgetown University

Panic Disorder and Agoraphobia: Hypothesis Hothouse

DONALD KLEIN, MD

Professor of Psychiatry, Columbia University
Director of Research, New York State Psychiatric
Institute

Social Phobia: Everyone's Disorder?

JAMES JEFFERSON, MD

Distinguished Senior Scientist,
Dean Foundation for Health, Research, and Education
Clinical Professor of Psychiatry,
University of Wisconsin Medical School

Behavior Therapy: Endogenous Serotonin Therapy?

LEE BAER, PhD

Associate Professor of Psychology,
Harvard Medical Center
Director of Research—OCD Unit,
Department of Psychiatry, Massachusetts
General Hospital

The American Psychiatric Association (APA) is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. The APA designates this continuing medical education activity for 3 credit hours of Category 1 of the Physician's Recognition Award of the American Medical Association and for the CME requirement of the APA.

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educational grant from the Roerig Division of the
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To preregister for this program, please call 1-800-835-7633.

Award Lectures at Annual Meeting Feature Distinguished Leaders

Nine APA award winners will be presenting lectures at APA's annual meeting later this month in Miami.

Here are a list of the award winners and a brief description of the lectures they are presenting. (The time and location of each lecture will appear in the annual meeting program book to be distributed in Miami.)

Boris M. Astrachan, M.D., Administrative Psychiatry Award Lecture: Astrachan is a professor and head of the department of psychiatry at the University of Illinois in Chicago. In his lecture, titled "Learning to Breathe Underwater: Educating Psychiatric Leaders for the 21st Century," Astrachan will point out that the challenge for educators at a time when psychiatric practice is undergoing fundamental changes is to teach about the nature of those changes while remaining rooted in the values and constants of the profession. The challenge for psychiatric leaders is to maintain their focus on the patient as technologies and paradigms change.

June Jackson Christmas, M.D., Solomon Carter Fuller Award Lecture: Christmas is the founder, chair, and interim director of the Urban Issues Group, a research institute conducting policy analysis from the perspective of New Yorkers of African descent. She is also a clinical professor of psychiatry at the Columbia University College of Physicians and Surgeons, professor emeritus of behavioral science at the City University of New York, and a practicing psychiatrist. In her lecture, "Can Psychiatry Serve Tomorrow's Black Families: Challenges for a Profession in Transition," Christmas will emphasize that black psychiatrists must be more involved in public policy and that policies must reflect the needs of urban black communities.

Prakash N. Desai, M.D., Oskar Pfister Award Lecture: Desai is a professor of psychiatry and associate dean of the College of Medicine at the University of Illinois, Chicago. He is also chief of staff at the Veterans Affairs West Side Medical Center in Chicago and chair of APA's Caucus of International Medical Graduates. Desai's lecture is titled "Taking the Psyche Out of Psychiatry: The Case of Hindu Medicine." He will present an historical and cultural overview of ancient Indian medicine as a case example of what happens when the psyche is taken out of psychiatric medicine.

Laurie M. Flynn, M.A., Patient Advocacy Award Lecture: As executive director of the National Alliance for the Mentally Ill since 1984, Flynn has been instrumental in building an organization that now provides support and advocacy services to 140,000 mentally ill individuals and their friends and families. In her lecture, Flynn will address the issue of providing services and treatment for people with mental illness in a world of managed care. She asserts that it is time to focus energies on trying to shape the emerging health care systems to suit patients' needs and protect their rights rather than resist the changes already taking place.

Leston L. Havens, M.D., Benjamin Rush Award Lecture: Havens is a professor of psychiatry at Harvard Medical

School, principal psychiatrist and director of the psychiatric residency training program at Cambridge Hospital, and faculty member at the Boston Psychoanalytic Society and Institute. In his lecture, "What Is Psychiatry About?," Havens will examine psychiatry's continued struggle to define itself. The debate centers on a rapidly evolving neuroscience that may soon provide graphic measures of normal psychological functions and inspire respect for symbolic formations.

Michael L. Perlin, J.D., Manfred S. Guttmacher Award Lecture: Perlin is a professor of law at New York Law School in New York City. His three-volume treatise, *Mental Disability Law: Civil and Criminal*, won the 1990 Walter Jeffords Writing Prize. His lecture is titled "Myths, Realities, and the Political World: The Anthropology of Insanity Defense Attitudes." Jeffords will examine public attitudes toward the insanity defense and its ambivalence about the role of psychiatry in the criminal justice system. Until these attitudes are understood, he believes, there will be no progress in dealing with this issue. (This lecture is jointly sponsored by the American Academy of Psychiatry and the Law and APA.)

Judith L. Rapoport, M.D., Adolf Meyer Award Lecture: Rapoport is chief of the child psychiatry branch in NIMH's Division of Intramural Research Programs, a clinical professor of psychiatry and pediatrics at Georgetown University, and a professor of psychiatry at George Washington University. In her lecture "Neurodevelopmental Insights Into Psychiatric Disorder," Rapoport will explain how research on psychiatrically ill children presents unique advantages for understanding psychiatric illness in adults. In childhood, there is less learned behavior, less heterogeneity of samples, and better access to family pathology.

Carolyn B. Robinowitz, M.D., Seymour D. Vestermark Award Lecture: Formerly APA's senior deputy medical director, Robinowitz is an internationally recognized medical educator. She is now the associate dean for students at Georgetown University School of Medicine and a clinical professor of psychiatry and behavioral sciences and child health and development at George Washington University School of Medicine. In her lecture, "Psychiatric Education and the Future of Psychiatry," Robinowitz will discuss the trends affecting psychiatry and what they mean for the practice of the profession in the next century. She will recommend actions to optimize patient care and practitioners' satisfaction and to improve the interface between education and clinical practice.

Ruben D. Rumbaut, M.D., Simon Bolivar Award Lecture: Rumbaut is professor emeritus of psychiatry at Baylor College of Medicine in Houston and a consultant to the Social Security Administration's Office of Hearings and Appeals in Houston. In his lecture "Ibero-American Contributions to the History of Psychiatry," Rumbaut will review the contributions of several 15th and 16th century Ibero-Americans to the development of modern psychiatric thought and practice. This lecture will be given in Spanish and simultaneously translated into English.

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Reno Meets With Advocacy Group To Reduce Violence on TV

U.S. Attorney General Janet Reno reassured APA Deputy Medical Director Robert T.M. Phillips, M.D., Ph.D., and other members of the Citizens' Task Force on TV Violence in March that she and President Clinton would continue to speak out against TV violence.

The meeting was held on Capitol Hill with Senator Kent Conrad (D-N.Dak.), sponsor of the Children's Media Protection Act of 1995. This legislation would require the Federal Communications Commission (FCC) to regulate violent television programming (*Psychiatric News*, March 3).

Reno referred to the President's participation in the cable TV industry's Voices Against Violence Week, March 19 to 25, which coincided with the task force meeting with the Attorney General. Clinton, in his State of the Union address, had challenged the entertainment industry to take responsibility for "mindless, repetitive violence."

Phillips, in an interview with *Psychiat-*

ric News, praised the cable industry's effort to feature programming that addresses the issue of societal violence as "a necessary first step by a powerful industry."

However, he cautioned against "letting this effort dissuade us from the long-term goal of reducing the gratuitous violence that is broadcasted over the airwaves into our homes."

Reno also urged an advocacy and interdisciplinary approach to solving the problem of violence. Reno has been supportive of the task force agenda since she met with members and Conrad in late 1993. The Senator formed the task force representing medical specialty groups, law enforcement, educators, parents, and churches earlier that year to draw attention to the issue.

Conrad summarized his bill for Reno and asked her staff to review and comment on the constitutionality of his "safe harbor" provision, which prohibits programming



U.S. Attorney General Janet Reno and Senator Kent Conrad, sponsor of the Children's Media Protection Act of 1995, met with members of the Citizens' Task Force on TV Violence in March. APA is a member of this group.

that contains gratuitous violence between 6 a.m. and 10 p.m.

Phillips commented that the "safe harbor" provision "is a starting point for negotiation, and the goal is to strive toward a

happy medium. We are not suggesting that all television programming is bad. We can point to examples of programming that enriches on the Learning and Discovery channels. However, children are more likely to see gratuitous violence than educational shows when they flip channels."

Conrad initiated the bill after the television industry's voluntary efforts to police itself were largely unsuccessful. This measure is consistent with APA's 1993 position statement on television violence, which states, "Since voluntary measures have been ineffective in protecting our youth . . . reasoned regulatory action should be pursued, consistent with constitutional guarantees."

In addition, Phillips and other members of the task force and Conrad planned to meet with FCC commissioners at press time to discuss enforcing the Children's Television Act of 1990, which sets standards for children's programming. FCC Chair Reed Hundt has indicated a willingness to examine a television station's compliance with the law when its license is up for renewal, according to Phillips' office.

Phillips encouraged APA members to contact their legislators to support Conrad's bill, which contains a provision on the enforcement of the Children's Television Act.

Also, Reno recommended that viewers write or call the television networks to express their dissatisfaction with violent television programming.

Public Health Approach

APA's Phillips recommended to the Attorney General that the Justice Department take a public health approach to the problem of violence similar to the successful antismoking campaign. The Attorney General agreed this would be a useful approach, according to Phillips.

"The public health model would allow the Administration to take certain actions to protect children by placing certain parameters around their exposure to gratuitous violence. The overriding issue is their health and welfare versus violating their individual rights. The greater risk is that they will become desensitized to the dangers of violence and react in violent ways," said Phillips.

He also compared the "pandemic of violence to infectious diseases, which can be found in every corner of society regardless of race, creed, or social status. We should respond to this phenomenon in much the same way we react to limit citizens' exposure to infectious agents."

Phillips said that when children see a violent response to conflicts, "it sows the seeds of social behavior that flourishes into problems."

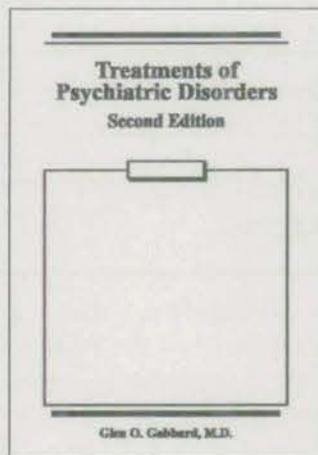
Reno told task force members that conflict resolution can be taught, and she en-

See "TV Violence," page 29

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In the Eye of the Beholder

By Barbara S. Herrington

The theme of this column is reality—people's perceptions and technology's representation of reality.

In a rare convergence of both, the half-hour documentary film "Larry" allows viewers inside the reality of a mind distorted by manic depression and delusions. Larry Harding, a formerly professional man with a doctorate in educational psychology, now spends his days on the streets of Boulder, Colo., deciphering license plates and writing coded postcards to his family that only he can interpret. His voice is the only narrative, leaving his experience largely unfiltered by the filmmaker and mental health professionals. It veers among lucid recollections of a happier past, current assessments

of the lonely present, and translations of plots and conspiracies from the configurations of numbers, letters, and colors on license plates and signs.

It wasn't always that way. Until he was "swept away" by illness in his late 40's, Larry had a loving wife, three children, a home, and a good job. His design of a computer-managed instructional system for the Civil Service was hailed as revolutionary. In 1985 he lost his job, divorced, and went on disability. "I was just too afraid—too ashamed—to get help when I first felt ill," he admits in the film. Now he lives day to day, hoping some new medication or treatment will bring relief.

His son Will, now 26, produced this poignant film, using a crew for a week and then living with his father for three months. It brought back his fear of inheriting the disease, a fear heightened by a psychiatric hospitalization after high school. Following that episode, he took his doctors' advice and severed ties with his father, working as a teacher and free-lance journalist in Eastern Europe. But he returned six years later to try to understand his father and to tell the story of one man's struggle with mental illness.

"Larry represents a group of people who've been forgotten in our society," Will says. "Maybe some viewers will find that by relating to 'Larry,' they can find common ground on which to relate to the mentally ill generally."

A film offering at a previous APA annual

meeting, the film will air this year on the Miami public television station WLRN, channel 17 (cable 34 and 35), during APA's annual meeting later this month.

Times Really Are Tough

The perception of reality for Americans in general right now has grown steadily more bleak since the Vietnam war and Watergate, reports the April *Longevity* in the first of a three-part series. Harris pollsters, who began tracking these issues 29 years ago, have found a "fairly remorseless" downward trend in confidence in leaders and institutions and an upward trend in alienation. The number-one fear concerns loss of a job and/or health coverage. After that comes worry over the decline in real wages, relationship anxieties, fears of violence, and concern about environmental degradation. Accelerated communication—television, radio, telephone, fax, e-mail—forces people to live increasingly by the hour, minute, and second.

Times really are tough, reassures one expert, opining that people are having normal reactions to abnormal situations. He recommends discovering sources of fun that are "cheap and people oriented" and rebuilding a sense of community.

Virtual Communities

That may not be so easy in an age in which communities and families have been fractured by distant jobs, auto travel, sub-

urbs, and shopping malls. Some, however, are finding virtual community in cyberspace on the Internet. *Utne Reader* devotes the first half of its March-April issue to articles pondering the benefits and drawbacks of these cyberhoods.

The negative point of view despairs of a society that worships technology and is reduced to electronic connections. The cyber community lacks breath and spirit as well as body language, sex, and other elements that make life real to most people. It also lacks diversity; users are liable to find themselves in an electronic suburb populated largely by white men under 50 with higher math skills, strong opinions, and lots of computer terminal time, not to mention money to pay for it. Users don't have time to look for the diversity that often exists in physical neighborhoods. A larger fear is that the information superhighway—made up of videoshopping, pay-per-view movies, and two-way videophones—will simply further invade our lives with more targeted marketing, drive up consumption, and sap our will to seek out "real" community.

The positive view sees cyberspace as offering another source of conviviality, the third essential "place" in people's lives after work and home, sort of how the corner bar, town square, beauty parlor, and cafe used to be, as author Ray Oldenburg proposes. These places provided the soil from which community sprang and the glue to

See "Media Watch," page 30

Suspension

Randall E. Pitone, M.D., of Clearwater, Fla., has been suspended from membership in the American Psychiatric Association and the Florida Psychiatric Society for three years for violation of Section 1, Annotation 1, and Section 2, Annotation 1, of the *Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry*. Pitone was found to have engaged in sexual activity with a patient while she was in treatment, and he practiced medicine in an incompetent manner. While his appeal was pending, Pitone resigned his membership in APA and in his district branch.



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Wiener to Present Special Awards at Annual Meeting

APA President Jerry Wiener, M.D., will present special presidential commendations to seven individuals at APA's annual meeting Convocation later this month in Miami.

The honorees are Virginia Q. Anthony, Sidney Berman, M.D., Irvin M. Cohen, M.D., Thelissa A. Harris, M.D., Rodrigo Munoz, M.D., Howard Rome, M.D. (posthumous), and Venie Palasota.

The Convocation will be held Monday, May 22, at 8 p.m. in Exhibit Hall D, level 1, Miami Beach Convention Center.

Anthony is being commended for her service as executive director of the American Academy of Child and Adolescent Psychiatry, a post she has held since 1973. In that time, she has been a tireless "advocate for the best interests of children, adolescents, and the subspecialty of child and adolescent psychiatry," according to the citation she will receive in the form of a plaque.

Berman is being honored as "one of the true pioneers and founders of modern-day child and adolescent psychiatry as a teacher, clinician, and past president of the American Academy of Child and Adolescent Psychiatry."

A "psychiatric man for all seasons," Cohen has spent years in service to APA as Assembly speaker; a member of the Board of Trustees, Council on Internal Organization, and Council on Research; and director of APA's Insurance Group.

Harris's commendation is in recognition of "her importance as a role model in APA" and her leadership and dedication as chair of the Council on Internal Organization.

Munoz is being recognized for his "sustained and vigorous leadership" as a member of the Board of Trustees and for his representation of and advocacy for the concerns and participation of minority and IMG members in APA affairs.

Rome is being honored posthumously for "his many contributions to American psychiatry" and for his service as an APA president and chair of psychiatry at the Mayo Clinic.

Palasota's commendation is in recognition of her years of "devoted service and dedication" to APA through her activities as a leader and president of the APA Auxiliary. She was instrumental in the publication of the Auxiliary's cookbook last year in conjunction with APA's sesquicentennial celebration.

International Psychiatry To be Focus of Symposium

The American Society of Hispanic Psychiatry and the Inter-American Council of Psychiatric Associations will sponsor a symposium titled "Perspectives on International Psychiatry" on Saturday, May 20, in conjunction with APA's annual meeting in Miami.

The location is the Fontainebleau Ballroom Section A, level 2, of the Fontainebleau Hilton.

The symposium will cover two major topics. "Psychiatric Education in the Americas," sponsored by the Inter-American Council of Psychiatric Associations, will be chaired by Antonio Pacheco, M.D., of Venezuela and co-chaired by Rodolfo Fahrer, M.D., of Argentina. "Violence: Multidisciplinary Perspectives," sponsored by the American Society of Hispanic Psychiatry, will be chaired by Renato D. Alarcon, M.D., M.P.H., of Emory University, Atlanta. The discussant will be APA Deputy Medical Director Robert T.M. Phillips, M.D., Ph.D.

Geriatric Psychiatry

from page 5

the burgeoning field of geriatric psychiatry is a case study in organized psychiatry's acquiescence to the dictates of pharmaceutical companies and managed care.

"I believe that psychiatry is being driven not only by the desire to heal people, but by an overzealous desire to categorize them and treat them medicinally," he told *Psychiatric News*. "This makes me uncomfortable because it falls so perfectly in line with economic agendas held by pharmaceutical and managed care companies."

Ablow believes that economic forces have robbed psychiatry of its psychotherapeutic soul, turning clinicians into "pill pushers" treating narrowly codified conditions.

"This is just the tip of the iceberg," he added. "Organized psychiatry needs to re-

"These statements are public health hazards—like arguing that cigarettes don't cause disease."

examine how the component of healing—which is immeasurable—is being fostered It won't be fostered by selling millions of dollars worth of *DSM-IV* or by credentialing subspecialty practitioners who wish to regard their knowledge or expertise as better than other psychiatrists'. I guess we are headed down a road where we will someday board certify psychiatrists who treat menopausal women and who will—incidentally, we will say—come up with medicine that will be particularly useful in that population and coincidentally write into [the diagnostic manual] a disorder that corresponds with their mood swings.

"I don't debate that elderly people suffer and that the ways in which they suffer might be classified into categories," he added. "What I resonate with negatively is the assumption that their suffering is medically based and cannot be alleviated through human connections."

He added, "I think I represent the views of many frustrated practitioners who wonder in what way they can make known the fact that the best things they've done for people can't always be described in a five-digit code."

Scientific Knowledge

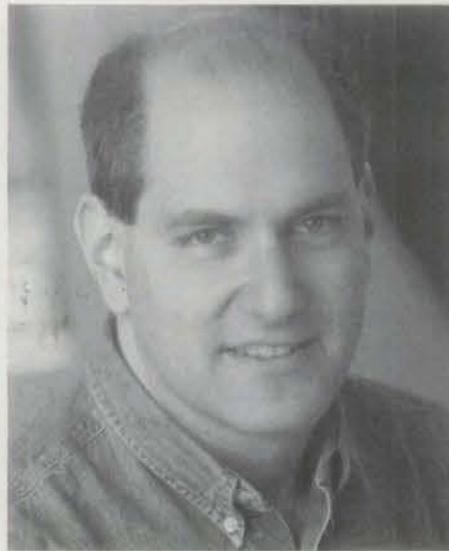
But Katz is equally passionate in his defense of the scientific base of geriatric psychiatry.

"Our basic assumption that scientific knowledge really carries a lot of weight in the marketplace of ideas has to be questioned" in the light of the articles, he told *Psychiatric News*.

"When so many of us started in geriatric psychiatry, the field was marked by myths. The first generation of research was devoted to distinguishing between what is normal aging and what is disease," he said. "So many of us had assumed that the battle was won, and now we could move on to other battles. The recent articles by Ablow and Jacobson show that it is a battle we have to look at in an ongoing fashion."

Katz also derided Ablow's claim that the Medicare program gives psychiatrists a financial incentive to treat the elderly.

"That certainly shows a lack of familiarity with the realities of Medicare reimbursement," Katz said. "Here at the University of



Keith Ablow, M.D.: "I believe that psychiatry is being driven not only by the desire to heal people, but by an overzealous desire to categorize them and treat them medicinally."

Pennsylvania, for an hour of attendant-level care [the reimbursement] is between \$50 and \$60. Our costs are substantially greater than that. . . . If he thinks people are going into geriatric psychiatry opportunistically, he is much better at the business of it than any of us at the University of Pennsylvania."

To Katz, the *Atlantic Monthly* article and Ablow's piece are evidence of the persistence of firmly held beliefs that fly in

New York

from page 7

tures on mental health services have grown by 15 percent yearly, far more than other state programs. In response, Pataki's proposal would—justifiably, they say—cut mental health services far more sharply than other services.

"Given that large rate of increase," said OMH spokesperson Roger Klingman, the state will be able to absorb the proposed cuts and "still launch an array of new programs to serve 2,500 additional outpatients, provide 2,256 new residential beds, and add 400 new work program slots." But the figures cited reflect a substantial reduction from the original CRA blueprint, which would have provided for 4,100 additional outpatients and 3,926 new housing slots, Klingman conceded.

"I understand the disappointment among the advocates that more funding isn't available," said Klingman. "But state aid has been growing at 15 percent per year with no light at the end of tunnel. You reach a point where you have to ask if the state can sustain that rate of growth, or do we have to look at new ways of providing services."

Partial Offset

Although the Pataki proposal would reduce state aid to community mental health programs by about \$50 million, that would be partially offset by a Medicaid increase, bringing the net reduction to \$39.3 million, Klingman said. In fiscal 1994-95 \$75.3 million went to a combination of various community mental health programs, he said. Remaining community mental health funding for fiscal 1995-96 and 1996-97 would come to \$69.3 million combined, said Klingman.

Cuts would affect various programs, including a plan to increase staff-to-patient ratios in state psychiatric centers, and a \$30 million initiative for the mentally ill homeless using funds from closed state hospitals,



Ira Katz, M.D.: "If [Ablow] thinks people are going into geriatric psychiatry opportunistically, he is much better at the business of it than any of us at the University of Pennsylvania."

the face of science.

"Both articles make the point that pathology is normal in aging, that hallucinations can be comforting, that depression is inevitable, and that to deny its roots in the aging process is to do patients a disservice," Katz noted.

"These statements are public health hazards—like arguing that cigarettes don't cause disease," he said.

according to Klingman. In the last fiscal year, the state spent \$10 million of the \$30 million, he said. Another \$5 million to have been spent this year would be cut.

Patient Abandonment

While Pataki's critics concede that he faces a tough fiscal environment, they argue that it is no reason to abandon the mentally ill.

"It would be nice if government could help everyone," said Jaffe. "But given tough choices, who should we help? It should be those in need. If you look at suicide rates, homelessness, arrest rates, hospitalization rates, and joblessness rates, you'll find the seriously mentally ill are those most in need of government assistance."

But Jaffe and other mental health advocates are hopeful that \$200 million from hospital closures over a five-year period originally earmarked for community services and now being diverted to tax cuts and deficit reduction may be salvaged. There is little optimism that other aspects of the proposal will be reversed, however.

"New York has a long history of abandoning these people," said Jaffe. "The sad part of it is, the more they abandon community-based treatment, the more untreated people there are in the streets, and the more the communities resist community-based services." —R.B.K.

There's Still Time

It's not too late for employers to list their open positions in this year's computerized On-Site Job Bank at APA's 1995 annual meeting in Miami in May. For more information, call (202) 682-6108.

APA Residents Among Winners Of Leadership Awards

The AMA has informed APA that five psychiatry residents have won the AMA/Burroughs Wellcome Co. Leadership Award for resident physicians.

They are Toi Lynn Blakley, M.D., John D. Edgar, M.D., Kevin Kinback, M.D., John D. McLennan, M.D., and Rael David Strous, M.D.

The AMA established the leadership program in 1988 with a grant from Burroughs Wellcome Co. The program is designed to build ties between organized medicine and resident physicians who have displayed a commitment to community service. A total of 40 residents won this year's awards.

Blakley is a resident at the Baylor College of Medicine and an APA/Center for Mental Health Services (CMHS) fellow. Blakley was cited for a broad history of community service and academic involvement. She has volunteered with the homeless and has worked as a tutor, mentor, and fund raiser. She also participates in a program that allows her to utilize schools, churches, and medical and legal settings to heighten the recognition and improve the treatment of traumatized children.

Edgar, a resident at Mount Sinai Medical Center in New York, was recognized for his volunteer work with an organization that serves homeless mentally ill adults in Manhattan's East Harlem community. He provides medical and psychiatric evaluations, diagnostic screens, treatment planning, medication, crisis intervention, and psychotherapy for patients who otherwise would go without care.

Kinback is a resident at the Loma Linda University Medical Center. Kinback was a volunteer in medical relief efforts for trauma victims in the 1994 Los Angeles earthquake. He serves in a nationwide training conference for critical incident stress debriefings, participates in annual overseas medical trips to impoverished jungle areas, teaches courses on relationships, and provides free crisis counseling at local churches. For more than 10 years he has taught advanced and basic cardiac life support to medical students and the general public. He also formed a group to educate and encourage medical student interest in psychiatry.

McLennan, a University of Pittsburgh Medical Center resident, started volunteer-



From left: Psychiatry residents Toi Lynn Blakley, M.D., John D. Edgar, M.D., Kevin Kinback, M.D., John D. McLennan, M.D., and Rael David Strous, M.D., are among the 40 residents who won this year's AMA/Burroughs Wellcome Co. Leadership award for resident physicians.

ing at a clinic for malnourished children in the Dominican Republic in 1989. He studied infant feeding practices in the local shantytown communities to improve the nutrition education program used by local health promoters. He also identified and referred malnourished children to the clinic, trained health promoters, worked in the clinic's nutrition center, and designed a safer and more cost-effective program for realimentation. McLennan now directs a

group of local health promoters involved in an infant growth monitoring program that emphasizes primary and secondary prevention and provides technical support to the clinic.

Strous, a resident at the Albert Einstein College of Medicine in New York, has coordinated numerous charity programs and a national convention for South African youth. He has volunteered as a community crisis counselor and orphanage supervisor and

mentor, and he provided rehabilitation for a brain-damaged child. His work with the homeless has included establishing two clinics, serving as a medical overseer at a shelter, and working on a project that provides food. Strous has volunteered as a physician in urban South Africa, rural Ethiopia, and rural Canada. In New York, he coordinated and initiated conflict resolution and dialogue sessions between black and Jewish teenagers.

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Program Chair

Depression and Personality Disorders: Debate

ROBERT M.A. HIRSCHFELD, MD

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Department of Psychiatry and Behavioral Sciences,
University of Texas Medical Branch at Galveston

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Chronic Depression

ALAN GELENBERG, MD

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Antidepressant Treatment in the Elderly

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Mental Health Center

Treatment Resistant Depression

MICHAEL THASE, MD

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Director, Division of Mood, Anxiety, and Related Disorders,
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Depression and Substance Abuse

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Director, Alcohol Research Center,
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Discussant

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from page 1

tial appointment that has a vision for mental health and substance abuse service issues, the need for a more defined mental health treatment and prevention entity, and not merely moving it to a sufficiently high level 'box' in any reorganization."

No Detailed Plan

He noted the lack of a detailed plan. "I repeatedly asked them why and how they thought the merger would work, and they did not define it. They talked about working more closely together and making HCFA, SAMHSA, and HRSA co-equals. They denied that HCFA would be in charge."

Cutler said that officials from the three agencies slated for the reorganization appeared "appropriately politically supportive." Also, they mentioned that "certain internal restructuring might not require legislation if, for example, they placed certain elements of other agencies within the Office of the Secretary," said Cutler.

Mary Jane England, M.D., also attended the meeting on the proposed merger in her role as president of the Washington Business Group on Health. She told *Psychiatric News* later that she was concerned that "folding SAMHSA and HRSA into HCFA would result in financing driving the program instead of patients and their treatment needs."

In addition, HCFA historically has not provided full and nondiscriminatory coverage for mental health and substance abuse services in its Medicaid and Medicare programs, according to England.

"Until we are reassured that we can have parity with medical and surgical services, I strongly urge that SAMHSA be continued to focus advocacy efforts for these vulnerable populations. I am also concerned that HCFA is not responsive to the needs of children. Children make up almost half of the Medicaid-eligible population, yet HCFA pays only 15 percent of their expenditures."

Another concern she raised at the meet-



Mary Jane England, M.D., is concerned that HCFA is not responsive to the needs of children.



HHS Secretary Donna Shalala: "Our goal is to provide better service to our customers at a lower cost to taxpayers."

ing was that absorbing SAMHSA into HCFA would "abrogate the role of federal agencies to advocate for populations with special health care needs in the communities precisely at the time when states are in the

midst of profound reorganization of their public health care delivery systems under the movement to organized system of care." She advocated reforming SAMHSA's delivery system to "carry out aggressive demonstrations to develop comprehensive and effective service delivery systems for child and family mental health. These delivery systems must integrate child welfare, education, juvenile justice, substance abuse, public health, and mental health," she told the audience of advocacy groups and federal officials.

SAMHSA was established in 1992 to strengthen the nation's prevention and treatment delivery system for persons with mental and addictive disorders. It was created as part of the reorganization of the Alcohol, Drug Abuse, and Mental Health Administration.

England noted that SAMHSA's child and family branch has launched 22 demonstration programs in local communities to develop integrated delivery systems for child and family mental health.

"These sites are directly relevant to the widespread movement by the state Medicaid programs to convert to managed care and capitation. These demonstrations can provide examples of the development of special systems of care for vulnerable populations," said England.

Other Reinventing Proposals

Another proposal Shalala referred to in her March memo would consolidate surveys in the health statistics and research agencies to improve coordination of data standards and data collection. The *Post* article, which the Secretary described as premature and somewhat inaccurate, mentioned shifting three agencies into one "numbers agency" that would affect the National Center for Health Statistics, Agency for Health Care Policy and Research, and Office of Research of the Medicare program, which were budgeted at \$81 million, \$163 million, and \$89 million, respectively, in the previous fiscal year.

One item being debated is whether to hire private medical groups to perform some of the services at the National Institutes of Health (NIH) clinical center in Bethesda. The proposal also calls for "public-private partnerships" to conduct various research now performed by NIH and other Public Health Service (PHS) employees.

Another preliminary proposal would give Shalala more control over all public health decisions by merging the staff functions of the assistant secretary of health with the Office of the Secretary.

The HHS options reflect the Administration's accelerated "reinventing government" initiative, which would help pay for the President's promised middle-class tax cut.

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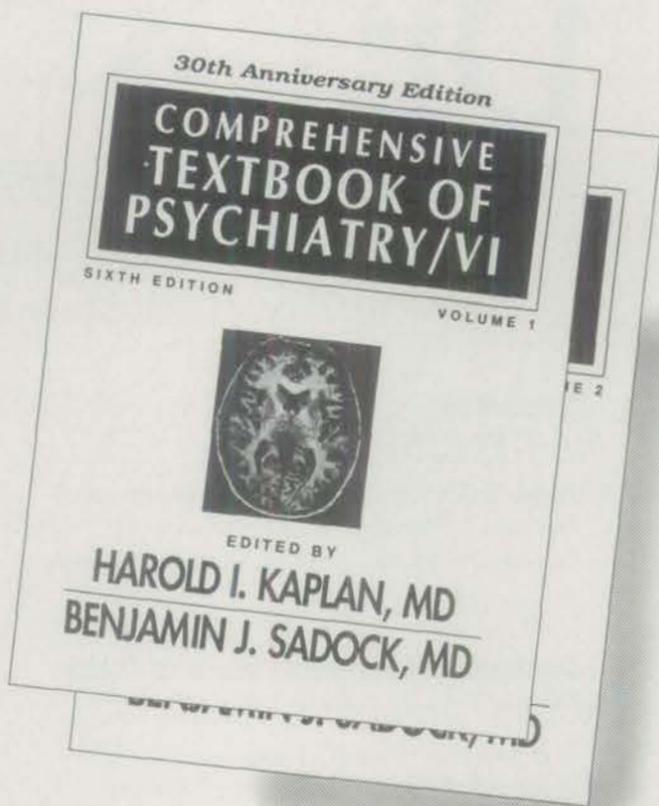
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APA Announces Recipients of Roeske Certificate of Excellence

The APA Committee on Medical Student Education has announced the recipients of the Fifth Annual Nancy C.A. Roeske, M.D., Certificate of Recognition for Excellence in Medical Student Education.

This certificate is awarded to APA members who have made outstanding and sustaining contributions to medical education, in both salaried and volunteer positions. Qualified nominees must have demonstrated significant contributions to the advancement of medical student education, including lectures, small group teaching, supervision, course design, and so on. The following is a list of the 1995 recipients:

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*No direct comparisons have been made.

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FIRST-LINE TREATMENT OF DEPRESSION

ABPN Exam Schedule

The American Board of Psychiatry and Neurology (ABPN) has announced its 1995-96 examination schedule.

The Part I (written) exam and added qualifications in geriatric psychiatry exam will be held on the same dates in 1995 and 1996, October 17, 1995, and November 6, 1996. The application deadline for each of the above exam dates is February 1 of the corresponding year. To obtain information on other ABPN exams and applications, contact Stephen Scheiber, M.D., Executive Vice President, ABPN Inc., 500 Lake Cook Road, Suite 335, Deerfield, Ill. 60015; (708) 945-7900

The Guiteau Trial: Battle of the Forensic Experts

By Lucy D. Ozarin, M.D.

On July 2, 1881, while in Union Station in Washington, D.C., President James A. Garfield was shot and wounded by one Charles Guiteau. The President died as a result of his wounds the following September. The assassin, who had been apprehended at the scene, was brought to trial in November 1881, found sane and guilty in January 1882, and sentenced to hang. The hanging took place on June 30, 1882.

The trial of Guiteau was a widely recorded event both in the United States and abroad. Since the outcome depended on whether the assassin was sane or insane at the time of the shooting, American psychia-

try was on trial as much as the prisoner.

Equally eminent psychiatrists testified for the defense and the prosecution. Almost all of the testifying experts were superintendents of mental hospitals, and at least six had been presidents of APA's forerunner. The lead psychiatrist for the prosecution was Dr. John Gray, superintendent of the Utica State Hospital and editor of the *American Journal of Insanity*. For the defense was Dr. Edward Spitzler, president of the New York Neurological Association and a member of the editorial board of the *Journal of Nervous and Mental Disease*. Spitzler, a neurologist, was a harsh critic of the lead-

ership of the Association of Medical Superintendents of American Institutions for the Insane, and especially of Dr. Gray.

Life on the Fringe

Guiteau was born in Illinois in 1841. His mother died when he was 7. His father, a bank cashier, was a convert to the doctrines of John Noyes, founder of the Oneida (N.Y.) community (which today might be regarded as a cult). His followers believed in perfectionism through absolute faith. At the age of 19, Guiteau entered the Oneida community and remained until age 25, though he later returned briefly.

Over the next years, Guiteau led an unstable life. He became a lawyer in Chicago, wrote religious tracts, gave poorly attended lectures on religion in various cities, incurred unpaid debts, and appeared to have grandiose ideas about his capabilities. In a letter to his father in 1865, he wrote, "I claim inspiration, I am in the employ of Jesus Christ. . . . [W]hat I can do is limited only by [His] power and purpose." He appeared to equate "inspiration" with divine guidance.

When Garfield was nominated for president, Guiteau tried unsuccessfully to have a role in the campaign. After the election,

See "History Notes," page 28

References: 1. Data on file, Burroughs Wellcome Co. 2. Walker PW, Cole JO, Gardner EA, et al. Improvement in fluoxetine-associated sexual dysfunction in patients switched to bupropion. *J Clin Psychiatry*. 1993;54:459-465. 3. Gardner EA, Johnston JA. Bupropion—an antidepressant without sexual pathophysiological action. *J Clin Psychopharmacol*. 1985;5(1):24-29. 4. American Psychiatric Association. *Practice Guideline for Major Depressive Disorder in Adults*. 1993. 5. Jacobsen FM. Fluoxetine-induced sexual dysfunction and an open trial of yohimbine. *J Clin Psychiatry*. 1992;53(4):119-122. 6. Segraves RT. Sexual dysfunction complicating the treatment of depression. *J Clin Psychiatry Monograph*. 1992;10(1):75-79. 7. Reimherr FW, Chouinard G, Cohn CK, et al. Antidepressant efficacy of sertraline: a double-blind, placebo- and amitriptyline-controlled multicenter comparison study in outpatients with major depression. *J Clin Psychiatry*. 1990;51(12, suppl 8):18-27. 8. Cohn CK, Shrivastava R, Mendels J, et al. Double-blind, multicenter comparison of sertraline and amitriptyline in elderly depressed patients. *J Clin Psychiatry*. 1990;51(12, suppl 8):28-33. 9. Ferris RM, Cooper BR. Mechanism of antidepressant activity of bupropion. *J Clin Psychiatry Monograph*. 1993;11(1):2-14. 10. WELLBUTRIN package insert, Burroughs Wellcome Co. 11. Feighner JP, Gardner EA, Johnston JA, et al. Double-blind comparison of bupropion and fluoxetine in depressed outpatients. *J Clin Psychiatry*. 1991;52:329-335. 12. *Depression in Primary Care: Volume 2. Treatment of Major Depression. Clinical Practice Guideline, Number 5*. Rockville, Md: US Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research; 1993. AHCPR publication 93-0551.

WELLBUTRIN® (bupropion hydrochloride) Tablets

Before prescribing, please consult complete product information, a summary of which follows:

INDICATIONS AND USAGE: WELLBUTRIN is indicated for the treatment of depression. A physician considering the initiation of WELLBUTRIN should be aware that the drug may cause generalized seizures with an approximate incidence of 0.4% (4/1000). This incidence may exceed that of other antidepressants as much as fourfold. This relative risk is only an approximation since no direct comparative studies have been conducted.

CONTRAINDICATIONS: WELLBUTRIN is contraindicated in patients: with a seizure disorder; with a current or prior diagnosis of bulimia or anorexia nervosa, because of a higher incidence of seizures noted in such patients; who have shown an allergic response to it; or who are currently being treated with an MAO inhibitor. At least 14 days should elapse between discontinuation of an MAO inhibitor and initiation of treatment with WELLBUTRIN.

WARNINGS: SEIZURES: WELLBUTRIN is associated with seizures in approximately 0.4% (4/1000) of patients treated at doses up to 450 mg/day. This incidence of seizures may exceed that of other marketed antidepressants by as much as fourfold. This relative risk is only an approximate estimate because no direct comparative studies have been conducted. The estimated seizure incidence for WELLBUTRIN increases almost tenfold between 450 and 600 mg/day, which is twice the usually required daily dose (300 mg) and one and one-third the maximum recommended daily dose (450 mg). Given the wide variability among individuals and their capacity to metabolize and eliminate drugs, this disproportionate increase in seizure incidence with dose incrementation calls for caution in dosing.

During the initial development, 25 among approximately 2400 patients treated with WELLBUTRIN experienced seizures. At the time of seizure, seven patients were receiving daily doses of 450 mg or below, for an incidence of 0.33% (3/1000) within the recommended dose range. Twelve patients experienced seizures at 600 mg per day (2.3% incidence); six additional patients had seizures at daily doses between 600 and 900 mg (2.8% incidence).

A separate, prospective study was conducted to determine the incidence of seizure during an 8 week treatment exposure in approximately 3200 additional patients who received daily doses of up to 450 mg. Patients were permitted to continue treatment beyond 8 weeks if clinically indicated. Eight (8) seizures occurred during the initial 8 week treatment period and five seizures were reported in patients continuing treatment beyond 8 weeks, resulting in a total seizure incidence of 0.4%.

The risk of seizure appears to be strongly associated with dose and the presence of predisposing factors. A significant predisposing factor (e.g., history of head trauma or prior seizure, CNS tumor, concomitant medications that lower seizure threshold, etc.) was present in approximately one-half of the patients experiencing a seizure. Sudden and large increments in dose may contribute to increased risk. While many seizures occurred early in the course of treatment, some seizures did occur after several weeks at fixed dose.

Recommendations for reducing the risk of seizure: Retrospective analysis of clinical experience gained during the development of WELLBUTRIN suggests that the risk of seizure may be minimized if (1) the total daily dose of WELLBUTRIN does not exceed 450 mg, (2) the daily dose is administered i.d., with each single dose not to exceed 150 mg to avoid high peak concentrations of bupropion and/or its metabolites, and (3) the rate of incrementation of dose is very gradual. Extreme caution should be used when WELLBUTRIN is (1) administered to patients with a history of seizure, cranial trauma, or other predisposition(s) toward seizure, or (2) prescribed with other agents (e.g., antipsychotics, other antidepressants, etc.) or treatment regimens (e.g., abrupt discontinuation of a benzodiazepine) that lower seizure threshold.

Potential for Hepatotoxicity: In rats receiving large doses of bupropion chronically, there was an increase in incidence of hepatic hyperplastic nodules and hepatocellular hypertrophy. In dogs receiving large doses of bupropion chronically, various histologic changes were seen in the liver, and laboratory tests suggesting mild hepatocellular injury were noted. Although scattered abnormalities in liver function tests were detected in patients participating in clinical trials, there is no clinical evidence that bupropion acts as a hepatotoxin in humans.

PRECAUTIONS: General:

Agitation and Insomnia: A substantial proportion of patients treated with WELLBUTRIN experience some degree of increased restlessness, agitation, anxiety, and insomnia, especially shortly after initiation of treatment. In clinical studies, these symptoms were sometimes of sufficient magnitude to require treatment with sedative/hypnotic drugs. In approximately 2% of patients, symptoms were sufficiently severe to require discontinuation of treatment with WELLBUTRIN.

Psychosis, Confusion, and Other Neuropsychiatric Phenomena: Patients treated with WELLBUTRIN have been reported to show a variety of neuropsychiatric signs and symptoms including delusions, hallucinations, psychotic episodes, confusion, and paranoia. Because of the uncontrolled nature of many studies, it is impossible to provide a precise estimate of the extent of risk imposed by treatment with WELLBUTRIN. In several cases, neuropsychiatric phenomena abated upon dose reduction and/or withdrawal of treatment.

Activation of Psychosis and/or Mania: Antidepressants can precipitate manic episodes in Bipolar Manic Depressive patients during the depressed phase of their illness and may activate latent psychosis in other susceptible patients. WELLBUTRIN is expected to pose similar risks.

Altered Appetite and Weight: A weight loss of greater than 5 pounds occurred in 28% of patients receiving WELLBUTRIN. This incidence is approximately double that seen in comparable patients treated with tricyclics or placebo. Furthermore, while 34.5% of patients receiving tricyclic antidepressants gained weight, only 9.4% of patients treated with WELLBUTRIN did. Consequently, if weight loss is a major presenting sign of a patient's depressive illness, the anorectic and/or weight reducing potential of WELLBUTRIN should be considered.

Suicide: The possibility of a suicide attempt is inherent in depression and may persist until significant remission occurs. Accordingly, prescriptions for WELLBUTRIN should be written for the smallest number of tablets consistent with good patient management.

Use in Patients with Systemic Illness: There is no clinical experience establishing the safety of WELLBUTRIN in patients with a recent history of myocardial infarction or unstable heart disease. Therefore, care should be exercised if it is used in these groups.

Because bupropion HCl and its metabolites are almost completely excreted through the kidney and metabolites are likely to undergo conjugation in the liver prior to urinary excretion, treatment of patients with renal or hepatic impairment should be initiated at reduced dosage as bupropion and its metabolites may accumulate in such patients beyond concentrations expected in patients without renal or hepatic impairment. The patient should be closely monitored for possible toxic effects of elevated blood and tissue levels of drug and metabolites.

Information for Patients: Consult complete product information.

Drug Interactions: No systematic data have been collected on the consequences of the concomitant administration of WELLBUTRIN and other drugs.

However, animal data suggest that WELLBUTRIN may be an inducer of drug metabolizing enzymes. This may be of potential clinical importance because the blood levels of co-administered drugs may be altered.

Alternatively, because bupropion is extensively metabolized, the co-administration of other drugs may affect its clinical activity. In particular, care should be exercised when administering drugs known to affect hepatic drug-metabolizing enzyme systems (e.g., carbamazepine, cimetidine, phenobarbital, phenytoin).

Studies in animals demonstrate that the acute toxicity of bupropion is enhanced by the MAO inhibitor phenelzine (see CONTRAINDICATIONS).

Limited clinical data suggest a higher incidence of adverse experiences in patients receiving concurrent administration of WELLBUTRIN and L-dopa. Administration of WELLBUTRIN to patients receiving L-dopa concurrently should be undertaken with caution, using small initial doses and small gradual dose increases.

Concurrent administration of WELLBUTRIN and agents which lower seizure threshold should be undertaken only with extreme caution (see WARNINGS). Low initial dosing and small gradual dose increases should be employed.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Lifetime carcinogenicity studies were performed in rats and mice at doses up to 300 and 150 mg/kg/day, respectively. In the rat study there was an increase in nodular proliferative lesions of the liver at doses of 100 to 300 mg/kg/day; lower doses were not tested. The question of whether or not such lesions may be precursors of neoplasms of the liver is currently unresolved. Similar liver lesions were not seen in the mouse study, and no increase in malignant tumors of the liver and other organs was seen in either study.

Bupropion produced a borderline positive response (2 to 3 times control mutation rate) in some strains in the Ames bacterial mutagenicity test, and a high oral dose (300, but not 100 or 200 mg/kg) produced a low incidence of chromosomal aberrations in rats. The relevance of these results in estimating the risk of human exposure to therapeutic doses is unknown.

A fertility study was performed in rats; no evidence of impairment of fertility was encountered at oral doses up to 300 mg/kg/day.

Pregnancy: Teratogenic Effects: Pregnancy Category B. Reproduction studies have been performed in rabbits and rats at doses up to 15 to 45 times the human daily dose and have revealed no definitive evidence of impaired fertility or harm to the fetus due to bupropion. (In rabbits, a slightly increased incidence of fetal abnormalities was seen in two studies, but there was no increase in any specific abnormality.) There are no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Labor and Delivery: The effect of WELLBUTRIN on labor and delivery in humans is unknown.

Nursing Mothers: Because of the potential for serious adverse reactions in nursing infants from WELLBUTRIN, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: The safety and effectiveness of WELLBUTRIN in individuals under 18 years old have not been established.

Use in the Elderly: WELLBUTRIN has not been systematically evaluated in older patients.

ADVERSE REACTIONS: (See also WARNINGS and PRECAUTIONS) Adverse events commonly encountered in patients treated with WELLBUTRIN are agitation, dry mouth, insomnia, headache/migraine, nausea/vomiting, constipation, and tremor.

Adverse events were sufficiently troublesome to cause discontinuation of treatment with WELLBUTRIN in approximately ten percent of the 2400 patients and volunteers who participated in clinical trials during the product's initial development. The more common events causing discontinuation include neuropsychiatric disturbances (3.0%), primarily agitation and abnormalities in mental status; gastrointestinal disturbances (2.1%), primarily nausea and vomiting; neurological disturbances (1.7%), primarily seizures, headaches, and sleep disturbances; and dermatologic problems (1.4%), primarily rashes. It is important to note, however, that many of these events occurred at doses that exceed the recommended daily dose.

The table below is presented solely to indicate the relative frequency of adverse events reported in representative controlled clinical studies conducted to evaluate the safety and efficacy of WELLBUTRIN under relatively similar conditions of daily dosage (300 to 600 mg), setting, and duration (3 to 4 weeks). The figures cited cannot be used to predict precisely the incidence of untoward events in the course of usual medical practice where patient characteristics and other factors must differ from those which prevailed in the clinical trials. These incidence figures also cannot be compared with those obtained from other clinical studies involving related drug products as each group of drug trials is conducted under a different set of conditions.

Finally, it is important to emphasize that the tabulation does not reflect the relative severity and/or clinical importance of the events. A better perspective on the serious adverse events associated with the use of WELLBUTRIN is provided in WARNINGS and PRECAUTIONS.

TREATMENT EMERGENT ADVERSE EXPERIENCE INCIDENCE IN PLACEBO-CONTROLLED CLINICAL TRIALS* (Percent of Patients Reporting)

Adverse Experience	WELLBUTRIN Patients (n = 323)	Placebo Patients (n = 185)	Adverse Experience	WELLBUTRIN Patients (n = 323)	Placebo Patients (n = 185)
CARDIOVASCULAR			Dry Mouth	27.6	18.4
Cardiac Arrhythmias	5.3	4.3	Excessive Sweating	22.3	14.6
Dizziness	22.9	16.2	Headache/Migraine	25.7	22.2
Hypertension	4.3	1.6	Impaired Sleep Quality	4.0	1.6
Hypotension	2.5	2.2	Increased Salivary Flow	3.4	3.8
Palpitations	3.7	2.2	Insomnia	18.6	15.7
Syncope	1.2	0.5	Muscle Spasms	1.9	3.2
Tachycardia	10.8	8.6	Pseudoparkinsonism	1.5	1.6
DERMATOLOGIC			Sedation	19.8	19.5
Pruritus	2.2	0.0	Sensory Disturbance	4.0	3.2
Rash	8.0	6.5	Tremor	21.1	7.6
GASTROINTESTINAL			NEUROPSYCHIATRIC		
Anorexia	18.3	18.4	Agitation	31.9	22.2
Appetite Increase	3.7	2.2	Anxiety	3.1	1.1
Constipation	26.0	17.3	Confusion	8.4	4.9
Diarrhea	6.8	6.6	Decreased Libido	3.1	1.6
Dyspepsia	3.1	2.2	Delusions	1.2	1.1
Nausea/Vomiting	22.9	18.9	Disturbed Concentration	3.1	3.8
Weight Gain	13.6	22.7	Euphoria	1.2	0.5
Weight Loss	23.2	23.2	Hostility	5.6	3.8
GENITOURINARY			NONSPECIFIC		
Impotence	3.4	3.1	Fatigue	5.0	6.6
Menstrual Complaints	4.7	1.1	Fever/Chills	1.2	0.5
Urinary Frequency	2.5	2.2	RESPIRATORY		
Urinary Retention	1.9	2.2	Upper Respiratory Complaints	5.0	11.4
MUSCULOSKELETAL			SPECIAL SENSES		
Arthritis	3.1	2.7	Auditory Disturbance	5.3	3.2
NEUROLOGICAL			Blurred Vision	14.6	10.3
Akathisia	1.5	1.1	Gustatory Disturbance	3.1	1.1
Akinesia/Bradycinesia	8.0	8.6			
Cutaneous Temperature Disturbance	1.9	1.6			

*Events reported by at least 1% of patients receiving WELLBUTRIN are included.

Other Events Observed During the Development of WELLBUTRIN: The conditions and duration of exposure to WELLBUTRIN varied greatly and a substantial proportion of the experience was gained in open and uncontrolled clinical settings. During this experience, numerous adverse events were reported, however, without appropriate controls. It is impossible to determine with certainty which events were or were not caused by WELLBUTRIN. The following enumeration is organized by organ system and describes events in terms of their relative frequency of reporting in the data base. Events of major clinical importance are also described in WARNINGS and PRECAUTIONS.

The following definitions of frequency are used: Frequent adverse events are defined as those occurring in at least 1/100 patients. Infrequent adverse events are those occurring in 1/100 to 1/1000 patients, while rare events are those occurring in less than 1/1000 patients.

Cardiovascular: Frequent was edema; infrequent were chest pain, EKG abnormalities (premature beats and nonspecific ST-T changes), and shortness of breath/dyspnea; rare were flushing, pallor, phlebitis, and myocardial infarction.

Dermatologic: Frequent were nonspecific rashes; infrequent were alopecia and dry skin; rare were change in hair color, hirsutism, and acne.

Endocrine: Infrequent was gynecostasia; rare were glycosuria and hormone level change.

Gastrointestinal: Infrequent were dysphagia, thirst disturbance, and liver damage/jaundice; rare were rectal complaints, colitis, G.I. bleeding, intestinal perforation, and stomach ulcer.

Genitourinary: Frequent was nocturia; infrequent were vaginal irritation, testicular swelling, urinary tract infection, painful erection, and retarded ejaculation; rare were dysuria, anuresis, urinary incontinence, menopause, ovarian disorder, pelvic infection, cystitis, dyspareunia, and painful ejaculation.

Hematologic/Oncologic: Rare were lymphadenopathy, anemia, and pancytopenia.

Musculoskeletal: Rare was musculoskeletal chest pain.

Neurological: (see WARNINGS) Frequent were ataxia/incoordination, seizure, myoclonus, dyskinesia, and dystonia; infrequent were mydriasis, vertigo, and dysarthria; rare were EEG abnormality, abnormal neurological exam, impaired attention, sciatica, and aphasia.

Neuropsychiatric: (see PRECAUTIONS) Frequent were mania/hypomania, increased libido, hallucinations, decrease in sexual function, and depression; infrequent were memory impairment, depersonalization, psychosis, dysphoria, mood instability, paranoia, formal thought disorder, and rigidity; rare was suicidal ideation.

Oral Complaints: Frequent was stomatitis; infrequent were toothache, trismus; gum irritation, and oral edema; rare was glossitis.

Respiratory: Infrequent were bronchitis and shortness of breath/dyspnea; rare were epistaxis, rate or rhythm disorder, pneumonia, and pulmonary embolism.

Special Senses: Infrequent was visual disturbance; rare was diplopia.

Nonspecific: Frequent were flu-like symptoms; infrequent was nonspecific pain; rare were body odor, surgically related pain, infection, medication reaction, and overdose.

Postintroduction Reports: Voluntary reports of adverse events temporally associated with WELLBUTRIN that have been received since market introduction and which may have no causal relationship with the drug include the following:

Cardiovascular: orthostatic hypotension, third degree heartblock

Endocrine: syndrome of inappropriate antidiuretic hormone secretion

Gastrointestinal: esophagitis, hepatitis

Hemic and Lymphatic: ecchymosis, leukocytosis, leukopenia

Musculoskeletal: arthralgia, myalgia, muscle rigidity/fatigue/habdominomyolysis

Nervous: coma, delirium, dream abnormalities, paresthesia, unmasking of tardive dyskinesia

Skin and Appendages: Stevens-Johnson syndrome, angioedema, exfoliative dermatitis, urticaria

Special Senses: linitus

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Letters

from page 12

child who is not an unconscious and unaware embryo or fetus but a living, feeling, conscious, aware, and reactive person? Further, what morality justifies adding to the pool of children for whom there already exists in this country and the world inadequate parenting, poor or nonexistent housing, unstable families, malnutrition, high morbidity and mortality, ineffective education and job training, and nonexistent jobs? And what morality is it that would force women to seek "back-alley" abortions by denying them legal and safe abortions?

I do not believe that my morality is of lesser value or righteousness than that of those who insist theirs is superior or closer to God and that we all must believe and act like them. In more than 50 years in practice, I have learned from my female patients to respect their individuality, dignity, and right to choose. I think the Trustees made the proper statement for our Association.

Arnold M. Kallon, M.D.
Livingston, N.J.

have distorted the AMA's report. In the *Psychiatric News* article Robert P. Cabaj, M.D., a leader of the gay caucus within our organization and one who helped draft the AMA report, has expanded this omission into the realm of the fictitious and thereby propagated an untruth to thousands of readers. He is quoted as follows:

"I only wish that APA was as out front as the AMA in *condemning* reparative therapies to change sexual orientation" (emphasis added).

There is nothing in the AMA report that indicates a condemnation of psychotherapy (reparative therapy is simply a brief form of psychotherapy based on analytic principles); only aversive behavioral treatments are contraindicated in this report, and these are not practiced by psychoanalytically oriented therapists. A careful study of the AMA report supplied to us by the AMA reveals that there is no mention whatsoever of "reparative therapy."

We acknowledge that many homosexual men and women do not wish to change their psychosexual adaptation, and we respect their wishes not to seek therapy. However, we believe that treatment should be available, encouraged, and affirmed for those who voluntarily seek help. In its public health mission, APA should work to protect the rights of patients who seek treatment as well as the rights of the therapists who treat them.

A second major area of disagreement is the erroneous concept that psychotherapy promotes suicide. In reality, treatment intervention for those who wish our help prevents these individuals from giving up in despair and considering suicide.

We can only agree with Dr. Benjamin Schatz, executive director of the Gay and Lesbian Medical Association, that "prejudice and bias have no legitimate place in the practice of medicine." However, the false and slanted reporting of the AMA's declaration can only foster ignorance and misunder-

standing of the serious issues concerning the homosexual.

Charles W. Socarides, M.D.
Harold D. Voth, M.D.
C. Downing Tait, M.D.
Benjamin Kaufman, M.D.

Administrative Exam

APA's Committee on Administrative Psychiatry annually conducts the examination for certification in administrative psychiatry. The written portion will be given in December, and successful candidates take the oral section the following May.

The deadline for receipt of completed applications (including required letters of reference) for the 1995 examination cycle is August 1, 1995. An information brochure and application may be obtained by contacting the Committee on Administrative Psychiatry, Office of Education, APA, 1400 K Street, N.W., Washington, D.C. 20005 (202) 682-6109.

AMA and Homosexuality

It is a matter of professional responsibility that the National Association for Research and Therapy of Homosexuality (NARTH), with more than 400 members of the psychiatric, medical, psychological, and social work professions devoted to the study, care, and prevention of homosexuality, respond to your article "AMA Reverses Stand on Homosexual Issues" [*Psychiatric News*, January 20].

As members of APA and the AMA, some for more than 25 years, we are grateful to and applaud the AMA for turning its attention to "educating physicians on the health care needs of gay men and lesbians," as well as the "encouraging research to identify the unique health care needs of gay men and lesbians to improve diagnosis and treatment of their health care needs." For as practicing psychiatrists, psychologists, and psychoanalysts, we have been in the vanguard of doing just that for many years.

As members of NARTH, our most important function is to provide psychological understanding of the cause, treatment, and behavioral patterns associated with the homosexual condition. We are for the civil as well as psychiatric rights of all homosexuals. Psychiatric rights should not be eroded of sociopolitical activism, which declares homosexuality simply an "alternative life style."

We agree with many of the recommendations of the AMA Council on Scientific Affairs and their approval by APA. However, we have several serious disagreements. First, the deletion from the current AMA report of the phrase "and the possibility of sex-preference reversal in select cases," a valid position taken in the 1981 Council on Scientific Affairs report (AMA policy #160.991) is a tragic error on the part of the AMA working in concert with the APA gay group. The removal of this phrase is most regrettable, as it will profoundly distress thousands of individuals who look to the AMA and APA with trust and belief. These individuals believe that homosexuality is completely contrary to their value system and that they are victims of certain intrapsychic processes that have subverted their heterosexuality and made for profound disturbances in their lives.

Gay activists within our organization have misused this deletion and, in so doing,

1995 APA Annual Meeting

Miami Beach Convention Center
Rooms C125-C126, Level 1

"Major Advances in the Treatment of Schizophrenia"

Saturday, May 20, 1995
7:00 PM—10:00 PM

Current psychopharmacologic and psychosocial treatment strategies for schizophrenia, based on the results of research studies, will be presented at this symposium. Included in this program is an examination of the economic significance of using these treatment approaches in planning mental health services.

AGENDA/FACULTY

Welcome and Introduction
Marvin I. Herz, MD, Chairman
University of Rochester
Rochester, New York

Pharmacotherapy of First Episode Acute and Refractory Patients
Jeffrey A. Lieberman, MD
Hillside Hospital
Glen Oaks, New York

Advances in Maintenance Treatment
Nina R. Schooler, PhD
University of Pittsburgh Medical Center
Pittsburgh, Pennsylvania

Psychosocial Treatment
Marvin I. Herz, MD

Schizophrenics with Substance Abuse: Treatment
Richard J. Frances, MD
Hackensack Medical Center
Hackensack, New Jersey

Using Cost-effectiveness Data in Benefit Design
Howard H. Goldman, MD
University of Maryland
Baltimore, Maryland

"Psychotic Disorders: Many Forms, Common Themes"

Sunday, May 21, 1995
9:00 AM—NOON

This forum will provide the audience with an overview and update of the clinical forms of psychoses from childhood to old age. The faculty will examine similarities and differences that influence the diagnoses, therapeutic approaches, and management issues related to each of these psychotic disorders.

AGENDA/FACULTY

Welcome and Introduction
Henry A. Nasrallah, MD, Chairman
Ohio State University Medical Center
Columbus, Ohio

Psychoses in Children and Adolescents
Herman A. Tolbert, MD
Ohio State University Medical Center
Columbus, Ohio

Management of Schizophrenia
Stephen R. Marder, MD
West Los Angeles VA Medical Center
Los Angeles, California

Psychotic Mania
Susan L. McElroy, MD
University of Cincinnati College of Medicine
Cincinnati, Ohio

Major Depression with Psychotic Features
William H. Coryell, MD
University of Iowa College of Medicine
Iowa City, Iowa

Delusional Disorder
Theo C. Manschreck, MD
Brown University School of Medicine
Providence, Rhode Island

Management of Late-life Psychosis
Dilip V. Jeste, MD
San Diego VA Medical Center
San Diego, California

Discussant
Stephen C. Olson, MD
Ohio State University Medical Center
Columbus, Ohio

"Progress in Psychoses"

Sunday, May 21, 1995
1:30 PM—4:30 PM

This program will explore the diagnosis and treatment of schizophrenia including the neurobiology of dopamine and serotonin, appropriate uses of newer drugs and clinical aspects of positive and negative symptoms.

AGENDA/FACULTY

Welcome and Introduction
Jack M. Gorman, MD, Chairman
Columbia University
New York, New York

Dopamine and Serotonin in Schizophrenia
Daniel E. Casey, MD
VA Medical Center
Portland, Oregon

Genetic and Epigenetic Factors in Psychoses
Jack M. Gorman, MD

Towards a New Generation of Antipsychotic Drugs
David Pickar, MD
National Institute of Mental Health
Bethesda, Maryland

Effects of Drugs on Positive and Negative Symptoms
Richard L. Barison, MD
Medical College of Georgia
Augusta, Georgia

Treatment of Refractory Schizophrenia
Stephen R. Marder, MD
West Los Angeles VA Medical Center
Los Angeles, California

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Can Earthquakes Trigger Heart Attacks? Answer May Depend on Time and Place

Two studies using the aftermath of major California earthquakes to assess whether fear can trigger heart attacks have reached conflicting conclusions.

A survey of heart attack rates following the October 1989 Loma Prieta earthquake in the San Francisco Bay area found no link between earthquake-induced fear and heart attack incidence.

But another study, also released in March, found that heart attack rates increased significantly in the wake of the January 1994 Los Angeles area earthquake, particularly in the vicinity of the epicenter.

Both quakes were similar in impact, each causing more than 60 deaths.

Despite the different findings on heart attack incidence, both studies found no difference in cardiac-related deaths.

The Bay area survey was conducted by Stanford University psychiatrist C. Barr Taylor, M.D., codirector of the Stanford Cardiac Rehabilitation Center. Taylor presented his findings at the annual meeting of the Society for Behavioral Medicine in San Diego in March.

Stanford researchers examined records from five major hospitals in Santa Clara County near the earthquake's epicenter for the weeks just before and after it occurred. The earthquake, the largest in the Bay area since 1906, killed 62 people and left 12,000 homeless.

While Taylor and his colleagues found a statistically significant increase in the number of patients who came to the five hospitals complaining of chest pain and heart palpitations right after the earthquake, there was no increase in either the number of

heart attacks or cardiac-related deaths. In fact, said Taylor, there may have been a slight decrease in the number of documented heart attacks.

With a population of approximately one million people in the Bay area, it is "pretty remarkable" that there was no demonstrable increase in heart attacks, said Taylor. He recorded 270 cardiac-related emergency-room admissions the week before, 294 the week of, and 274 the week after the earthquake.

He does not rule out the possibility that intense, prolonged stress and some emotional profiles—particularly the classic "Type A" personality associated with heart disease—may contribute to heart attack risk.

For people without serious heart disease, however, brief—even intense—emotional reactions are not problematic, Taylor concluded.

Robert Kloner, M.D., of Good Samaritan Hospital in Los Angeles checked 72 coronary care units in Southern California in the week before that earthquake and the week after.

Not only did Kloner find a significantly higher incidence of heart attacks following the quake, but also he found a markedly higher percentage increase within 15 miles of the epicenter compared with farther away.

He identified 149 heart attacks the week before the quake compared with 201 the week after. There was a 79 percent increase in heart attacks at hospitals within 15 miles of the epicenter, but only a 41 percent increase at hospitals farther away.

In looking at the conflicting conclusions of the two studies, said Kloner, it is important to focus on differences in study design.

In his Los Angeles area earthquake study,

there was a significant difference in heart attack incidence related to distance from the epicenter, a variable not reflected in the Loma Prieta study, said Kloner. Another variable was time of day. The Los Angeles earthquake occurred at 4:30 a.m., Kloner noted, while the Loma Prieta earthquake was in "the late afternoon. . . . We know that in the morning when people wake up, catecholamines go up," said Kloner. "We know that the highest incidence of heart attack is within the first one to two hours after waking."

Taylor agreed that time of day and circadian rhythms might have made a difference, and he pointed out other differences as well.

One difference involved the damage pattern in the two quakes. Unlike the Los Angeles quake, much of the worst damage in the Loma Prieta quake was farther away from the epicenter. Also, the epicenter in the Loma Prieta quake was in the mountains in a thinly populated area.

"It may be that in our particular area the magnitude of the quake near the hospitals I looked at was not as great as in the [Los Angeles area quake]. We may not have had as great a magnitude of scare as they did in [Los Angeles]," said Taylor.

Another factor involves the need for earthquake victims in poor physical condition to exert themselves after an earthquake by engaging in strenuous digging, pushing, and pulling, said Taylor. "A lot of people who are poorly conditioned in times of earthquake begin to do a lot of physical exertion," he observed. "This may account for some heart attacks."

In their study, exertion was not a factor, because of the nature of the damage, whereas in the Los Angeles area quake, there was more of the kind of damage that could result in having to do excessive physical work, Taylor said. —R.B.K.

Nominations Invited For Administrative Psychiatry Award

The American Psychiatric Association and the American Association of Psychiatric Administrators invite applications for their jointly sponsored Administrative Psychiatry Award. The recipient is someone who has demonstrated extraordinary competence in psychiatric administration over a substantial period and has achieved a national reputation for the foregoing. In addition, he or she must have directed a comprehensive program for the care of patients with mental illness and have contributed significantly to the field of psychiatric administration through activities such as teaching and research. Membership in APA and board certification are additional requirements.

Nominations may be made by writing a letter indicating why the candidate should be given serious consideration. A copy of the nominee's curriculum vitae must be enclosed. The recipient will present a special lecture at the next APA annual meeting.

The deadline for nominations is August 1. Material should be sent to the Committee on Administrative Psychiatry, APA Office of Education, 1400 K Street, N.W., Washington, D.C. 20005.

Resignation

Walter Guarino, M.D., of Vienna, Va., resigned from the American Psychiatric Association and the Washington Psychiatric Society during the course of an ethics investigation.

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WARNING

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INDICATIONS

Treatment of manic episodes of manic-depressive illness. Maintenance therapy prevents or diminishes the intensity of subsequent episodes in those manic-depressive patients with a history of mania.

WARNINGS

Lithium should generally not be given to patients with significant renal or cardiovascular disease, severe debilitation or dehydration, or sodium depletion.

Chronic lithium therapy may be associated with diminution of renal concentrating ability. Such patients should be carefully managed to avoid dehydration with resulting lithium retention and toxicity. Morphologic changes with glomerular and interstitial fibrosis and nephron atrophy have been reported. Morphologic changes have also been seen in manic-depressive patients never exposed to lithium. During lithium therapy, progressive or sudden changes in renal function, even within the normal range, indicate the need for reevaluation of treatment.

An encephalopathic syndrome (characterized by weakness, lethargy, fever, tremulousness and confusion, extrapyramidal symptoms, leukocytosis, elevated serum enzymes, BUN and FBS) has occurred in a few patients treated with lithium plus a neuroleptic. In some instances, the syndrome was followed by irreversible brain damage. Patients receiving such combined therapy should be monitored closely for early evidence of neurologic toxicity and treatment discontinued promptly if such signs appear. Caution patients about activities requiring alertness.

Lithium may prolong the effects of neuromuscular blocking agents. Such agents should be given with caution to patients receiving lithium.

Lithium carbonate may cause fetal harm when administered to a pregnant woman. If a patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus.

Nursing should not be undertaken during lithium therapy except in rare and unusual circumstances.

Not recommended in children under 12.

Elderly patients often require lower lithium dosages to achieve therapeutic serum levels. They may also exhibit adverse reactions at serum levels ordinarily tolerated by younger patients.

PRECAUTIONS

Caution should be used when lithium and diuretics are used concomitantly. Patients receiving such combined therapy should have serum lithium levels monitored closely and the lithium dosage adjusted if necessary.

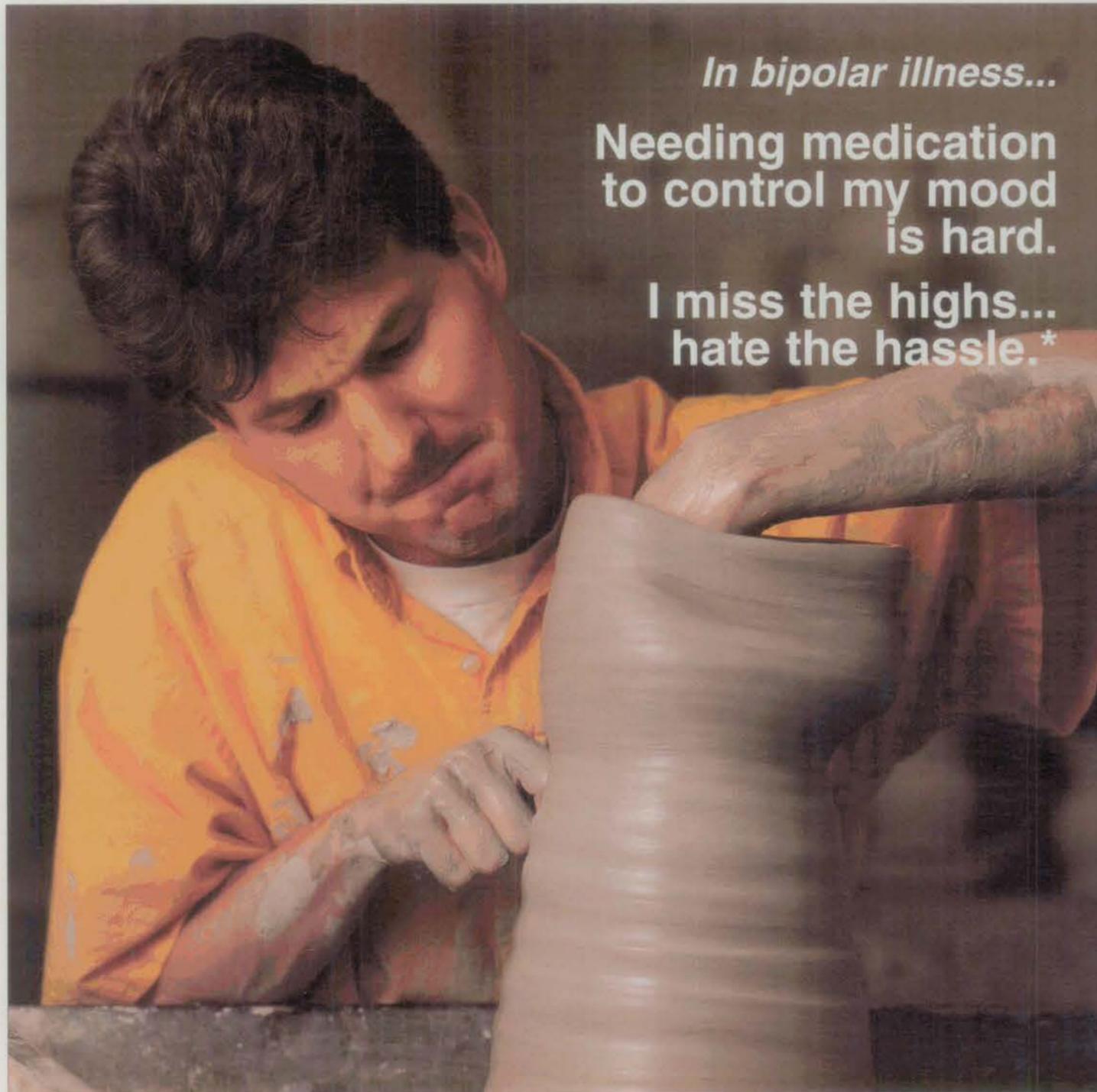
Sweating, diarrhea and concomitant infection with elevated temperatures may also necessitate a temporary reduction or cessation of medication.

Indomethacin and piroxicam have been reported to increase significantly, steady state plasma lithium levels. There is also some evidence that other nonsteroidal anti-inflammatory agents may have a similar effect. When such combinations are used, increased plasma lithium level monitoring is recommended. Concurrent use of metronidazole with lithium may provoke lithium toxicity due to reduced renal clearance. Monitor patients receiving such combined therapy closely.

When used with angiotensin-converting enzyme inhibitors, such as enalapril and captopril, lithium dosage may need to be decreased; measure plasma lithium levels more often.

Concurrent use of calcium channel blocking agents with lithium

(continued)



In bipolar illness...

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Gathering for a photo after the presentation of the Gerald L. Klerman Award were Herbert Pardes, M.D., president of NARSAD's Scientific Council; Connie Lieber, president of NARSAD; Elizabeth Abercrombie, Ph.D., who received honorable mention; Myrna Weissman, Ph.D., the award presenter; and Rajiv Tandon, M.D., the award winner.

NARSAD Confers Awards

The National Alliance for Research on Schizophrenia and Depression (NARSAD) announced that it is conferring \$8 million in research grants for 1995. A total of 16 scientists in the Established Investigator group received one-year grants of \$100,000. NARSAD awarded 112 two-year grants of \$30,000 per year in the young investigator group of scientists from postdoctoral rank through assistant professor.

The \$8 million in research grants represents both the largest amount of money and the biggest number of individual grants ever awarded at one time by a private sector, contribution-supported organization, according to NARSAD.

The Gerald L. Klerman Award of \$1,000 was conferred on Rajiv Tandon, M.D., of the University of Michigan. The award was presented by Myrna Weissman, Ph.D., a professor of epidemiology and psychiatry at the College of Physicians and Surgeons at Columbia University. Weissman initiated the award in memory of her late husband, psychiatrist Gerald L. Klerman, M.D.

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The APA designates this continuing medical education activity for 15 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association and for the CME requirement of the APA.

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Adverse reactions may be encountered at serum lithium levels below 1.5 mEq/L. Mild to moderate adverse reactions may occur at levels from 1.5 to 2.5 mEq/L, and moderate to severe reactions may be seen at levels of 2.0 mEq/L and above. Fine hand tremor, polyuria and mild thirst may occur during initial therapy and may persist throughout treatment. Transient and mild nausea and general discomfort may also appear during initial therapy. These side effects usually subside with continued treatment or a temporary reduction or cessation of dosage. Diarrhea, vomiting, drowsiness, muscular weakness and lack of coordination may be early signs of lithium intoxication, and can occur at lithium levels below 2.0 mEq/L. At higher levels, ataxia, giddiness, tinnitus, blurred vision and a large output of dilute urine may be seen. Serum lithium levels above 3.0 mEq/L may produce a complex clinical picture, involving multiple organs and organ systems. Serum lithium levels should not be permitted to exceed 2.0 mEq/L during the acute treatment phase.

The following reactions appear to be related to serum lithium levels, including levels within the therapeutic range. **Neuro-muscular/Central Nervous System**—tremor, muscle hyper-irritability (fasciculations, twitching, clonic movements of whole limbs), hypertonicity, ataxia, choreo-athetotic movements, hyperactive deep tendon reflex, extrapyramidal symptoms including acute dystonia, cogwheel rigidity, blackout spells, epileptiform seizures, slurred speech, dizziness, vertigo, down-beat nystagmus, incontinence of urine or feces, somnolence, psychomotor retardation, restlessness, confusion, stupor, coma, tongue movements, tics, tinnitus, hallucinations, poor memory, slowed intellectual functioning, startled response, worsening of organic brain syndromes; **Cardiovascular**—cardiac arrhythmia, hypotension, peripheral circulatory collapse, bradycardia, sinus node dysfunction with severe bradycardia (which may result in syncope); **Gastrointestinal**—anorexia, nausea, vomiting, diarrhea, gastritis, salivary gland swelling, abdominal pain, excessive salivation, flatulence, indigestion; **Genitourinary**—glycosuria, decreased creatinine clearance, albuminuria, oliguria and symptoms of nephrogenic diabetes insipidus including polyuria, thirst and polydipsia; **Dermatologic**—drying and thinning of hair, alopecia, anesthesia of skin, acne, chronic folliculitis, xerosis cutis, psoriasis or its exacerbation, generalized pruritus with or without rash, cutaneous ulcers, angioedema; **Autonomic**—blurred vision, dry mouth, impotence/sexual dysfunction; **Thyroid Abnormalities**—euthyroid goiter and/or hypothyroidism (including myxedema) accompanied by lower T₄ and T₄ I¹³¹ uptake may be elevated. (See PRECAUTIONS.) Paradoxically, rare cases of hyperthyroidism have been reported; **EEG Changes**—diffuse slowing, widening of the frequency spectrum, potentiation and disorganization of background rhythm; **EKG Changes**—reversible flattening, isoelectricity or inversion of T-waves; **Miscellaneous**—fatigue, lethargy, transient scotomata, exophthalmos, dehydration, weight loss, leukocytosis, headache, transient hyperglycemia, hypercalcemia, hyperparathyroidism, excessive weight gain, edematous swelling of ankles or wrists, metallic taste, dysgeusia/taste distortion, salty taste, thirst, swollen lips, tightness in chest, swollen and/or painful joints, fever, polyarthralgia, dental caries.

Some reports of nephrogenic diabetes insipidus, hyperparathyroidism and hypothyroidism which persist after lithium discontinuation have been received.

A few reports have been received of the development of painful discoloration of fingers and toes and coldness of the extremities within one day of the starting of treatment with lithium. The mechanism through which these symptoms (resembling Raynaud's syndrome) developed is not known. Recovery followed discontinuance.

Cases of pseudotumor cerebri (increased intracranial pressure and papilledema) have been reported with lithium use. Lithium should be discontinued, if clinically possible, if this syndrome occurs.

HOW SUPPLIED

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Group Home

from page 1

als per single-family house. This regulation precludes the proposed group home and would do so for similar homes for mentally retarded or mentally ill persons. There is no limit on the number of related family members who can occupy a residence.

"We are concerned that if read broadly, the act's exemption could allow any municipality to exclude group homes," stated Richard Ciccone, M.D., chair of APA's Commission on Judicial Action. "We wanted the Court to see the reasonableness" of allowing group homes to locate in residential areas, he said in explaining the commission's decision to urge APA's participation in the case.

APA strongly agrees with attorneys for Oxford House—the group home fighting the Edmonds zoning prohibition—that such restrictive provisions should not be allowed to override the Fair Housing Act's attempt to ensure that local governments make reasonable accommodation to the housing needs for their handicapped citizens, he indicated.

Joining APA in the amicus brief on behalf of Oxford House are the American Society of Addiction Medicine, the National Council on Alcoholism and Drug Dependence, the National Association of Alcohol and Drug Abuse Counselors, the Society of Americans for Recovery, and the National Association of Social Workers.

Intent of the Act

The amicus brief, which was filed at the Supreme Court on January 23, urges the justices to rule that the Fair Housing Act's exemption for laws governing the number of

individuals living in a single residence be narrowly drawn so that protections that affect housing options for the handicapped are not gutted along with a major intent of the act.

This exemption, it argues, was included to permit localities to impose a limit on the number of residents based on square footage in the sleeping areas of a property—an exemption stemming from concerns about the health and safety of residents in any dwelling.

To assume that Congress intended to allow zoning laws to limit the number of unrelated residents, but not family members, countervails all the thinking that went into setting the Fair Housing Act's goals, the brief emphasizes. Since the Edmonds statute does not apply to families, the brief's authors insist that the city was not regulating to protect health and safety but to create a "single-family zone."

The city is asking the high court to overturn a federal appeals court ruling that held illegal its zoning policy regarding restrictions on group homes. Its attorneys contend that the exemption does not specify a square-footage basis and simply allows a jurisdiction to set limits for the number of occupants in homes in residentially zoned areas.

Positive Effects of Group Homes Attorneys supporting the right of the home to open emphasize that the mentally ill or retarded reap numerous benefits from being integrated in an established residential community instead of being isolated in residences in industrial or deteriorating areas. In passing the Fair Housing Act in 1988, Congress recognized that "[a]llowing per-

sons with disabilities to interact with the community in an ordinary setting may develop confidence and coping skills that cannot be duplicated in an institutional setting," the brief points out, and "allows individuals to share a supportive family environment. . . ."

This finding is a primary reason APA agreed to participate in the amicus brief, said Ciccone. "We have research that shows that individuals who move from institutions to community settings do quite well; it is an important part of their reintegration into society," he said in an interview with *Psychiatric News*. "Many mentally disabled individuals who live in group homes eventually go on to live on their own and lead constructive lives. Even those who can't move to independent living benefit from this level of care."

In the absence of laws that keep open the option of putting group homes in residential neighborhoods, however, local officials have often bowed to pressure from those already living nearby to locate these residences elsewhere—a situation referred to as the NIMBY (not in my backyard) syndrome.

Counteracting this trend was a fundamental motivation of the Fair Housing Act's Congressional backers. According to the lawyers arguing for the right of the group home to open, the act's legislative history clearly shows Congress's goal was to open up rather than limit the opportunity for disabled persons "to reside in a single-family neighborhood, like any other American."

The Supreme Court heard arguments in the case on March 1, and the justices are expected to hand down a decision in May or June. —K.H.

Lithium Used To Treat Subtype of Severe Aggression

A new study suggests that lithium may be effective in children with a severe type of aggression that doesn't respond well to standard treatments.

The psychoactive drug may be particularly helpful in treating children with the affective or hostile subtype of aggression, characterized by anger, irritability, or rage and not necessarily provoked by any specific event, according to a study published in the April *Journal of the American Academy of Child and Adolescent Psychiatry*.

Researchers distinguished the affective subtype of aggression from the "predatory" subtype, which is often brought on by specific stimuli. They noted that the neurochemical basis may be different, thus explaining why the affective type responds to lithium.

The team of investigators led by psychiatrist Madga Campbell, M.D., of New York University conducted a double-blind study with 50 children who were diagnosed with the conduct disorder subtype characterized by affective aggression and treated for six weeks with lithium or a placebo. Sixty-eight percent of the children treated with lithium showed at least moderate improvement, compared with 40 percent of those receiving the placebo. In addition, 40 percent of the lithium-treated children showed marked improvement, compared with only 4 percent of the placebo-treated subjects. Lithium specifically helped reduce symptoms of bullying, fighting, and temper outbursts, according to the article. Lithium's side effects were stomachaches and vomiting.

Obsessive-Compulsive Disorder: A Decade of Progress

Sunday, May 21, 1995

1:30 pm—4:30 pm

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Program Chairman/Moderator

ERIC HOLLANDER, MD

Associate Professor of Psychiatry
Director, Clinical Psychopharmacology
Clinical Director, Seaver Autism Center
Mt. Sinai School of Medicine

A Decade of Progress in OCD Brain Imaging

LEWIS R. BAXTER, MD

Professor of Psychiatry and
Biobehavioral Sciences
UCLA School of Medicine

Diagnostic and Epidemiologic Evolution of Obsessive-Compulsive Disorder

MICHAEL JENIKE, MD

Associate Professor of Psychiatry
Harvard Medical School
Associate Chief of Psychiatry for
Research
Massachusetts General Hospital

Impulsivity and Compulsivity: Phenomenology and Treatment

ERIC HOLLANDER, MD

An Update on the Serotonergic Hypothesis of Obsessive-Compulsive Disorder

JOSEPH ZOHAR, MD

Professor and Chairman of Psychiatry
Chaim Sheba Medical Center
Tel Aviv University, Israel

Developments in the Treatment of Obsessive-Compulsive Disorder

WAYNE GOODMAN, MD

Professor of Psychiatry
University of Florida

Discussion by:

STUART A. MONTGOMERY, MD

Professor of Psychiatry
St. Mary's Hospital Medical School

This symposium is supported by an unrestricted educational grant from CoCensys Inc.

DEATHS

The deaths of the following APA members were reported to the Association between August 1, 1994, and February 28, 1995:

- John Adams Abbott, M.D.
- Walter Abeles, M.D.
- Clark Hazen Adair, M.D.
- Mary H. Allen, M.D.
- Robert C. Anderson, M.D.
- Ernesto Andia, M.D.
- Basil C. Archer, M.D.
- Edward T. Auer, M.D.
- Frederic L. Baer, M.D.
- Dorothy E. Baker, M.D.
- Lidia Bales, M.D.
- Hyman S. Barahal, M.D.
- Anna Bauman, M.D.
- Robert M. Bell, M.D.
- Eufrocino N. Beltran, M.D.
- Rick Bernier, M.D.
- Jessie H. Blaszczewski, M.D.
- Manfred E. Bleuler, M.D.
- Reuben B. Breslin, M.D.
- Ruth C. Burton, M.D.
- Robert G. Carnahan, M.D.
- A. Carroll Jr., M.D.
- William S. Carter Jr., M.D.
- John Allen Caudle, M.D.
- Louis S. Chase, M.D.
- Horace I. Cholmondeley, M.D.
- Roland David Ciaranello, M.D.
- Paul C. Clark, M.D.
- Edwin M. Cole, M.D.
- Henry S. Colony, M.D.
- Gertrude V. Cotts, M.D.
- David Davila-Katz, M.D.
- Chester R. Dietz, M.D.
- Patricia Donovan, M.D.
- Hans Bernd Drexler, M.D.
- Jeffrey A. Dutton, M.D.
- B. Russell Eby, M.D.
- Carl Willard Emmons Jr., M.D.
- Marvin W. Evans, M.D.
- Victor L. Farland, M.D.
- Roger L. Feller, M.D.
- David M. Ferber, M.D.
- Antonio J. Ferreira, M.D.
- Bernard D. Fine, M.D.
- Sydney G. Fine, M.D.
- William A. Fischer, M.D.
- John M. Flumerfelt, M.D.
- Ralph Fredman, M.D.
- Joseph J. Friedman, M.D.
- John Fuma, M.D.
- Samuel Futterman, M.D.
- Sofya G. Galin, M.D.
- Francis J. Gerty, M.D.
- George Robert Gewirtz, M.D.
- Frank E. Gill, M.D.
- Marcus R. Gilliss, M.D.
- Ralph G. Gladen N.D.
- Jean Golday, M.D.
- Harvey Goldey, M.D.
- Ephraim R. Gomberg, J.D.
- Milton Greenblatt, M.D.
- Rudolfo J. Guiral, M.D.
- Luden A. Gutierrez, M.D.
- Arthur Leon Harris, M.D.
- James J. Hartford, M.D.
- Sylvia M. Helfrick, M.D.
- Uno H. Helgesson, M.D.
- B. Hernandez M.D.
- James R. Hodge, M.D.
- Adolphe D. Jonas, M.D.
- Edmund P. Jones Jr., M.D.
- Gary Robert Jones, M.D.
- Benjamin M. Jurin, M.D.
- Robert R. Keim Jr., M.D.
- Baldwin L. Keyes, M.D.
- Morris W. Kilgore, M.D.
- Albert Kniaz, M.D.
- Kumud Vijay Kumar, M.D.
- Pierre Lacombe, M.D.
- Henry D. Lamb, M.D.
- John Hopkins Lamont, M.D.

- John William Lathen, M.D.
- Paul Leeds, M.D.
- Wladimir T. Liberson, M.D.
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- Georges H. Lussier, M.D.
- Elmar G. Lutz, M.D.
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Salloway Elected

Stephen Salloway, M.D., has been elected to a three-year term as a director of the American Neuropsychiatric Association (ANPA). He is an assistant professor in the departments of clinical neuroscience and psychiatric and human behavior at the Brown University School of Medicine and director of neurology and codirector of the Quantitative Neuroimaging Laboratory at Butler Hospital in Providence, R.I.

To go back to my case of suffering I would not bear. I firmly believe there is no one not over you

APA
1995

Psychiatry & the Arts
Special Lecture



Henry Darger:
In the Realms
of the Unreal

John M. MacGregor, Ph.D.

Tuesday, May 23, 1995
11:00 AM - 12:30 PM

Room C-125, Level 1
Miami Beach Convention Center

Henry Darger (1892-1973) lived a double life: by day, janitor, dishwasher, loner; by night, man of action, creator, unread author, unseen artist.

Poorly educated, artistically untrained, he invented his own narrative and artistic forms. Unconcerned with the making of "art," money or reputation, he fashioned, in secret, a parallel universe in which he could assume his rightful place, be the self he knew himself to be: intelligent, creative, compassionate, heroic, truthful.

In his room at night, behind the closed door, Henry recorded the events of an alternate world he had created: chaos and violence, cruelty and innocence, heroism and high adventure. The resulting work encompassed a manuscript of 15,145 pages and a magnificent series of over 300 watercolor compositions, each ten to twelve feet in length.

Then he died, and the door to the room was opened.

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Manual

from page 1

"The reality is that by increasing the recognition of mental diagnoses, the number of referrals to psychiatrists will significantly increase and there will be more appropriate uses of psychiatric treatment."

In addition, "primary care physicians are not learning about mental disorders from psychiatrists. This is an excellent attempt to bridge that gulf and bring us closer to primary care in a very direct way."

The manual is compatible with the *DSM-IV* and facilitates primary care clinical management by grouping together disorders based on presenting symptoms. It provides diagnostic pathways for common disorders such as depressed mood, anxiety, unexplained general medical complaints, substance abuse, sleep disorders, and sexual

"[The manual] will only encourage the competition by giving them a stronger basis for making diagnoses and to begin treatment."

problems (*Psychiatric News*, January 20).

Area 6 Trustee Daniel Borenstein, M.D., expressed his support in general but asked whether the document could devote some attention to the need for consultation and referral to psychiatrists.

"We hope there are instances when the document promotes that, thus furthering our alliances with primary care physicians," he said.

Speaker of the Assembly Norman Clemens, M.D., expressed his support with



Former APA presidents Joseph T. English, M.D. (left), and John McIntyre, M.D., join in the Board of Trustees' discussion on the publication of an edition of *DSM-IV* for primary care physicians.

the caveat that some corrections be made such as spelling out "PC" in the title *DSM-IV-PC*.

He said, "Psychiatrists I work with might want to give this publication, assuming the cost is reasonable, to primary care physicians in conjunction with training courses that would build in referral issues, but it would be better to have some guidelines on when to refer in print." McIntyre responded to the suggestion about including guidelines on consultations and referrals.

"I don't think it is appropriate to mention this here because it is a diagnostic and not a treatment manual," he said. "Working with family physicians related to treatment protocols, how the manual is presented, and teaching issues are important topics to be addressed elsewhere."

APA President Jerry Wiener, M.D., added that "using the diagnostic manual as a teaching tool doesn't preclude psychiatrists from talking about treatment."

McIntyre praised the collaboration be-

tween APA and leading primary care specialty organizations in developing the manual. He called it "a very important step in working more closely together." The primary care organizations included the American College of Physicians, Society of General Internal Medicine, American College of Obstetricians and Gynecologists, and the American Academy of Pediatrics.

"The reality is that by increasing the recognition of mental diagnoses, the number of referrals to psychiatrists will significantly increase. . . ."

History Notes

from page 22

he began to write to the President and other officials about obtaining a consulship in Europe. Before he shot Garfield, Guiteau had left a sheaf of papers at a newsstand in Union Station in which he stated that removing the President was necessary to save the country and also to create a demand for his own writings.

Was Guiteau Sane?

The trial considered at length the following questions: Was there an entity termed moral insanity? Did the defendant know right from wrong and the consequences of his act? Was there an irresistible impulse?

There was no question that Guiteau understood the nature of his act. He held that he was mentally sane but legally insane. He was "inspired" and hence not responsible for his act.

The question of moral insanity remained unresolved. The concept had come into use about the time of Pinel and had been widely accepted in Britain and the United States. At the trial, Spitzler testified that he had proved the opinion that Guiteau was insane even before examining him using the term "moral monstrosity," a born cripple in respect to moral sense. Spitzler, who was also a neuroanatomist, said that Guiteau showed evidence of imperfect brain development indicated by the shape of his head and by his eyes. Spitzler also cited inherited insanity since several Guiteau collaterals had

been judged insane, and his father's religious ideas were mentioned.

The physical evidence was refuted by the prosecution's experts. (The autopsy report proposed the brain might show early dementia paralytica.) The psychiatrists on both sides rejected this diagnosis, while noting an inherited predisposition might exist. Most declared that insanity was a product of a diseased brain.

Other psychiatrists supporting the defense plea of insanity included Dr. W.W. Godding, superintendent of the Government Hospital for the Insane in Washington, D.C. He urged that a neutral commission be appointed to examine the defendant, Dr. Michals of the Bloomingdale (N.Y.) Asylum and Dr. Folsom of the Mclean (Mass.) Asylum. A total of eight psychiatrists was called for the defense.

The prosecution presented 16 experts, mostly asylum superintendents. The star witness was Dr. John Gray of Utica. Much hinged on whether Guiteau's claim to be inspired was a delusion; however, the prisoner had conducted his daily life in an ordinary fashion. Strong religious convictions were not evidence of insanity. The prisoner had told Dr. Gray that the assassination was God's act and that the killing was inspired by pressure from God and hence he could not be held responsible.

Dr. Gray, who pronounced the defendant sane, pointed out that Guiteau controlled

his acts and was coherent; he talked clearly and without evidence of irresistible impulse.

Charles Rosenberg says in the introduction of his book *The Trial of Guiteau: Psychiatry and the Law in the Gilded Age*, "There is no doubt that Guiteau suffered from mental illness. The precise diagnosis is another matter." In a closing chapter, Rosenberg says the trial provided a cross-section of psychiatric thought in the pre-Freudian era. After Guiteau's hanging, few physicians doubted his insanity, calling the trial a miscarriage of justice.

The trial put an end to the idea of moral insanity. It showed that the circumstances of a case have much to do with its disposition and that the system of expert testimony needed amending.

The *Journal of Nervous and Mental Disease* in 1882 and 1883 published a number of articles concerning the trial, supporting the finding of insanity and the diagnosis of moral insanity. In 1882 the *American Journal of Insanity* published a long excerpt of the trial, including the direct testimony of the psychiatrists. In the article, Dr. Gray discusses criminal responsibility and whether all criminal actions can be seen as the result of a diseased mind. He wrote, "Where science cannot speak definitively and with authority, it is her duty to be silent. . . . Medical science cannot offer. . . a protecting shield."

NAPHS Installs New Officers

At its January 30 Board of Trustees meeting in Washington, D.C., the National Association of Psychiatric Health Systems (formerly the National Association of Private Psychiatric Hospitals) installed E. Mac Crawford as its new president.

Crawford is chair and chief operating officer of the Atlanta-based Charter Medical Corporation. He succeeds psychiatrist George T. Harding IV, M.D., in the post.

The organization's new president-elect is Paul Jay Fink, M.D., vice president of InterCare Behavioral Health and senior consultant to Charter Fairmount Behavioral Health System in Philadelphia. Fink, a past president of APA, is chair of its Council on Economic Affairs.

Other newly elected officers are First Vice President A. Joyce Bossett, regional vice president for mental health services at Columbia/HCA Corp.; Second Vice President Jean P. Smith, chief operating officer of South Oaks Hospital in Amityville, N.Y.; Secretary Richard L. Munich, M.D., of the Westchester Division of New York Hospital-Cornell Medical Center, and Treasurer William T. Zieverink, M.D., director of behavioral medicine at Southwest Washington Medical Center in Vancouver, Wash.

Several new NAPHS board members were also chosen. They are Alan A. Axelson, M.D., Richard Bangert, Sandra Carson, Barbara Hekimian, Edward C. Irby, Xavior Mastrianni, M.D., and Edward Stack.



E. Mac Crawford is the new president of the National Association of Psychiatric Health Systems.

Early Career

from page 1

- Make special efforts to include the field of academic psychiatry.
- Initiate district branch-level mentoring, recruitment, and retention efforts, employing social activities locally and taking advantage of national meeting opportunities.

The Assembly Committee on Planning, chaired by Donna Norris, M.D., provided an outline of how the five-year pilot program would affect the Assembly. There would be one early career psychiatrist representative and one deputy representative to the Assembly from each Area Council. These representatives would be selected by the Area Council from early psychiatrist APA members nominated by the district branches in that Area.

An Assembly Committee of Early Career Psychiatrist Representatives and Deputy Representatives would elect a chair who would be a member of the Assembly Executive Committee.

Anne Rivers Siddons to Speak at Auxiliary Luncheon

Best-selling author Anne Rivers Siddons will speak at the APA Auxiliary luncheon at APA's annual meeting in Miami on Tuesday, May 23. All Auxiliary members, APA members, and their guests are invited to attend the luncheon, which begins at 11:30 a.m. in the Bayfront Room of the Hotel Inter-Continental in Miami. The on-site cost per person is \$55.

Siddons is the recipient of the Auxiliary's 1995 Media Award.

The *Atlanta Journal and Constitution* has called Siddons "the Jane Austen of modern Atlanta," and the *Los Angeles Times Book Review* has compared her with Truman Capote and Tennessee Williams.

Among her novels are *Peachtree Road*, *Outer Banks*, *Colony*, *Hill Towns*, and, most recently, *Downtown*.

The Auxiliary will also be sponsoring two workshops at APA's annual meeting. They are "Supporting the Doctor and Family During Litigation," on Monday, May 22, Imperial Room 2, Fontainebleau Hilton, and "Psychiatrists and the Media: Friends and Foes," on Tuesday, May 23, Pasteur Room, also at the Fontainebleau.



McDaniel

from page 11

tractive partners in the emerging networks that make up the brave new world of health care reform.

"Psychologists can easily get drawn into competitive struggles with physicians about who provides the best care to patients," she also wrote. "...Psychologists may resent the financial and social power that physicians have in our society. This resentment can be a formidable barrier to effective collaboration. Large-scale bread-and-butter issues are best handled through action by the American Psychological Association and other professional organizations. The one-to-one interactions between psychologists and physicians work best when founded on mutual support and respect. ..."

The kinds of collaborative relationships are limited only by the creativity of the psychologists and physicians involved, McDaniel states. She added that a small but growing number of family psychologists now practice with family physicians.

Profiles

from page 9

Sobel said that this will include changes in practice patterns, with the psychiatrist serving as backup to psychologists and social workers.

"The market is going to dictate that we as psychiatrists have a certain level of comfort and facility doing medication backup to therapists," Sobel said. "We need to be comfortable with a model in which patients see a psychologist or social worker for therapy."

Longer-term psychodynamic psychotherapy will always have a place, Sobel said, especially for patients with Axis II pathologies. "But you have to be more selective," he said. "There are some businesses that will pay for a worker to get over a crisis, but not to work out neurotic issues. That is a fact. When it is appropriate, we would try to support it, but the question is who will pay for it."

While acknowledging that the experience of changing their professional lives has been a "roller coaster," both Sobel and Baurer believe the ride will prove to have been worth it.

"As much as we may not like it, it makes sense to try to work within the system and establish a role for high-quality care run by professionals," Sobel said. "The benefits are that we are assuming control of our own fate."

"It seems clear that just waiting around will mean people without medical degrees are going to make these decisions for us," he added. "And then there will be patients who may not get the care they need."

TV Violence

from page 16

couraged all the disciplines to join together to find a solution to violence.

Phillips said psychiatrists, in particular child and adolescent psychiatrists, are "uniquely qualified to help parents and the schools understand what exposure to violence does to the development of children and their behavior. They can also help parents and teachers acquire discriminatory skills in knowing how to use television in healthy ways instead of as an electronic babysitter. We must think of educational and social alternatives to allowing children to vegetate in front of television sets." —C.L.

New Vistas in the Management of Depression

Sunday, May 21, 1995, 7:30 p.m. - 10:30 p.m.
Grand Ballroom East, Level 2, Fontainebleau Hilton

Chairman/Moderator

Charles B. Nemeroff, M.D., Ph.D.
Reunette W. Harris Professor and Chairman
Department of Psychiatry and Behavioral Sciences
Emory University School of Medicine
Atlanta, Georgia

Despite numerous recent advances in the treatment of depressive disorders, many unanswered questions remain for the clinician. Among these, the role of the selective serotonin reuptake inhibitors (SSRIs) in the treatment of severe depression, optimal treatment of refractory depression, and management of anxiety-depressive disorders are of clinical importance. In addition, the growing population of elderly and medically ill patients, many of whom are at risk of depression, requires that clinicians stay informed of currently accepted diagnostic and treatment strategies. Finally, depression in younger patients is of increasing concern as disease in this previously understudied population begins to achieve the clinical attention it deserves.

All physicians in attendance will receive a course workbook containing detailed abstracts, reprints of presentation slides, and a reading list. Symposium attendees will be offered refreshments after the program, which takes place from 7:30 p.m. to 10:30 p.m.

The symposium is being supported by an unrestricted educational grant from SmithKline Beecham Pharmaceuticals.

Selective Serotonin Reuptake Inhibitors in Severe Major Depression

Alan F. Schatzberg, M.D.
Professor and Chairman
Department of Psychiatry
Stanford University Medical Center
Stanford, California

Management of Treatment Refractory Depression

Charles B. Nemeroff, M.D., Ph.D.
Chairman/Moderator

Management of Depression in Patients with Comorbid Medical Illness

Charles F. Reynolds III, M.D.
Professor of Psychiatry and Neurology
University of Pittsburgh School of Medicine
Director, Sleep Evaluation Center
Western Psychiatric Institute and Clinic
Pittsburgh, Pennsylvania

Management of Depression in the Younger Patient

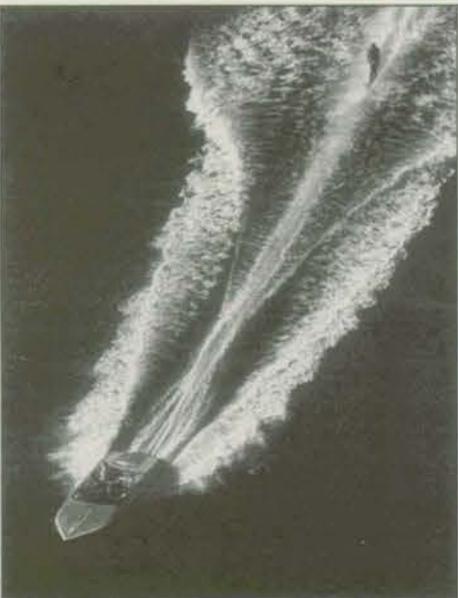
Michael Strober, Ph.D.
Professor, Division of Child and Adolescent Psychiatry
Department of Psychiatry
UCLA School of Medicine
Director, Adolescent Mood Disorders Program
UCLA Neuropsychiatric Institute
Los Angeles, California

Management of Mixed Depression-Anxiety States

Jack M. Gorman, M.D.
Professor of Clinical Psychiatry
Columbia University College of Physicians and Surgeons
Deputy Director, New York State Psychiatric Institute
New York, New York

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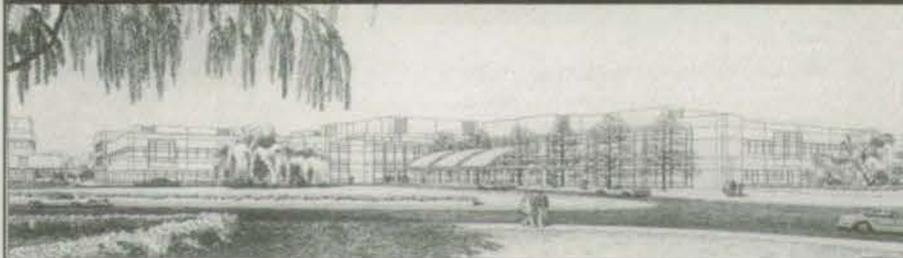
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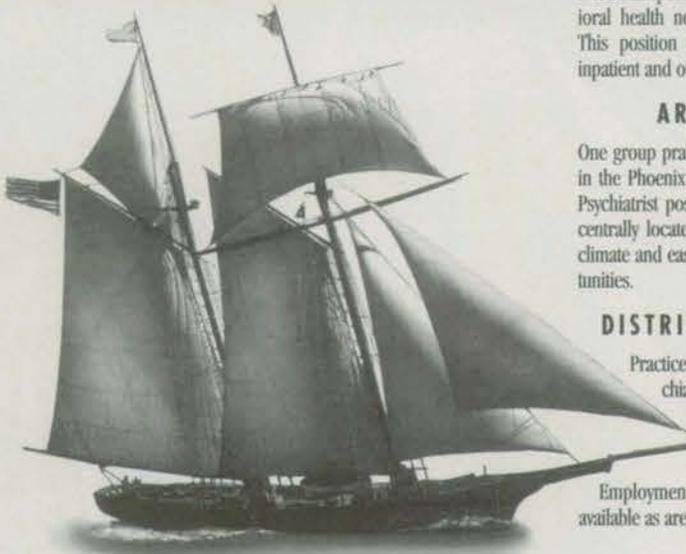
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DISTRICT OF COLUMBIA

Practice opportunities for a General Psychiatrist with specific interest in Geriatrics and a Child and Adolescent Psychiatrist currently exist in the DC area. Employment opportunities are presently available as are group practice affiliations.

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Practice opportunities for a Child and Adolescent Psychiatrist and a General Psychiatrist with Addiction Medicine experience are currently available in the "Sunshine State." Ocala, Ft. Myers, Largo, Orlando and Tampa are all thriving areas eager to welcome a physician into practice in their communities. Options are presently available for tailor-made independent private practice or employment opportunities. Florida has an abundance of cultural, recreational and academic offerings able to support widely diverse lifestyles.

GEORGIA

If Georgia is on your mind, we have several excellent opportunities for you to consider. Private practice and employment situations currently exist for a General Psychiatrist with Addiction Medicine experience, a General Psychiatrist with Geriatric experience and a Child and Adolescent Psychiatrist. Athens, Augusta and Macon are all lovely cities within driving distance to both mountain and coastal areas making leisure time most enjoyable.



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LOUISIANA

We are actively seeking General Psychiatrists for our behavioral healthcare systems in Shreveport, Lafayette and Lake Charles, Louisiana. Due to rapid growth in outlying areas, we are currently offering salaried staff psychiatry positions.

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An outstanding opportunity for a Child and Adolescent Psychiatrist to do both in-patient and out-patient work for our behavioral health system in Albuquerque. Albuquerque is surrounded by mountains with abundant recreational activities and a beautiful climate to enjoy. Comprehensive financial assistance and relocation support are available to meet your individual needs.

NORTH CAROLINA

North Carolina is home to beautiful coastal areas, sandy beaches and the Blue Ridge and Smoky Mountains. The area offers a multitude of outdoor recreational options within easy driving distance from any one of several large metropolitan centers. Practice opportunities are currently available for General and Child and Adolescent Psychiatrists in Raleigh, Winston-Salem, Charlotte and Greensboro.



*Charter Medical Corporation owns
and operates over 100 behavioral health systems
in the United States and abroad.*

PENNSYLVANIA

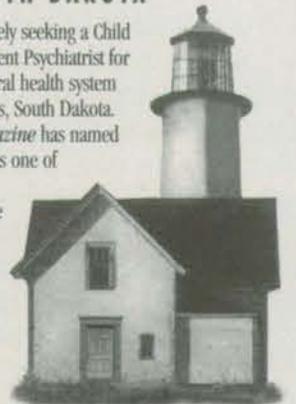
We are actively seeking a General Psychiatrist with experience in Addiction Medicine or an Addictionist to join our behavioral health system in Williamsburg. This practice opportunity is for a staff physician and is complete with a salary and benefits. Williamsburg is located in the mountains of central Pennsylvania. Come raise your family in an area with a low crime rate and cost of living. In addition, we are seeking psychiatrists in all specialty areas for our behavioral health system in Philadelphia.

SOUTH CAROLINA

South Carolina, the "Keystone of the South Atlantic Seaboard" offers an abundance of outdoor recreational activities as well as a multitude of cultural options. Private practice and employment opportunities with possible leadership roles are currently available in Charleston, Columbia and Greenville for Child and Adolescent and General Psychiatrists.

SOUTH DAKOTA

We are actively seeking a Child and Adolescent Psychiatrist for our behavioral health system in Sioux Falls, South Dakota. *Money Magazine* has named Sioux Falls as one of the top ten places to live in America for the last three years. This university town located on the Big Sioux River



is surrounded by rolling hills. This practice opportunity is for a staff physician and is complete with a salary and benefits.

TENNESSEE

Private practice or employment opportunity is currently available in Memphis for a General Psychiatrist. Memphis offers an abundance of outdoor recreational activities as well as a multitude of cultural options.

TEXAS

Private practice and employment opportunities with possible leadership roles are currently available in McAllen, Corpus Christi and Austin for Child and Adolescent and General Psychiatrists. All have excellent costs of living. McAllen is near the Gulf of Mexico and the Mexican Border. Corpus Christi is located near the Padre Island National Seashore on the Gulf of Mexico.

VIRGINIA

Private practice and employment opportunities with possible leadership roles are currently available in Leesburg for Child and Adolescent and General Psychiatrists. Leesburg is located 30 miles northwest of Washington, D.C. on the Potomac River with easy access to all the amenities our nation's capitol has to offer.

General Adult Psychiatrists...

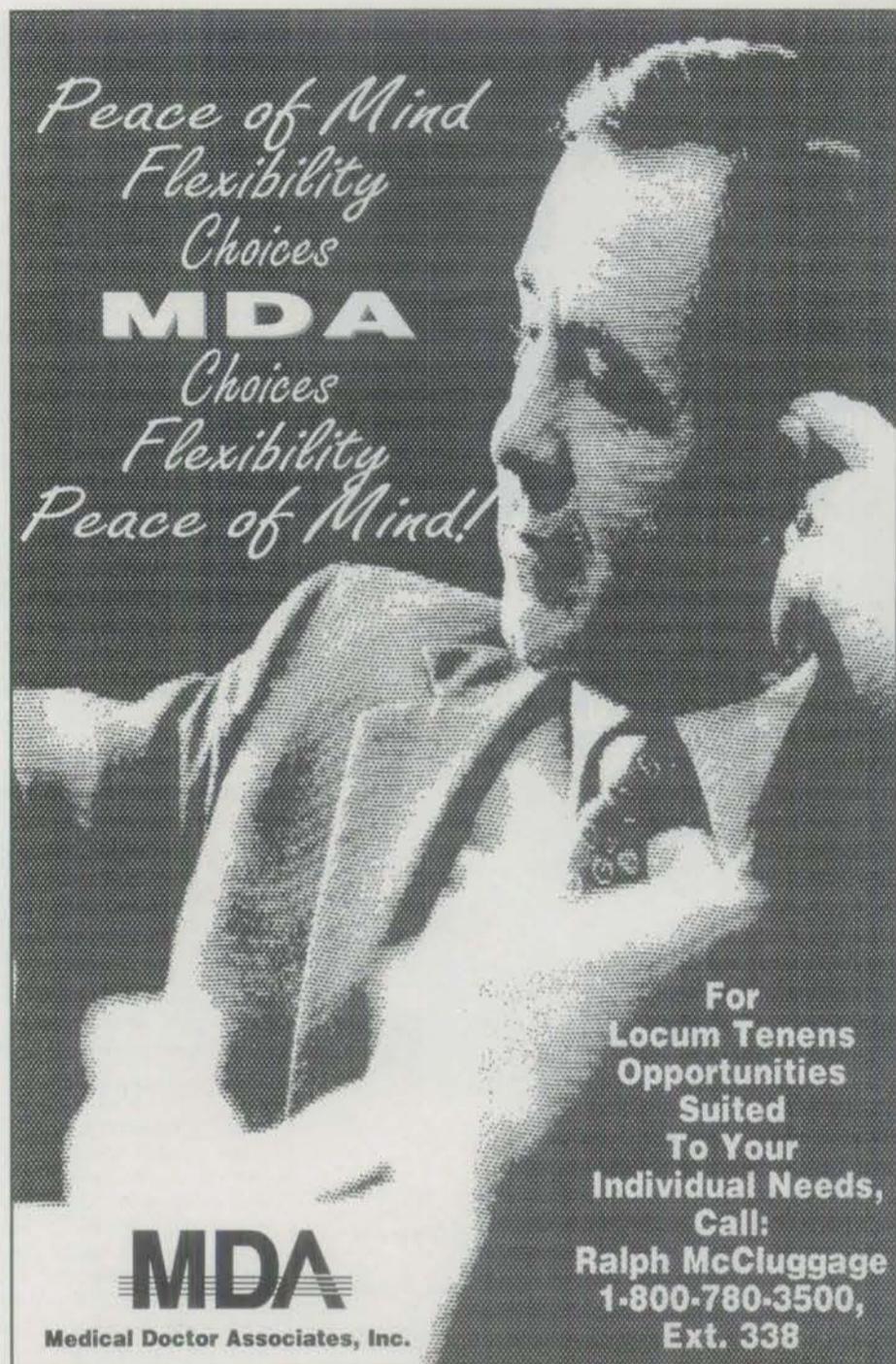
needed for an outstanding group practice!

We are seeking BC/BE colleagues to join us in our medically-oriented practice. Psychiatrists are needed at both Geisinger Medical Center, our 577-bed tertiary care medical center in Danville, PA, and for our new 20-bed inpatient unit at The Bloomsburg Hospital in nearby Bloomsburg, PA. Our diverse practice encompasses inpatient psychiatry with 50 beds, consultation-liaison psychiatry, a busy outpatient practice, adult and adolescent partial programs, community outreach, plus opportunities for teaching within the multidisciplinary approach.

Geisinger offers superb career growth opportunities with a generous salary plus excellent benefits, including malpractice, health, life, dental, long term disability insurances and retirement plans, as well as eight weeks of CME and vacation. Although in relative proximity to numerous East Coast urban centers, Geisinger physicians enjoy an environment and lifestyle unique to its small town setting. Our area has excellent schools, affordable housing, three nearby universities with numerous cultural activities, and unparalleled outdoor recreational activities. If you are looking for professional fulfillment and an excellent personal quality of life contact the **Physician Recruitment Office PSYC-BY, Geisinger, 100 N. Academy Avenue, Danville, PA 17822-3024, or call 800-845-7112.**

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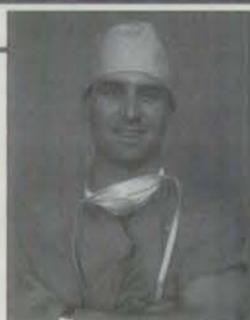
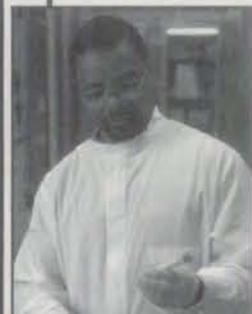
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MS. JEAN HARRIS

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WOMEN AND CHILDREN"

WEDNESDAY, MAY 24, 1995
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The **ASSOCIATION OF GAY & LESBIAN PSYCHIATRISTS** is a professional, educational, and social organization for psychiatrists who are gay or lesbian and/or involved in the treatment of gay and lesbian patients. For further info, write to **AGLP, 3331 Ocean Park Blvd., Suite 201, Santa Monica, CA 90405**. Confidentiality respected.

CHARTER MEDICAL CORPORATION
SEE OUR AD ON PAGE 33

Your next professional opportunity is just a phone call away. For a confidential discussion of today's job market, contact **Rebecca Kilmer, APA's Psychiatric Placement Service**. Unlike other search firms, our service works exclusively with psychiatrists looking for a change and has access to the collective resources of the APA. For more information, write or call: **PPS, 1400 K St., NW, Washington, DC 20005; (202) 682-6108**.

NATIONWIDE—Many good opportunities for General Adult and Child and Adolescent Psychiatrists available!!! Locations include Alabama, Alaska, CT, Georgia, IA, Maine, Missouri, Montana, New Jersey, New York, North Dakota, Pennsylvania, South Carolina, Washington, and West Virginia. Salary/income guarantees in excess of \$150K. Call (610) 889-4850 for details. FAX CV to (610) 889-4964.

PSYCHIATRIST PSYCHIATRIST

Help! We're going crazy trying to find Psychiatrists!!! Call Advanced Careers, Barbara or Maggie (800) 835-8449 or FAX CV (203) 282-1197.

PSYCHIATRY, ADULT & CHILD/ADOLESCENT—APOGEE, one of the nation's largest independent mental healthcare providers is seeking **BE/BC Psychiatrists as Part Time & Full Time** employees, for their multidisciplinary mental healthcare group practices. Opportunities exist in Phoenix AZ, CALIFORNIA, Baltimore MD (CHP), DC Metro (CHP), FLORIDA (CHP & Adult), PENNSYLVANIA, RHODE ISLAND (CHP), & TENNESSEE. Additional expansion in OREGON & WASHINGTON expected soon. Get a competitive edge by joining this established, rapidly expanding, premiere mental healthcare group. For immediate consideration, fax (610) 992-0843 or send your resume to Doug Page, APOGEE, 1018 W. Ninth Ave., Suite 202, Dept. CPN6, King of Prussia, PA 19406; (800) 432-7643, ext. 4. EOE. Visit booth #526 at the APA Convention!

PSYCHIATRIC RESIDENTS AND FELLOWS—You have an ally when it comes to your job search! The APA's Psychiatric Placement Service can get the ball rolling as you move from postgraduate training to the workforce. The PPS will provide you with up-to-date information on the job market, identifying professional opportunities you may not even know exist. We do so at no cost to you. It's just one of the many services available to all psychiatrists through the APA. For information on how to enroll, call or write: **PPS, 1400 K St., NW, Washington, DC 20005; (202) 682-6108**.

OPPORTUNITIES NATIONWIDE FOR GEROPSYCHIATRISTS AND ADULT PSYCHIATRISTS. A variety of opportunities are available across the country whether you want small town life or a metro area; warm weather or cold or somewhere in between. **Currently available—Geropsychiatry: IL, MA, PA, KY. Adult Psychiatry: MI, IL, WI.** Call for details about these or other upcoming opportunities. **Contact Terry Banfield Good (formerly Terry Macheski) or Steve Short at (800) 355-4884, or fax CV to (703) 506-9308, or mail CV to HMHM, Dept. NAT-0505, 7601 Lewinsville Rd., Ste. 202, McLean, VA 22102. EOE.**

REGIONAL

EAST COAST PSYCHOPHARMACOLOGISTS—Major national managed care organization seeks private-practicing psychiatrists with interest and competence in psychopharmacology to join its provider network. Our care management process is quality focused and we strive for non-burdensome utilization review. Psychiatrists are needed throughout **Pennsylvania, New Jersey, Delaware, Maryland, West Virginia, Virginia, the District of Columbia, and North Carolina** to provide diagnostic evaluations and medication management for adults, adolescents, and children. Please submit CV and other relevant information to Psychiatrist Search, PO Box 9036, Lutherville, MD 21093.

ALABAMA

CHARTER MEDICAL CORPORATION
SEE OUR AD ON PAGE 33

Northeast Alabama—CHILD AND ADULT PSYCHIATRISTS—Immediate positions. Mid-size city - central to Chattanooga, Birmingham, Rome, Georgia, Huntsville, Atlanta. Locally operated psychiatric hospital among medical facilities. Excellent base and production opportunities. Quality setting and accessibility. Please contact Jon Orr, Mountain View Hospital, Gadsden, AL, (800) 245-3645.

SOUTHEAST ALABAMA—Unusual opportunity/ 18-year thriving practice/office building for sale. Serve Tri-state catchment area of 600,000. Short drive to beautiful white sand dunes of Gulf Coast beaches. Beautiful private office building. Convenient location. Extremely experienced staff. Just walk in. Will assist with introduction to medical community and transition. Moving to West Coast. Call for specifics (334) 794-0719.

ALASKA

MEDICAL DIRECTORSHIP for 20-bed Adult/Child and Adolescent Unit affiliated with one of Alaska's major medical centers. Currently 2 FT Psychiatrists, expanding, growing, stable program. Beautiful area in the heart of the Alaska glaciers. Salary \$150K. Call (610) 889-4850 for details.

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June 16	June 2
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Software
Miscellaneous

The publisher reserves the right to accept or reject advertisements for Psychiatric News. All advertisers in this section must employ without regard for race, sex, age, nationality, or religion in accordance with the law. APA policy also prohibits discrimination based on sexual orientation. Readers are urged to report any violations immediately to the executive editor.

ARIZONA

CHARTER MEDICAL CORPORATION
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PSYCHIATRISTS—Need MONEY to pay off those loans for your education? We are an approved site for the loan repayment program from the Public Health Service National Health Service Corps. On top of all this, we offer excellent career and lifestyle opportunities! Clear air, sunshine, and an abundance of recreational activities are at your doorstep along with modern outpatient and inpatient facilities for adults, youth, seriously mentally ill, and CD clients. A position with the loan repayment option is currently available in Bullhead City, Arizona for a general or child psychiatrist (BC/BE). Salary: \$90,000+ plus complete benefits package. Send CV to Susan Morley, Director of Human Resources, Northern Arizona Regional Behavioral Health Authority, 125 E. Elm, Suite E, Flagstaff, AZ 86001; (602) 774-7128. Fax (602) 774-5665 AA/EOE.

Tucson—Tucson VA Medical Center, in conjunction with the University of Arizona (UA) School of Medicine, seeks a full-time Chief, Psychiatry Service. Appointee must be board certified in psychiatry and qualify for a clinical or tenure track faculty appointment at the UA. In addition to outstanding clinical skills, candidates must demonstrate abilities and interest in administration and academic psychiatry, including scholarly achievement in teaching and research. VA salary commensurate with specialty/sub-specialty and fringe benefits. Send CV to Jayendra H. Shah, M.D., Chief of Staff, VAMC, Tucson, AZ 85723 or telephone (520) 629-1815. Review of applications will begin June 1, 1995 and continue until the position is filled. Tucson VAMC and UA are EEO/AA/ADA employers. Women and minorities are encouraged to apply.

ARKANSAS

CHILD/ADOLESCENT PSYCHIATRIST

Opportunity available in an expanding, fiscally sound, private non-profit community mental health center serving 6 counties in beautiful western Arkansas. Comprehensive diagnostic and treatment services provided in both urban and rural settings. Primary service center located in a pleasant city of 75,000 with good schools. Community college and low crime. Surrounding area includes picturesque small towns, lakes, streams, rolling hills and forests. Climate consists of 4 seasons and mild winters. Salary negotiable, based on experience. Phone or write Larry Leroy, Director of Clinical Services, Western Arkansas Counseling and Guidance Center, P.O. Box 2887, Fort Smith, Arkansas 72913-2887. (501) 452-6650; FAX (501) 452-5847.

GENERAL PSYCHIATRISTS—To work in a private, non-profit CMHC. Comprehensive diagnostic and treatment services provided in a fiscally sound center serving 6 counties in western Arkansas. Inpatient and outpatient psychiatric services are provided in both urban and rural settings in the beautiful Arkansas River Valley and mountain areas > (\$120K, additional pay for on-call services). Phone or write to Larry LeRoy, Dir. of Clinical Svcs., Western Ark. Counseling and Guidance Ctr., P.O. box 2887, Ft. Smith, AR 72913-2887; (501) 452-6650; FAX (501) 452-5847.

CALIFORNIA

The Department of Psychiatry, University of California, Davis is recruiting two full-time faculty members; one for a senior leadership position as Professor of Psychiatry, Vice Chair of the Department of Psychiatry, and Medical Director of the Sacramento County Mental Health Treatment Center; and the other to a more junior faculty position as Assistant/Associate Professor,

CLASSIFIEDS

coordinator of the medical student clerkship and consultation-liaison psychiatrist.

For the senior position, the successful candidate will have medical responsibility for directing all psychiatric services at the University Medical Center (C&L and OPD), and the adjacent county mental health treatment center (80 acute and intermediate inpatient beds and an acute crisis intervention service). At least 10 years of experience in clinical administration and academic leadership are required. Demonstrated experience in quality improvement programs and managed mental health services are necessary. Significant experience in teaching and supervision of residents, medical students and allied mental health professionals is required. Advanced management training (MBA, MPA, MPH or equivalent) is desirable. The successful candidate will have one or more areas of special expertise such as geriatrics, neuropsychiatry, psychopharmacology or mental health services research.

For the more junior position demonstrated teaching skills in medical student education and clinical experience in C&L psychiatry is required. Board eligibility or certification in psychiatry is necessary, and in another related medical specialty is desired. Post-residency fellowship training in C&L psychiatry is also desirable.

UC Davis is an equal opportunity employer and encourages applications from minority candidates. Please send a CV and names of 5 references to Dr. Thomas Anders, Chair, Department of Psychiatry, 4430 V St., Sacramento, CA 95817. Deadline for receipt of applications is April 30, 1995. Indicate which one of the two positions your application is directed.

MEDICAL DIRECTOR/STAFF PSYCHIATRIST—Interested in a rural setting on the Northern California coast? We are looking for a psychiatrist experienced in working as a Medical Director and Staff Psychiatrist, and as an interdisciplinary team member, in an overall county system of care. Contact: Joseph S. Krzesni, Mental Health Director, 720 Wood St., Eureka, CA 95501; (707) 445-7300.

DIRECTOR OF CHILD AND ADOLESCENT PSYCHIATRY

The Department of Psychiatry and Human Behavior, College of Medicine, University of California at Irvine, is seeking a director for our child and adolescent program at the new neuropsychiatric hospital. The position is full-time and includes the development of both inpatient and outpatient clinical programs, development of grant-funded research, and direction of the child and adolescent fellowship training program. Faculty rank and tenure status are commensurate with qualifications. The successful candidate must be board-certified in child and adolescent psychiatry and have a strong track record in clinical programs and research accomplishments, including continuous success in competitive federal grant support. The University of California is an Equal Opportunity, Affirmative Action Employer, "Rooted in education, enriched by diversity".

Please send a CV and five references to the Chairman of the Search Committee, Dr. Curt Sandman, Director of Research, 2501 Harbor Blvd., Costa Mesa, CA 92626.

Atascadero—Atascadero State Hospital, a University of California affiliated, JCAHO-accredited hospital, the nation's largest center for the treatment of mentally ill offenders, located midway between San Francisco and Los Angeles on the scenic central California coast, seeks bd.cert/elig. psychiatrists. Senior clinicians as well as recent graduates of approved residencies are invited to join our highly qualified staff of 40 psychiatrists and 10 non-psychiatric physicians.

We offer a spectacularly beautiful environment in San Luis Obispo County with temperate climate, beaches, cultural activities, sailing, riding, clean air, and excellent schools through the University level. Salary with certification up to \$106,000 plus benefit package valued at an additional 30%, plus professional liability coverage. Liberal additional pay for on-call duties, if desired. Applicants must hold current California license, or have pending application with the Medical Board of California. Send CV for prompt and confidential review to **David Saunders, M.D., F.A.P.A., P.O. Box 7001, Atascadero, CA 93423-7001; (805) 468-2005.EOE.**

Modesto—FT INPATIENT Psychiatrist, starting late spring (early summer) with Stanislaus County Department of Mental Health. Modesto is located in the San Joaquin Valley near San Francisco, Yosemite, Monterey and the Sierras. Personal service contract up to \$125,000 plus for FT per year, including optional on-call. Send inquiries to Ronald Melmed, M.D., 1501 Claus Rd., Modesto, CA 95355 or call (209) 524-4888. AA/EOE

Northern California—Outstanding opportunities are now available for adult outpatient, child/adolescent, and inpatient psychiatrists with Kaiser Permanente at several Northern California locations. These new positions are part of a region wide program expanding and improving out psychiatric services by strengthening the partnership between departments of medicine and psychiatry. Training and experience in brief psychotherapy and psychopharmacology are essential. Board certification/eligibility is required. Competitive salary and comprehensive benefits package. Interested candidates should send CV with cover letter to: Brenda Ferguson, The Permanente Medical Group, Inc., Physician Recruitment, Dept. 41, 1814 Franklin, 4th Floor, Oakland, CA 94612-3497. EOE.

NORTHERN CALIFORNIA—The Kaiser Permanente Medical Center in Santa Clara has an outstanding opportunity for a Chief of Psychiatry with documented administrative experience and familiarity with HMO psychiatry. Board certification is required. The psychiatry department comprises adult, child/adolescent and chemical dependency outpatient divisions at three different sites. Our 60-member department includes psychiatrists, psychologists, psychiatric social workers and psychiatric nurses. We are presently engaged in a five-year process of carrying out a new model of care for mental health that includes new research design for measuring outcomes. Interested candidates should send CV to: Brenda Ferguson, The Permanente Medical Group, Inc., Physician Recruitment, Dept. 41, 1814 Franklin, 4th Floor, Oakland, CA 94612-3497. EOE.

Northridge—Part-time Bd-cert. Neurologist or Psychiatrist for research position. Our research team is growing! We need an additional physician (4-6 hours/week + free office space for your private patients). Appropriate candidate has a substantive interest in medicine, research, patient care and the clinical aspects of psychiatry/neurology. M.D. will function as an investigator and/or co-investigator on studies from which data are submitted to the FDA. Some domestic travel is required and compensated. Excellent opportunity. Submit resume/CV and salary requirements (e.g. hourly rate), in confidence, to: Dr. Charles Wilcox, Exec. Dir., Pharmacology Research Institute, 8435 Reseda Blvd., Northridge, CA 91324.

Sacramento

ADULT/ADOLESCENT PSYCHIATRIST

Community Psychiatric Centers, a national provider of psychiatric inpatient and outpatient services, is seeking F/T Program Director psychiatrists at both of their Sacramento hospitals. BE/BC Adult/Adolescent psychiatrists seeking an active inpatient and outpatient practice. Sacramento is conveniently located between the San Francisco Bay area and Lake Tahoe with outstanding financial growth opportunities. For consideration send CV to: CPC Sierra Vista Hospital, 8001 Bruceville Rd., Sacramento, CA 95823, Attn: L. Kreyche, M.D., Medical Director.

COLORADO

PSYCHIATRISTS—Suburban Denver: Psychiatrists needed for Adult Psychiatry. Contact: Robert J. Nathan, M.D., Medical Director, Jefferson Center for Mental Health, 5265 Vance St., Arvada, CO 80002; (303) 425-0300. EOE M/F/D/V.

Denver—BE and BC Psychiatrists. Excellent full and part-time opportunities are currently available within our progressive Community Mental Health Center. You will work within a multidisciplinary treatment team environment to provide services to severe and persistently mentally ill clients. We can also offer the added advantage of life in the "Mile High City" environment where the city life offers the convenience of the arts, shopping, sports and corporate mingling while the peaceful mountain landscape lies minutes away. Salary is competitive and commensurate with experience and qualifications. Flexible schedules are available. Strong benefits package including 403(b) retirement plan. Academic opportunities through University of Colorado. Apply to Mental Health Corporation of Denver, c/o Haydee Kort, M.D., Psychiatric Consultant, 4 Country Club Village, Pueblo, CO 81008; (719) 545-6546. We are an EOE/AA employer. M/F/D/V.

Denver—Faculty Psychiatrist. The C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect and the Dept. of Psychiatry University of Colorado Health Sciences Center (UCHSC), are recruiting for a BE/BC child and adolescent psychiatrist for a full-time faculty position. Position will be primarily at the Kempe National Center, with 30% time allocated to UCHSC activities. General po-

sition requirements include: clinical staff supervision, consultation on child maltreatment cases, direct patient care, development of research interests, and administration. Research commitment in areas consistent with the Kempe National Center mission is expected. Expertise in child maltreatment is essential. Salary/faculty rank commensurate with qualifications. Call or write (with CV): Susan Hiatt, Ph.D., Director; Kempe National Center, 1201 Oneida St., Denver, CO 80220-2944; (303) 321-3963. The University of Colorado is an equal opportunity/affirmative action employer.

Fort Lyon—Vacancies exist at this Medical Center for BE/BC Psychiatrists. Teaching experience desirable. Applicants should be U.S. citizens and must have a current license to practice in any state of the U.S. Congenial staff; good working conditions with maybe benefits. Historic Fort Lyon is located along the Santa Fe Trail on the high plains of southeastern Colorado in the Arkansas River Valley. Living is rural, comfortable with virtually non-existent crime. Local schools are excellent. Starting salary is \$125,000+, depending on qualifications and experience. Interested applicants should contact Joyce Maupin, Recruiter, at (719) 384-3480, or send current CV to Joyce Maupin (05), VA Medical Center, Fort Lyon, CO 81038. Interested applicants can also call I. David Bornstein, M.D., Chief, Psychiatry Service for more information.

Pueblo—University of Colorado Health Sciences Center recruiting for Psychiatrists—**Adult, Forensic, Child and Adolescent, Geriatric**—for 635-bed psychiatric center. Nation's best state hospital (Nader Report, 1988) located in America's most liveable community (University of Kentucky, 1990). Money Magazine—Top Five Small City (1994). Regular hours. Salary competitive, commensurate with qualifications, plus faculty benefits, paid malpractice. Position carries academic appointment at UCHSC. Send CV to Graham W. Hoffman, M.D., Chief of Medical Staff, Colorado Mental Health Institute, 1600 West 24th Street, Pueblo, CO 81003-1490; (719) 546-4637.

Southern Colorado—University of Colorado Health Sciences Center recruiting fulltime Psychiatrists for the Dept. of Corrections. Jobs available in the Canon City/Pueblo area. Flexible hours. Competitive salary. Appointments available January 1996. Faculty benefits with paid malpractice. Position carries academic appointment at UCHSC. Send CV to Mark Diamond, DO, Clinical Services, CTCF/C House, PO Box 1010, Canon City, CO 81215-1010; (719) 269-4097.

CONNECTICUT

CHILD PSYCHIATRIST P/T

Board Eligible/Board Certified child psychiatrist 8-12 hours **Child Guidance Clinic.** Provide diagnostic assessments and psychiatric input to multidisciplinary team. Varied patient population. Stimulating professional environment. Excellent opportunities for teaching and supervision. Minorities, bilingual Spanish/English encouraged to apply. Easy NYC commute. Resumes: ED, CGC, 103 W. Broad St., Stamford, CT 06902. EOE.

CHILD PSYCHIATRIST

PSYCHOTHERAPY CENTER OF ESSEX—Private Practice. A well established multidisciplinary, multispecialty group practice located in the scenic town of Essex, which is along the CT River, is currently interviewing qualified BE/BC child psychiatrists for a full-time partnership opportunity to join a dynamic and rapidly growing practice. Capacity to work in a collegial, multidisciplinary team model is essential. Although our population is primarily outpatient, applicants with recent post-graduate inpatient experience, preferably at the level of unit chief, are most desirable. Proven skills in diagnosis, psychopharmacology, treatment planning and review are required. Send resume in confidence to: Psychotherapy Center of Essex, Diana Harbison, M.D., Medical Director, Robert Mallinson, Ph.D., Clinical Director, P.O. Box 182, Centerbrook, CT 06409.

Darien—Group practice in Geriatric Psychiatry with substantial nursing home and outpatient services. Excellent salary plus partnership opportunity. Contact Geriatric Psychiatry Associates, P.C., Malcolm Gordon, M.D., Executive Director, 10 Corbin Dr., Suite 5, Darien, CT 06820; (203) 655-1559.

Fairfield—Group Psychiatric Practice seeking full-time Child and Adult Psychiatrist. Varied inpatient and outpatient work. Partnership opportunity. We offer a competitive salary. Send re-

sume to Mark Waynik, M.D., 52 Beach Rd., Fairfield, CT 06430.

Litchfield County—The Charlotte Hungerford Hospital located in Northwest CT is currently seeking two (2) BC/BE psychiatrists for expanding department. Interested candidates should forward resume/CV to: **Samuel Langer, M.D., Director, Psychiatry, The Charlotte Hungerford Hospital, 540 Litchfield St., Torrington, CT 06790. EOE.**

Litchfield County—Outstanding opportunity for Psychiatrist to join well established private practice in the Litchfield County area. Multidisciplinary staff. Computerized billing. Strong referral and managed care contracts. High level, motivated and interesting patient population. Excellent investment and high income opportunity. Contact June at (203) 266-0077.

New Britain—Seeking BE/BC general psychiatrist to join attending staff of eight BC psychiatrists at New Britain General Hospital (NBGH), a 340-bed university affiliated teaching institution. The position is currently configured half-time hospital based and half-time private practice, but a full-time configuration is possible. Membership in developing multidisciplinary mental health network. Many "niche" opportunities available, including women's medicine, geriatrics, and bilingual practice - Polish and Spanish. Reply to Mahlon S. Hale, M.D., Chief, Department of Behavioral Health Services, NBGH, 100 Grand St. New Britain, CT 06050; (203) 224-5449 or FA. (203) 224-5734. AA/EOE.

SOUTHERN PART OF FAIRFIELD COUNTY—Group practice seeking a part-time Psychiatrist, possibility of full-time in future & possibility of Partnership. Please send your resume to: Fax # (203) 323-7317

DELAWARE

DREAM COME TRUE?—A small, friendly hospital (138 bed) with the high tech advances of a sophisticated facility but located in the beautiful East Coast sea resort community of **Lewes, DE...**with you as its **Medical Director and Chief of Psychiatric Services?** **Beebe Medical Center's** 13-bed inpatient unit has just such an upper level opening. Candidate must possess strong credentials, administrative experience, demonstrated interpersonal skills, dedication to team effort. Competitive compensation package. For information call Stephen H. Short at (800) 355-4884, or fax your CV to (703) 506-9308. EOE.

DISTRICT OF COLUMBIA

PRIVATE PRACTICE OPPORTUNITY—Office available July 1, Excellent central DC location. Ample private parking; convenient public transportation. Share FT secretary, expenses 4 other general psychiatrists: C.D. Kyropoulos, M.D., (202) 462-7111; D.A. Starr, M.D., (202) 387-7123.

PSYCHIATRIST—The Department of Psychiatry and Behavioral Sciences at the George Washington University is recruiting for one full-time faculty psychiatrist position at the Assistant or Associate professor level for the Medical Director of the Psychiatry Day Treatment Program. This position provides an exciting opportunity to direct a partial hospitalization program providing intensive services for acute and chronic illnesses and as a day program for patients with substance abuse and teaching. Board certification preferred. Position is available as of July 1, 1995. Review of applications will begin on May 1, 1995 and continue until the position is filled.

Send CV and letter of interest to Jerry M. Wiener, M.D., Chairman, Department of Psychiatry and Behavioral Sciences, George Washington University, 2150 Pennsylvania Ave., NW, Washington, DC 20037, Attn: Linda Hancock, Departmental Manager. The George Washington University is an equal opportunity/affirmative action employer. Applications from women and minority groups are encouraged. A license to practice in the District of Columbia will be required.

FULL-TIME FACULTY CHILD PSYCHIATRIST—The Department of Psychiatry and Behavioral Sciences at George Washington University is recruiting for one full-time faculty position at the Assistant or Associate Professor level for the Child and Adolescent Team Attending Psychiatrist in the Division of Ambulatory Care. The psychiatrist will lead a multidisciplinary clinical training team with emphasis on outpatient consultation, diagnostic evaluation and treatment planning, crisis intervention, brief therapies and pharmacotherapy. The psychiatrist will function as Coordinator for mental health training in primary care pediatrics residency and participate in

CLASSIFIEDS

child training in the general psychiatry residency in affiliation with Childrens National Medical Center.

Candidates should be board eligible/certified and a license to practice in the District of Columbia will be required. Experience in managed mental health care, primary care pediatrics, consultation-liaison, pharmacotherapy, brief psychotherapies, and multicultural treatment is highly desirable. Position will be available as of July 1, 1995 and review of applications will begin immediately and continue until the position is filled.

Send CV and letter of interest to Stuart Sotsky, M.D., M.P.H., Director of DAC, Department of Psychiatry and Behavioral Sciences, George Washington University, 2150 Pennsylvania Ave., NW, Washington, DC 20037, Attn: Linda Hancock, Departmental Manager. The George Washington University is an equal opportunity/affirmative action employer. Women and minority applicants are encouraged.

CHARTER MEDICAL CORPORATION
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FLORIDA

PSYCHIATRISTS

Immediate openings for Board Eligible/Certified Psychiatrists and a Board Certified Medical Executive Director at Northeast Florida State Hospital. Florida License required. Hospital has affiliation with University of Florida, Department of Psychiatry. Clinical Faculty appointment available for qualified applicants. Hospital is located 30 minutes from Jacksonville and 50 minutes from Gainesville. Comprehensive benefit package, including malpractice insurance, retirement, health and life insurance. Salary negotiable. Contact Ms. Sandra T. McDonald, Medical Staff Coordinator at (904) 259-6211, ext. 1118. EOE/AA.

CHARTER MEDICAL CORPORATION
SEE OUR AD ON PAGE 33

CLINICAL PSYCHIATRIST—Positions available for medical psychiatry units at Florida Hospital—total of 50 beds, level 3 psych.med. and 4 psych.med. in one of America's premier hospitals. Candidates who are double boarded in internal medicine and medical subspecialties with strong interest in medical psychiatry preferred. Teaching and research components to job as well as direct patient care. Excellent salary and benefits in one of America's premier cities. Contact Richard C.W. Hall, M.D., Medical Director, Psychiatric Programs, Florida Hospital, Center for Psychiatry, 601 East Rollins Street, Orlando, Florida 32803; (407) 897-1801.

Ft. Walton—Seeking Child/Adolescent Psychiatrist to join existing hospital staff. Opportunity to do both inpatient and outpatient work. Excellent compensation and benefit package. Great location with superior beaches and low cost-of-living. B/E and current FL license required. For confidential consideration, please call David Lassiter at (800) 844-0080 or send your CV to:

Vendell Healthcare, Inc.
3401 West End Ave., Suite 500
Nashville, TN 37203
CALL (800) 844-0080
FAX (615) 269-7525

Miami—Seeking growth oriented FL lic. psychiatrist for active priv. prac.; affluent area; inpt./outpt. settings; excel incentive plan incl. sal., bnfts. Call Dr. Chiert, So. FL Psych. Assoc., 305-935-6060; fax 305-949-9393.

Miami—Part-time Psychiatrist needed to work at South Florida Reception Center, a state correctional facility, in the Mental Health Clinic. Hours M-F from 8:00am to 12:00pm with no call. Florida license required. Excellent compensation/paid malpractice. Contact: Eileen MacLean at (800) 422-3672, x-7468 or mail/fax CV to EMSA, 1200 South Pine Island Rd., Suite 600, Ft. Lauderdale, FL 33324-4460; Fax (305) 424-3270. EEO/AA/M/F.

Miami Beach—Private practice seeking FL Licensed Psychiatrist with experience in Adult, Geriatric pharmacology and HIV disease. Inpatient and outpatient treatment. Forward CV to: 4045 Sheridan Ave., Suite 233, Miami Beach, FL 33140; fax (305) 531-6619.

Orlando—Director of Adolescent Acute Inpatient Psychiatric Unit, Florida Hospital—Board certified child and adolescent psychiatrist, preferably with academic background, to direct active child and adolescent in and outpatient programs. Excellent salary and benefits in one of America's premier cities. Contact Richard D.W. Hall, M.D., Medical Director, Psychiatric Programs, Florida Hospital, Center for Psychiatry,

601 East Rollins Street, Orlando, FL 32803; (407) 897-1801.

Panama City—Psychiatrist to join multidisciplinary mental health center staff in providing inpatient and outpatient treatment. Located in beautiful Gulf Coast area with wonderful weather and beaches, cultural and educational opportunities, and reasonable cost of living. Board-eligible and Florida license required. Full-time salary and \$140,000 with excellent fringe benefits. Send CV to: Peter T. Hampton, Ph.D., Executive Director, Life Management Center of NW Florida, Inc., 525 East 15th St., Panama City, FL 32405. EOE.

Pensacola—BE/BC CHILD PSYCHIATRIST. For large, comprehensive health center in Pensacola, FL. The position is 40 hours per week in the outpatient clinic, working with children and adolescents. Salary is \$112,000. Additional 3% for Board Certification in child psychiatry. Opportunity for additional compensation for on-call and inpatient duties. Excellent fringe benefits including professional liability insurance. Florida license is required. Pensacola is located on the Gulf of Mexico. It has some of the world's whitest beaches, a lower than average cost of living and excellent health facilities and schools. Please send resume to Lakeview Center, Inc., 1221 West Lakeview Ave., Pensacola, FL 32501-1857; (904) 432-1222, x-229. EOE/MF/Drug Free Workplace.

TALLAHASSEE—BE/BC PSYCHIATRIST

Apalachee Center for Human Services, a large, non-profit, comprehensive mental health center, has outpatient position available, M-F, 8 to 5. On-call optional, but additionally compensated. JCAHO accredited. Outstanding salary/benefit package. Located in a family-oriented community known for its pleasant climate, variety of recreational and cultural activities, and a high quality of life. Send or fax CV to Human Resources Director, P.O. Box 1782, Tallahassee, FL 32302; Fax (904) 487-0851. EOE/Drug Free Workplace.

Tallahassee, Florida Area—BE/BC General Adult or Geriatric Psychiatrist for progressive mental health facility. Pleasant community setting. Florida license required. Malpractice coverage available. Contact: ANNASHAE CORPORATION (800) 245-2662.

GEORGIA

ENJOY A LEISURELY LIFESTYLE—in a great university community about 90 minutes from Atlanta. BC/BE child psychiatrist desired for outpatient practice with a large, stable community mental health organization, offering a solid compensation package. Ideal setting mixes the historic, smaller southern city with the benefits of a major university. Great sports, cultural, and recreational opportunities. Call St. John Associates at (800) 737-2001 or fax CV to (812) 332-2727.

Open Rank—Academic Psychiatrists. The Mercer University School of Medicine, Department of Psychiatry, has FT openings in its Adult, Child, and Community Psychiatry Divisions. Outstanding opportunity for clinical practice, teaching, and research in America's newest medical school. Salary and rank commensurate with experience and qualifications, and supplemented by attractive faculty practice plan. Women and minorities encouraged to apply. Contact William Nelson, M.D., Professor and Chair, Dept. of Psychiatry, Mercer University School of Medicine, 1550 College St., Macon, GA 31207; (912) 752-4033. AA/EEO.

MEDICAL DIRECTOR GEORGIA

Green Spring Health Services, a leader in the field of managed mental health/substance abuse services, has a Medical Director opening in our Atlanta, GA office. Candidate will provide consultation and oversight regarding appropriate medical policy and practice, interface with the medical community and provide Physician Advisor services to utilization management staff.

Board Certified Psychiatrist (ACME approved medical school internship and residency, or equivalent foreign medical training and successful completion of the ECFMG and FLEX) must be licensure eligible in Georgia. Candidates must have at least five years post-residency clinical practice and administrative experience. Excellent salary and flex benefits including 401(k). Submit curriculum vitae to:

GREEN SPRING HEALTH SERVICES
Human Resources 94-379
5565 Sterret Pl., Suite 500
Columbia, MD 21044
EOE M/F/D/V

COMMUNITY MENTAL HEALTH, MENTAL RETARDATION, SUBSTANCE ABUSE CENTER OF MIDDLE GEORGIA—Two hours to Savannah, Atlanta, Augusta and less than an hour to Macon while living in a peaceful small town atmosphere. Great time to join an expanding and progressive area program. J.D. based on merit system specification is negotiable. Salary range: Bd.-elig. \$65,652-\$89,352; Bd.-cert. \$85,638-\$102,126 (negotiable based on experience). Excellent fringe benefits, including medical liability, generous sick and annual leave, 12 paid holidays yearly, solid retirement system, a variety of group insurance options and good working conditions. Reply with CV to Harry Pritchett, 2121A Bellevue Rd., Dublin, GA 31021, or call (912) 272-1190 or FAX (912) 275-6509. Equal Employment Opportunity.

CHARTER MEDICAL CORPORATION
SEE OUR AD ON PAGE 33

Atlanta—Emory University School of Medicine, Department of Psychiatry and Behavioral Sciences, Atlanta, GA, is recruiting Clinical Psychiatrists in the following areas: Adult General (inpatient) psychiatry; Geriatric Psychiatry; Child/Adolescent Psychiatry. Individuals should have a strong clinical orientation with expertise working within a managed care model of mental health delivery. Applicants should be Board eligible or Board certified with an interest in practicing clinical psychiatry within an academic setting. Please send curriculum vitae to Charles Nemeroff, M.D., Ph.D., Department of Psychiatry and Behavioral Sciences, Emory University, P.O. Box AF, Atlanta, GA 30322. EOE/AA.

ILLINOIS

LUCRATIVE OPPORTUNITY for One Who Loves the Less Hectic and Value-emphasized Atmosphere of Working in a Small Town. — Seeking Psychiatrist to head up new PHP in the Lawrence County Memorial Hospital—a small general hospital in southeastern IL. Also, involves inpatient, consultations, and setting up an outpatient office. Position has much flexibility, and if preferred, the physician can live in Evansville, IN (the closest large city of 150,000) only 60 miles from the hospital or anywhere in between. Call Terry Banfield Good (formerly Terry Macheski) for details, or fax CV to her at: (703) 506-9308, or mail CV to her at: HMHM, Dept. ILIN-0505, 7601 Lewinsville Rd., Suite 202, McLean, VA 22102. EOE.

An Hour And A Half From Chicago—A third Psychiatrist needed on adult psychiatric unit based in the Illinois Valley Community Hospital, Peru, IL. A wide-open opportunity for someone who likes geriatric work and would want to help develop and expand the geriatric track on unit. Excellent financial package which includes stipend, practice assistance income, and relocation expenses. Peru is within a 60 mile radius of Rockford, Rock Island, Peoria, Bloomington and Joliet. Call Terry Banfield Good (formerly Terry Macheski) at (800) 368-3589 or fax CV to Terry at (703) 506-9308, or mail CV to: Horizon Mental Health Management, Dept. PERU-0505, 7601 Lewinsville Rd., Suite 202, McLean, VA 22102. EOE.

CHICAGO MEDICAL SCHOOL-PGY-3 OPENING—New funding for innovative PGY-3 position in psychiatry. Outstanding neuropsychiatry, psychopharmacology and psychotherapy training. Call Dr. David Garfield at The Chicago Medical School (708)578-3330.

A NICE SITUATION!—45 minutes from the Univ. of IL, Champaign; only 2 hours from St. Louis and Indianapolis; 3 hours from Chicago. Need 3rd psychiatrist who will be busy from day one on this impressive general hospital-based 25-bed unit. Enjoy flexibility in your daily routine, whether your preference is inpatient, outpatient, consultations in the hospital or nursing homes, etc. Excellent income potential. The hospital is 5 minutes from Charleston—a quaint college town with beautiful old homes and numerous brand new homes, from duplexes to large estate homes. Perfect for the doctor who is tired of the competition and hassles of large city life, but wants to be close enough to enjoy the benefits when desired. Call Terry Banfield Good (formerly Terry Macheski) at (800) 355-4884 or fax CV to Terry at (703) 506-9308, or mail CV to Dept. IL0505, Horizon Mental Health Management, Suite 202, 7601 Lewinsville Rd., McLean, VA 22102. EOE.

ADULT PSYCHIATRIST—Excel opportunity to join a private practice of OP/IP psychiatry. Western suburb Naperville/Aurora. Sal/compensation negotiable. Send resume or call Freeda. FOX VALLEY PSYCHIATRIC, PO Box 1441, Aurora, IL 60507,(708)859-0120.

CHIEF OF PSYCHIATRY—The VA West Side Medical Center is seeking an energetic and visionary leader of its Psychiatry Service. We are a modern 385-bed tertiary hospital with one of the largest ambulatory care programs in the VA and a comprehensive spectrum of acute psychiatric services. A fully integrated graduate medical education program exists with the University of Illinois College of Medicine (UIC). We are looking for an energetic and visionary leader with a strong academic background and commitment to education and clinical/services-oriented research. A faculty appointment at the Associate Professor level or higher is expected. West Side offers an excellent salary and benefit package in a professionally stimulating atmosphere. VA and UIC are equal opportunity employers. Send CV to Subhash C. Kukreja, M.D., Chair, Search Committee (111), 820 S. Damen Ave., Chicago, IL 60612.

DIRECTOR OF PSYCHIATRIC MEDICINE—The University of Chicago is seeking a medical psychiatrist with academic interests to direct the Psychiatric Medicine programs. Responsibilities include clinical supervision, teaching and provision and direction of clinical care activities. Candidates must be board certified (or eligible) in Psychiatry. Additional qualifications in another medical specialty, preferably primary care, are desirable. A record of research and/or publications is desirable. Salary and faculty rank commensurate with experience and qualifications. Send curriculum vitae and cover letter to: Bennett Leventhal, M.D., Chair, Department of Psychiatry, University of Chicago, 5841 S. Maryland Ave., MC3077, Chicago, IL 60637. An AA/EEO employer.

DIRECTOR OF ADULT PSYCHIATRY—The University of Chicago, Department of Psychiatry is seeking an academic psychiatrist to direct Adult Psychiatry programs in an academic medical center. Responsibilities include research, clinical service, clinical supervision, teaching of medical students and psychiatry residents and direction of clinical care activities. The successful candidate must be board certified (or eligible), have a record of research and/or publications must qualify for academic appointment. Salary and faculty rank commensurate with experience and qualifications. Send curriculum vitae and cover letter to: Bennett L. Leventhal, M.D., Chair, Department of Psychiatry, The University of Chicago, 5841 S. Maryland Ave., MC 3077, Chicago, IL 60637. The University of Chicago is an AA/EEO employer.

GEROPSYCH DIRECTORSHIP POSITION—An outstanding opportunity to establish yourself in an area where no psychiatric professional currently specializes in geriatrics. A team of 3 other psychiatrists are available to assist with coverage and lend support. Work on a unit based in a very impressive full-service hospital in Danville—only 2 1/2 miles from Chicago; 35 miles from Champaign/Urbana, and 70 miles from Indianapolis. Salary with benefits or practice opportunity available. Call Terry Banfield Good (formerly Terry Macheski) at (800) 355-4884, or fax CV to Terry at (703) 506-9308, or mail CV to: Horizon Mental Health Management, Dept. DAN-0505, 7601 Lewinsville Rd., Suite 202, McLean, VA 22102. EOE.

Chicago—Jr. and Sr. Faculty positions available in growing Department of Psychiatry. Opportunity in most subspecialties. Contact B.L. Leventhal, M.D., Professor/Chair (Interim), Department of Psychiatry, University of Chicago, Box 411, 5841 S. Maryland Ave., Chicago, IL 60637. An EOE.

INDIANA

SOUTHERN INDIANA—For those interested in Evansville, Vincennes, the southwestern part of Indiana, please see our ad under Illinois: "Lucrative Opportunity for Dr. Who Loves the Work Atmosphere of Small Towns." EOE.

CHARTER MEDICAL CORPORATION
SEE OUR AD ON PAGE 33

BANKS OF THE WABASH—BC/BE adult psychiatrist needed for comprehensive multidisciplinary practice in a great historical center of Indiana. Enjoy all the charms of a college town with easy access to Louisville, Indianapolis, St. Louis and Evansville. Excellent call situation, strong salary and benefits. Call St. John Associates at (800) 737-2001 or fax CV to (812) 332-2727.

FAX YOUR AD TO (202) 682-6347

TODAY!!!

CLASSIFIEDS

KANSAS

CLINICAL DIRECTOR

Topeka State Hospital, a 266-bed, JCAHO accredited and HCFA certified psychiatric facility serving children, adolescent and adults, is recruiting for the position of Clinical Director. This position oversees all clinical disciplines and the hospital's residency and child fellowship programs with the Menninger Clinic, as well as other teaching programs. Qualifications: must be eligible for licensure in Kansas; board certification desired; progressive leadership abilities and administrative experience required. Excellent benefits. Topeka is a small city which enjoys a family-oriented lifestyle, excellent services and clean air. Randy Proctor, Acting Superintendent, (913) 296-4222; FAX (913) 296-4289. EOE.

Manhattan—Board Certified/Eligible Psychiatrist. Full-time position in expanding and active community mental health center. Join an experienced multidisciplinary staff offering services from prevention to rehabilitation. Major practice emphasis on outpatient care with some responsibilities for inpatient unit, consultation and supervision of other professional staff. Salary competitive/excellent fringe benefits including malpractice, retirement, health insurance, vacation, professional leave and relocation. University town located in the beautiful Flint Hills of Kansas provides excellent working conditions and environment. To apply or obtain further information, contact Don Schreiner, Executive Director, or Steve Eshelman, M.D., Medical Director, Pawnee Mental Health Services, 2001 Claffin, Manhattan, KS 66502. EOE.

Wichita—Full-time BE/BC general psychiatrist to join busy solo practice. Large general psychiatric practice both adult and adolescents located in Kansas' largest city. One full-time psychologist and several part-time therapists. Practice rapidly expanding to include 4 area hospitals. Affiliated with the University of Kansas School of Medicine-Wichita. Opportunity for unlimited earning potential. Very congenial group atmosphere, 5 full-time support staff. Income support and moving expenses available.

Wichita is a growing metropolitan area of approximately 400,000. Symphony orchestra, music theater, fine dining, many national retailers. Only 2 hours from Kansas City and 8 hours from the rocky mountains. Excellent private educational institutions. Beautiful residential areas abound. Large city atmosphere with small city conveniences. Respond to *Psychiatric News*, Box P-223, APA, PSD, 1400 K St., NW, Washington, DC 20005.

KENTUCKY

STAFF PSYCHIATRIST

Opening for full-time board-eligible or board-certified psychiatrist at progressive JCAHO accredited 355-bed hospital with excellent clinical staff. Starting salary: board eligible - \$105,000; without experience - \$100,000; and board certified - \$110,000. Generous fringe benefits: paid holidays, sick leave, annual leave, educational leave, medical and life insurance, free malpractice insurance, deferred compensation plan, and nearby housing. An Equal Opportunity Employer. One day a week clinic positions normally available at an additional \$20,000 yearly. Progressive city of 30,000 near TVA's "Land Between the Lakes". Contact Wayne Taylor, Facility Director, Western State Hospital, P.O. Box 2200, Hopkinsville, Kentucky 42241-2200; (502) 886-4431.

PSYCHIATRISTS (BC/BE) wanted for inpatient work in collaboration with area CMHCs. New 100-bed adult psychiatric hospital in EASTERN KENTUCKY APPALACHIAN MOUNTAINS. Friendly, rural community located 2 hours from Lexington, KY and 3 hours from Cincinnati, OH. Adjacent 208-bed acute care hospital. Salary \$100,000+, DOE, with increase for boards. On call 1 in 9. Comprehensive benefits package. Send CV to/contact Greg Davis, Appalachian Regional Healthcare, P.O. Box 8086, Lexington, KY 40533; (800) 888-7045 or (606) 281-2537. EOE M/F

RIGHT NEAR HUNTINGTON, WV—DIRECTORSHIP POSITION AVAILABLE—15-bed psychiatric unit in general hospital in northeastern KY—35 miles from Huntington, WV and Ashland, KY. Only 140 miles to Lexington and 218 miles to Cincinnati. Perfect for someone who likes a combination of inpatient, outpatient, and CL work; and who is looking for the quieter lifestyle of small town living in one of the most beautiful states in the country. Call Terry Banfield Good (formerly Terry Macheski) at (800) 355-4884, or fax CV to my at-

tention at (703) 506-9308, or mail CV to: Horizon Mental Health Management, Dept. KY-0505, 7601 Lewinsville Rd., Suite 202, McLean, VA 22102. EOE.

Danville—The expansion of Ephraim McDowell Regional Medical Center's Behavioral Medicine Program from 20 to 38 beds has created the need for an Associate Medical Director to direct our geropsychiatry service. Lack of competition, strong local business and industry, and an excellent payor mix provide for an outstanding practice opportunity. Located 35 miles south of Lexington, Danville offers unparalleled natural beauty and charm, a strong economy, local college and more! For details please contact Maureen Corrigan, Vice President, Recruitment, Specialty Healthcare Management, Inc., 3060 Williams Dr., Suite 200, Fairfax, VA 22031; FAX (703) 205-7690.

(800) 388-6449
APA Booth #1034

LOUISIANA

GET CONTROL OF YOUR PRACTICE!

DIRECTOR and ASSOCIATE CLINICAL STAFF needed for a medical system just a short drive from New Orleans. Position offers excellent fixed compensation, 9 weeks off, no on-call, academic affiliation, CME, and Paid Malpractice. Call Gary Michael Smith at (800) 331-7122; direct 24-hour message line is (610) 617-3698; or send your CV to: LIBERTY HEALTHCARE CORP., 401 City Ave., Suite 820, Bala Cynwyd, PA 19004; FAX (610) 667-5559. EOE.

MEDICAL DIRECTOR

Talented psychiatrist needed for leadership position at Lakewood Hospital in Morgan City, Louisiana. Opportunity for inpatient and outpatient practice in this underserved area located 1.5 hours from New Orleans and minutes from the Gulf.

You'll come for the professional opportunity, you'll stay for the...music, charm, history, culture, food, sports and people!

CONTACT:
Maureen Corrigan
VP Recruitment
Specialty Healthcare Management, Inc.
3060 Williams Drive, Suite 200
Fairfax, VA 22031
FAX (703) 205-7690
(800) 388-6449
APA Booth #1034

CHARTER MEDICAL CORPORATION **SEE OUR AD ON PAGE 33**

New Orleans—Excellent opportunities for psychiatrists to be an integral part of developing programs in Public Health Psychiatry within the Department of Psychiatry, LSU School of Medicine in New Orleans, LA. The positions carry a full-time academic appointment with rank appropriate to the individual's academic background, and offers major opportunities for research, teaching and other academic pursuits. Position responsibilities will vary depending on the program, position, skills and interests of the individual. Individuals experienced in the area of adult psychiatry are being sought. Salary is competitive and negotiable depending on qualifications and experience. LSUMC is an equal opportunity, affirmative action employer. Contact: Howard J. Osofsky, M.D., Ph.D., Head, Department of Psychiatry, LSU School of Medicine, 1542 Tulane Ave., New Orleans, LA 70112; (504) 568-6004.

MAINE

SOUTHERN MAINE BC/BE ADULT, CHILD, ADOLESCENT AND GERIATRIC PSYCHIATRISTS

Exciting practice opportunities are with Integrated Physician Services, P.A., Maine's premier psychiatric and behavioral health group practice. Based in South Portland, Maine, IPS, whose primary affiliate hospital is Jackson Brook Institute, provides psychiatric care in an expanding network of inpatient, outpatient, partial hospital, and community-based programs throughout southern and central Maine. Through its broad range of clinical programs, IPS serves the needs of northern New England's most therapeutically challenging psychiatric and chemically dependent patients including children, adolescents, adults and the elderly. We offer stimulating work in a supportive professional environment, an excellent salary and benefit package,

and a reasonable call schedule. Immediate availability. The greater Portland area, located on the coast of Maine 100 miles north of Boston, offers an excellent quality of life and easy access to a wide range of recreational, educational, and cultural activities. For further information about these unique opportunities, please contact Steven E. Katz, M.D., Medical Director/Executive Vice President or John Gale, Vice President/C.O.O., Integrated Physician Services, P.A., 25 Long Creek Dr., South Portland, ME 04106; telephone (207) 775-5527.

HALF-TIME CHILD PSYCHIATRIST

COAST OF MAINE—Mid-Coast Mental Health Center, a community mental health center, located in Rockland, Maine, is seeking a Board Certified or Eligible psychiatrist for a twenty hour position with our Child and Adolescent team. Other opportunities are also available. Mid-Coast Mental Health Center offers competitive compensation and an excellent benefit package.

For more information or confidential consideration, please call (207) 594-2541 or send your curriculum vitae to:

Robert Snead, M.D.
Mid-Coast Mental Health Center
P.O. Box 526
Rockland, Maine 04841
EOE/AA/504

PSYCHIATRIST/MEDICAL DIRECTOR—Immediate opening for BE/BC adult community psychiatrist and medical director for new and growing behavioral service organization in Maine's lakes and mountains region. Program provides emergency mental health services, outpatient mental health, and substance abuse services to 40,000 residents in rural communities of Franklin and northern Androscoggin counties. Responsibilities include clinical direction to a multidisciplinary team, acting as liaison with the community and medical service system, medication administration and monitoring, and outreach to clients. Region enjoys four seasons recreation with three major ski resorts and six golf courses close-by. Portland and the Maine coast are just ninety minutes away. Benefits include: competitive salary, excellent health benefits, 6 weeks paid vacation and CME, and malpractice. Send CV to: Andrea Nurse, Franklin Memorial Hospital, One Hospital Dr., Farmington, ME 04938; telephone (800) 987-2824, Fax (207) 779-2548.

MARYLAND

PSYCHIATRISTS

The Dept. of Psychiatry, Univ. of MD, is recruiting junior level board-eligible faculty in its Addictions, Adult, Child & Adolescent, Community, Consultation/Liaison, Geriatric and Research Psychiatry programs. Academic rank and salary commensurate with experience. CVs will be retained and considered for vacancies that occur in the next six months.

Send CV to: John A. Talbot, M.D., 645 Redwood St., Baltimore, MD 21201.

The Univ. of MD is an AA/EEO, ADA employer. Minorities and women are encouraged to apply.

"THE MARYLAND PLAN" is a nationally acclaimed program in training, recruitment, and retention of qualified psychiatrists in public psychiatry. Positions for child and adult psychiatrists in inpatient, residential, psychosocial, forensic, and community programs throughout MD. Academic involvement with med. schools in Baltimore and D.C. in your area of interest is encouraged. Job flexibility to meet personal and professional goals essential component of our programs. Salary is competitive. Please contact, with CV, professional area of interest, and geographic preference: Brian Hepburn, M.D., Co-Director of Psychiatric Education and Training, Mental Hygiene Administration, 201 W. Preston St., Baltimore, MD 21201.

PSYCHIATRIST with Training in Addictions—Carroll County Health Department Mental Health Bureau is in need of a part-time (15-20 hrs per week) psychiatrist with training in addictions work to work with our highly qualified staff in our dual diagnosis program starting July 1995. Please contact Michael J. Bisco, M.D., Medical/Clinical Director at (410) 876-4800.

PSYCHIATRIST

Frederick Memorial Hospital, a state of the art community hospital, located in historic, picturesque Frederick, Maryland, seeks a general psychiatrist to join our multidisciplinary team. Responsibilities include providing psychiatric care in our 15-bed inpatient unit, partial hospitalization program, and consultation liaison services.

Opportunities will exist to support expanding services and programs.

Board certification/eligible required. Competitive salary and full benefit package.

Frederick is located in central Maryland and is convenient to Washington, DC, Baltimore, Chesapeake Bay, and mountains.

Please direct CV and phone inquiries to Frank Venuto, Vice President Human Resources, Frederick Memorial Hospital, 400 W. 7th St., Frederick, MD 21701; Phone (301) 698-3998, fax (301) 698-3511.

MEDICAL DIRECTOR/ADDICTION MEDICINE SPECIALIST—Pathways, an affiliate of Anne Arundel Medical Center, is recruiting a full-time ASAM certified (or eligible) physician to coordinate the treatment of a 40-bed inpatient facility with a full continuum of OP services. Must be Maryland licensed or eligible. Salary commensurate with experience; excellent benefit package. Annapolis is convenient to both Baltimore and Washington, DC, and offers a broad range of cultural and recreational opportunities. Send letter of interest and CV, in confidence, to: Angela Sweetin, AAMC-HR Dept., Franklin & Cathedral Sts., Annapolis, MD 21401.

ADULT PSYCHIATRIST—BE/BC, FTE required for modern inpatient open-door JCAHO-accredited state psychiatric facility with 64 beds, located on the estuary of the upper Chesapeake Bay. Enjoy life in a historical collegiate Eastern Shore rural area, yet with easy access to the academic medicine of Baltimore, Washington, and Philadelphia. EOE. Maryland license required. Send CV to Judith Hegarty, M.D., FAPA, Clinical Director, Upper Shore Hospital Center, P.O. Box 229, Chestertown, MD 21620; (410) 778-6800.

CHARTER MEDICAL CORPORATION **SEE OUR AD ON PAGE 33**

Baltimore—**PSYCHIATRIST**, Franklin Square Hospital Center is seeking a psychiatrist for an expanding network of private-public sector services for Adults and Seniors. The psychiatrist needs to be interested in providing care across a continuum of outpatient, partial and inpatient settings. Position is full-time and available as of January 1, 1995. Requirements: Board Certified/Board Eligible for licensure in Maryland. State any interests/qualifications in treating special populations. Competitive salary with excellent fringe benefits offered. FSHC is located close to the Chesapeake Bay and Metro Baltimore/Washington, D.C. areas. Submit resume to M. Lawrence Spoot, M.D., Chairman, Department of Psychiatry, Franklin Square Hospital Center, 9000 Franklin Square Dr., Baltimore, MD 21237. EOE.

Salisbury/Eastern Shore—The Chesapeake Bay and Atlantic Ocean resorts await you! Board certified **Child & Adolescent Psychiatrist** and a **BE/BC Geriatric Psychiatrist** sought for multidisciplinary group practice. Salary guarantee, benefits and incentives. Contact Richard Adler, M.D., Comprehensive Psychiatric Group, 120 E. Main St., Salisbury, MD 21801; (410) 548-9400; FAX (410) 546-9587.

MASSACHUSETTS

CHILD PSYCHIATRIST SOUTHEASTERN MASSACHUSETTS/CAPE COD

Family and Community oriented agency seeks **PSYCHIATRIST(S)** to work with multidisciplinary teams providing clinical services to children, adolescents and adults. Our successful, expanding network of care is principally in eastern Massachusetts. Work in support of a variety of services including outpatient, home-based, residential, and emergency. We are a congenial group offering excellent opportunity, flexible hours, and a competitive salary.

Send CV to William Lesner, M.D., FCP, Inc., Crown Colony Office Park, 300 Congress St., Suite 305, Quincy, MA 02169.

AA/EEO

ADULT PSYCHIATRIST—Busy 3 M.D. psychiatric group practice located 20 minutes south of Boston seeks highly motivated psychiatrist to participate in expanding managed care opportunities.

Psychopharmacologic and consultative skills crucial. C.L. skills an asset. No psychiatric impairment. Opportunity for full partnership.

Please send CV to: Akos Beszterczey, M.D., 210 Whiting Pl., #5, Hingham, MA 02043.

CLASSIFIEDS

HOLYOKE HOSPITAL CENTER FOR PSYCHIATRY

Excellent opportunity for Board Eligible or Board Certified Psychiatrist to join our successful short-term psychiatric inpatient unit practice. This department is part of a general medical hospital with a full continuum of psychiatric services. Ability to work in short-term treatment model is necessary. Outpatient practice is encouraged and supported through office services. We are located in the beautiful Pioneer Valley College area, offering diverse recreational and cultural opportunities. **Position available June 1, 1995. Send CV to: Harry Rockland Miller, Director of Behavioral Services, Holyoke Hospital, 575 Beech St., Holyoke, MA 01040. An Equal Opportunity Employer.**

STAFF PSYCHIATRIST

South Bay Mental Health Center, a growing and innovative private outpatient mental health center, seeks an energetic, team oriented psychiatrist. The Clinic services a diverse population in nine offices located throughout southeastern Massachusetts. Duties include service on Multidisciplinary Team and Utilization Review Committee, training and consultation to staff, and psychopharmacology. Candidates should be board certified or eligible. Hours are flexible. Inquiries and resumes to:

Rose Scanlon
South Bay Mental Health Center
37 Belmont Street
Brockton, MA 02401
(508) 580-4691

CHARTER MEDICAL CORPORATION **SEE OUR AD ON PAGE 33**

CHILD PSYCHIATRIST

Harvard Community Health Plan, New England's largest and most experienced HMO has a 30-35 hour per week staff position for our Braintree Health Center. This opportunity is for a board-certified/board-eligible Child Psychiatrist with expertise in psychopharmacology, short term individual, family and group psychotherapy (25% adult). Strong team skills and a collaborative effort a must. Teaching and research opportunities may be available. We offer an excellent compensation and benefits package including paid malpractice.

If you are interested or would like additional information, please send your curriculum vitae to: Paul Solomon, M.D., Director, Physician Recruitment and Career Development, Harvard Community Health Plan, 10 Brookline Place West, Brookline, MA 02146, or call (617) 731-8275, Fax (617) 730-4675. An equal opportunity/Affirmative action employer.

Boston—Cambridge Psychiatric Services recruits for F/T, P/T, locum tenens, and moonlighting positions at hospitals and other healthcare organizations. We match physicians and positions with care. Call Esther Doggett, (617) 864-7452 for information.

Boston—PSYCHIATRISTS. Vinfen Corporation has a number of moonlighting vacancies for board-certified and board-eligible Psychiatrists in Massachusetts. Some near Cape Cod. Send CV to Dr. Joseph Paretto, Vinfen Corporation, 950 Cambridge Street, Cambridge, MA 02141 or call (617) 441-1788. An EO/AEE.

BOSTON—Massachusetts General Hospital, affiliated inpatient unit, expanding its service, has positions for attending Psychiatrists for acute and continuing care. Training site for MGH residents and Harvard medical students. Excellent salary and benefits. MGH and Harvard Medical School appointments. Opportunities for research. Please send C.V. to Patricia Pickett, M.D., Inpatient Director, Erich Lindemann Mental Health Center, 25 Staniford Street, Boston, MA 02114, or phone 617-727-5500 ext. 168. AA/EOE

Brockton/West Roxbury—VAMC, Chief of Psychiatry Service sought for this dynamic center with 330 psychiatry beds, extensive outpatient facilities. 57 Psychiatry Service members (full-time equivalents) and a record of excellence in the Department of Veterans Affairs system. Opportunities for teaching and research in this Harvard-affiliated center with its own residency program (Harvard-South Shore). Appointment at appropriate Harvard academic level, up to, and including, Professorial rank. Interested psychiatrists should send cover letter and CV to Robert W. McCarley, M.D., Deputy Chief of Staff/Mental Health, and Head, Harvard Department of Psychiatry, Brockton/West Roxbury VAMC, 116A, 940 Belmont St., Brockton, MA 02401. EOE.

Norfolk—Neponset Valley Health System—30 miles southwest of Boston, is seeking Psychiatrists for its Center for Behavioral Medicine. The Center for Behavioral Medicine is a well-established, growing system including Norwood and Southwood Community Hospitals with inpatient and outpatient psychiatry and substance abuse services.

Associate Medical Director, Geropsychiatric Services: Responsibilities include program leadership with excellent team participation in multidisciplinary quality assurance efforts, sharing in house and beeper coverage, cover outpatient clinic (5 hours/week) and treatment of inpatients.

Consulting Psychiatrist, Outpatient Services: Responsibilities include program development, psychopharmacological assessments and psychiatric assessments in our Norwood and South Weymouth Norcap Outpatient Clinics. Population consists of psychiatric and substance abuse patients. Up to 10 hours per week.

Competitive compensation packages with ample opportunity for private practice.

Please contact or send CV to Richard Young, M.D., Chief of Behavioral Medicine at Southwood Community Hospital, 111 Dedham St., Norfolk, MA 02056 at (508) 668-0385, x-440.

Pembroke—Adult Psychiatrist at Pembroke Hospital. This is a full-time position with an excellent salary and is best suited for a high energy individual who has outstanding focal treatment and managed care skills. Responsibilities include work in our emergency, inpatient, and outpatient services. Direct inquiries to Michael Engel, M.D., Medical Director, Pembroke Hospital, 199 Oak St., Pembroke, MA 02359.

Worcester—Private multidisciplinary mental health clinic is recruiting for full and part-time psychiatrists, child and adult. Excellent compensation, to start as soon as 5/95. Send CV to Cheryl L. Labossiere, Boston Road Clinic, 108 Belmont St., Worcester, MA 01605.

MICHIGAN

WAYNE STATE UNIVERSITY—The Department of Psychiatry and Behavioral Neurosciences is recruiting an EMERGENCY CARE PSYCHIATRIST. This position requires skills for the rapid management of some of the most difficult situations in psychiatry. The candidate should be seeking a challenging academically oriented program. MD and experience in Emergency Care is preferred. Please send CV and letter stating interest to: Dr. Thomas Uhde, Chairperson, Department of Psychiatry and Behavioral Neurosciences, 9B University Health Center, 4201 St. Antoine, Detroit, MI 48201; (313) 577-1808, FAX (313) 577-5900. Wayne State University is an equal opportunity/affirmative action employer. People working together to provide quality service. All buildings, structures and vehicles at WSU are smoke-free.

CHILD/ADOLESCENT PSYCHIATRISTS—Diversified opportunities in **Lansing, Grand Rapids and Kalamazoo** include working in established situations with IP, OP and partial programs. Excellent compensation/benefit package. For confidential consideration, please call David Lassiter at (800) 844-0080 or send your CV to: **Vendell Healthcare, Inc., 3401 West End Ave., Suite 500, Nashville, TN 37203. FAX (615) 269-7525.**

MINNESOTA

MEDICAL DIRECTOR

Board Certified Psychiatrist with administrative interests needed to provide medical leadership and "state-of-the-art" care in a 250+ bed chemical dependency, mental retardation, and mental health treatment center in Fergus Falls, MN.

- Highly Competitive Salary (\$93,413 - \$149,422, depending on qualifications)
- Relocation Expenses
- Paid Malpractice
- Joint Commission approved
- 60 miles to Fargo/Moorhead
- 160 miles to Mpls/St. Paul
- Excellent school system
- Great community support

For information call Michael S. Ackley, Chief Executive Officer at (218) 739-7224 or send CV to P.O. Box 157, Fergus Falls, MN 56538-0157.

AA/Equal Opportunity Employer

PSYCHIATRIST—Ramsey Clinic/St. Paul-Ramsey Medical Center. Ramsey Clinic, a 215-physician multi-specialty group, based at St. Paul Medical Center is seeking a psychiatrist to assume a position that would encompass both inpatient (60%) and outpatient (40%) work. Opportunities to teach and conduct research exist and are encouraged, but not required. Depending upon experience and professional accomplishments, this position includes a University of Minnesota Medical School faculty appointment. The level of academic appointment would be commensurate with qualifications.

Please forward your curriculum vitae to: Janet Zander, M.D., Associate Chair, Department of Psychiatry, St. Paul-Ramsey Medical Center, 640 Jackson St., St. Paul, MN 55101.

St. Paul-Ramsey Medical Center, Ramsey Clinic and the University of Minnesota are equal opportunity educators and employers.

PSYCHIATRIST—The St. Cloud Minnesota Veterans Affairs Medical Center is dynamic 556-bed facility providing excellent psychiatric intermediate, and chemical dependency care to veterans.

An exceptional opportunity exists for a physician who possesses leadership skills and is board certified/board eligible in Psychiatry with an interest in addiction therapy to be the Medical Director of a Chemical Dependency Center. We offer competitive salary and benefits combined with a stable 40-hour weekly schedule.

To explore this unique opportunity, call or write: Pat Barth, Human Resources Management Service at (612) 255-6301, or Dr. William Jordan, Chief, Psychiatry Service, at (612) 255-6368, VA Medical Center, 4801 N. 8th St., St. Cloud, MN 56303. An Equal Opportunity Employer.

CHILD & ADOLESCENT PSYCHIATRIST—The Department of Psychiatry & Psychology at Mayo Clinic Rochester is seeking a Board-eligible or Board-certified child and adolescent psychiatrist. This position requires strong integration of child psychiatry into a multispecialty integrated practice. Training/interest in community-based psychiatric programming is desirable. The responsibilities of this position will include both inpatient and outpatient psychiatric care of children and adolescents and teaching of residents and medical students. Academic appointment level would be commensurate with experience. Outstanding salary and benefits. We are particularly interested in qualified minority and female applicants. Interested applicants should send letter of application, curriculum vitae and three letters of reference to: J.E. Huxsahl, M.D., Division of Child & Adolescent Psychiatry, Mayo Clinic, 200 First Street SW, Rochester, MN 55905. Mayo Foundation is an affirmative action and equal opportunity educator and employer.

STAFF PSYCHIATRIST—FERGUS FALLS—BE/BC—Psychiatrist needed to provide leadership and "state-of-the-art" care in a +250-bed chemical dependency, developmentally disabled, and mental health treatment center.

- Highly Competitive Salary (\$88,973-\$142,530 depending on qualifications)
- Relocation Expenses
- Paid Malpractice
- Joint Commission approved
- 60 miles to Fargo/Moorhead
- 160 miles to Mpls/St. Paul
- Excellent school system
- Great community support

For more information call Bill Klein, Assistant Administrator at (218) 739-7260 or send CV to PO Box 157, Fergus Falls, MN 56538-0157

AA/Equal Opportunity Employer

Rochester—Mayo Clinic, Department of Psychiatry and Psychology, is seeking to add a psychiatrist with expertise in addiction psychiatry. Qualified applicants must be board certified and eligible/certified for added qualifications in addiction psychiatry. Only candidates who have completed a fellowship in addiction psychiatry or who have comparable experience will be considered. The responsibilities of this position will include clinical practice and teaching of both general and addiction psychiatry. Candidates with a demonstrated aptitude for research are especially encouraged to apply. Please send curriculum vitae and the names of three professional references by July 15 to: Joyce A. Tinsley, M.D., Department of Psychiatry and Psychology, Mayo Clinic, 200 First St. SW, Rochester, MN 55905. Mayo Foundation is an affirmative action and equal opportunity educator and employer.

JUNE 2 ISSUE DEADLINE - FRIDAY
MAY 19, 2:00 p.m., ET

MISSOURI

PSYCHIATRIST/CHILD PSYCHIATRIST

Comprehensive mental health center located in scenic southwest Missouri seeks applicants for Psychiatrist/Child Psychiatrist. A progressive community based mental health rehabilitation program with an interdisciplinary treatment setting dedicated to quality service. Minimum qualifications include M.D. or D.O. with residency completion in psychiatry, board eligible or board certified, and licensed to practice in Missouri. Salary negotiable with legal liability coverage and excellent fringe benefits. Enjoy a relaxed rural lifestyle within short driving distance of major metropolitan and lake resort areas. Contact Personnel Office, Southwest Missouri Mental Health Center, 600 West Edwards, Nevada, MO 64772; (417) 448-2117 or 2126.

The Missouri Department of Mental Health does not deny employment or services because of race, sex, creed, marital status, national origin, disability or age of applicants or employees.

CHILD/ADULT/GERIATRIC PSYCHIATRIST(S) (BE/BC)—Join our team of psychiatrists and behavioral health specialist and become part of a rapidly growing integrated health system, located in the beautiful Ozark Lakes region of southwest Missouri. Involvement with an exceptional range of treatment options, traditional as well as progressive. Flexibility for a hospital-based practice and/or outpatient-based practice. Competitive salary and benefits package. Low cost of living in community of 155,000 with a regional population of over 500,000. Contact Mary Jackson, Cox Health Systems, 1423 N. Jefferson, Springfield, MO 65802; (417) 836-3056 or FAX CV (417) 836-8204. EOE.

MEDICAL DIRECTOR—Position available for BC/BE Psychiatrist as Medical Director of 125-bed acute care psychiatric hospital in St. Louis, Missouri. Prior psychiatric administrative experience expected. Knowledge of Medicaid and Managed Care Initiative preferred. Familiarity with CQI, JCAHO and HCFA standards are essential. The facility also is a training site for psychiatric residents and medical students from Washington University School of Medicine. Clinical appointment with the Department of Psychiatry is available. Additionally, a new psychiatric hospital will be constructed with an opening date in 1996. St. Louis offers symphony, summer opera, major league sports and other attractions. Our new facility will be within 6 blocks of the fabulous Forest Park, home of the Art Museum, Zoo, Planetarium and Science Museum. Please send resumes to:

Yale S. Wolff
Personnel Officer
Malcolm Bliss Mental Health Center
5400 Arsenal Street
St. Louis, Missouri 63139
(314) 644-8038

"The Department of Mental Health does not deny employment or services because of race, sex, creed, marital status, national origin, disability or age of applicants or employees."

CHARTER MEDICAL CORPORATION **SEE OUR AD ON PAGE 33**

GERIATRIC PSYCHIATRIST

The Department of Psychiatry and Neurology at the University of Missouri-Columbia is seeking to expand its geriatric psychiatry program. This new position begins at seventy percent time and can be increased as the program expands. Duties involve: Associate Medical Director for a geriatric inpatient and partial hospitalization program at a nearby hospital, outpatient work in the new University outpatient clinic and residency training in both locations. Applicants should have two years of geriatric fellowship training or its equivalent. They should be certified with added qualification in geriatric psychiatry or be prepared to do so in the near future. Write to Bernard D. Beitman, M.D., 102 MMMHC, Three Hospital Dr., Columbia, MO 65201 by June 15, 1995 or until filled. For questions about Americans With Disabilities Act, or if you are in need of reasonable accommodations, please contact Richard Erwin at (314) 882-3176, x-243. The University of Missouri is an Equal Employment Opportunity/Affirmative Action Institution.

MISSOURI—40 hour week. Hospital based practice with one other psychiatrist. No night call. No paper work. No weekends. No HMO hassles. No drive by shootings. No gangs. No high taxes. No city congestion. In our community, you will know the police, sheriff, and teachers on a first name basis. You will be in the shopping mall of enter-

CLASSIFIEDS

NEW HAMPSHIRE

DARTMOUTH MEDICAL SCHOOL

The Department of Psychiatry, in a unique collaboration with the State of New Hampshire, is seeking a PSYCHIATRIST for inpatient responsibilities at the New Hampshire Hospital, a 132-bed acute psychiatric facility opened in 1989 and located in Concord, New Hampshire. The position is a full-time Dartmouth faculty position and the facility is the clinical research core facility for an innovative, statewide, comprehensive mental health system. Psychiatrists with expertise in general inpatient psychiatry or neuropsychiatry are encouraged to apply.

Academic duties include teaching and supervision of medical students and residents. Research opportunities available and encouraged. Candidates should be board certified or eligible in Psychiatry. Academic rank and salary consistent with experience. A curriculum vitae and three letters of reference should be sent to: Robert M. Vidaver, M.D., Prof. of Psychiatry and Vice Chair, Dept. of Psychiatry, New Hampshire Hosp., 105 Pleasant St., Concord, NH 03301. Dartmouth College is an Equal Opportunity/Affirmative Action Employer.

PSYCHIATRIST—FT BE/BC psychiatrist needed to join two physician psychiatry practice located in the capitol of New Hampshire. We are affiliated with a community hospital inpatient unit and partial hospitalization program. We have a busy office practice responding to both psychopharmacology and psychotherapy treatment needs. We will also be a clinical training site for the Dartmouth Family Practice Residency starting 7/95. The region offers excellent cultural, recreational and professional opportunities. Salary and fringe benefits are very competitive. Send CV to Concord Hospital, 250 Pleasant St., Concord, NH 03301, Attn: Kris Fay.

NEW JERSEY

PSYCHIATRIST—A full-time psychiatrist needed for a wellness oriented medical practice utilizing biofeedback, i.e., Beam Testing, PET Scans and Research Foundation. Please send resume to PATH-Medical, 212 Commons Way, Bldg. 2, Princeton, NJ 08540.

CLINICAL ASSISTANT PROFESSOR CHILD PSYCHIATRIST

We seek a Board certified/eligible child psychiatrist for a full-time position with our Child/Adolescent inpatient/day hospital services. The position includes teaching of medical students and supervision of adult and child psychiatric residents, requiring appointment to the faculty of the Department of Psychiatry of Robert Wood Johnson Medical School of the University of Medicine and Dentistry of New Jersey. Psychopharmacology research experience preferred.

We are located in Piscataway, NJ, halfway between New York and Philadelphia, half an hour north of Princeton. Application deadline is May 19, 1995.

Applicants interested in this position should reply with CV to the attention of Harris S. Goldstein, M.D., Director of Child & Adolescent Services, UMDNJ-Community Mental Health Center at Piscataway, P.O. Box 1392, 671 Hoes Lane, Piscataway, NJ 08855-1392.

UMDNJ is an Affirmative Action/Equal Opportunity Employer, m/f/d/v, and a member of the University Health System of New Jersey.

PSYCHIATRIST—Excellent opportunity for a psychiatrist to join a rapidly expanding private practice in the Toms River area, on a part-time basis (approximately 20 hours per week). We offer flexible hours and excellent working conditions. For more information contact Bio Behavioral Health, 601 Hwy. 37 West, Toms River, NJ 08755; (908) 244-2299.

CHARTER MEDICAL CORPORATION **SEE OUR AD ON PAGE 33**

CHILD/ADOLESCENT PSYCHIATRIST—BE/BC Psychiatrist to work PT in inpatient unit in Hoboken, NJ. Excellent benefits. Send resume to: Gabriel Kaplan, M.D., St. Mary CMHC, 314 Clinton St., Hoboken, NJ 07030.

CHILD/ADOLESCENT PSYCHIATRIST—BE/BC Psychiatrist to work PT in inpatient unit in Hoboken, NJ. Excellent benefits. Send resume to: Gabriel Kaplan, M.D., St. Mary CMHC, 314 Clinton St., Hoboken, NJ 07030.

BC/BE PSYCHIATRIST—To join growing private psychiatric practice in New Jersey Shore Community. Outpatient/Consultation. Please send curriculum vitae to: Phone: (908)286-4411, Fax: (908)341-3955.

FOR THE BEST OF PHILADELPHIA COME TO SOUTH JERSEY

Cooper Hospital/University Medical Center, Robert Wood Johnson Medical School at Camden, University of Medicine and Dentistry of New Jersey is expanding its faculty and has openings in the following Divisions:

Division of Consultation/Liaison Division of Inpatient Psychiatry Division of Children/Adolescent Psychiatry

Cooper Hospital/University Medical Center is located only two miles from historical Philadelphia. Extensive medical student and psychiatric resident teaching as well as an opportunity for clinical research is available. The patient population is very diverse including both large suburban and urban areas. The salaries and benefits are highly competitive with other academic institutions in the area. The position carries an appointment to Robert Wood Johnson Medical School at Camden, University of Medicine and Dentistry of New Jersey.

For application and inquiries write or call: G. Pirooz Sholevar, M.D., Professor and Chief, Department of Psychiatry, Cooper Hospital/University Medical Center, Room 356, 401 Haddon Ave., Camden, NJ 08103; (609) 757-7799.

COASTAL SOUTH JERSEY—Psychiatrist(s) needed to join our multidisciplinary team PT/FT. Office and Hospital work. Specialty interests welcome (adolescent, geriatric, etc.). Excellent salary/benefits with marvelous growth potential. Near Phila/NY. Must be team player with enthusiasm and sense of humor. BE/BC. NJ license. Fax CV (609) 926-1228 and call Norman Chazin, M.D., (609) 926-0013.

NEW MEXICO

CHARTER MEDICAL CORPORATION **SEE OUR AD ON PAGE 33**

NEW YORK CITY & AREA

STAFF PSYCHIATRIST—Board Certified/Eligible for Staten Island Inpatient Gero Psychiatric Unit. Full-time and Part-time positions including one weekend per month. \$100,000 and benefits for full-time career opportunity. Fax CV to (212) 595-8039.

DIRECTOR OF ACUTE PSYCHIATRIC INPATIENT SERVICES—Our growing Psychiatric Department seeks full-time Director to supervise and coordinate activities of our multidisciplinary team while ensuring quality care and service is provided to each patient. Qualified candidate will be able to interact with all levels of staff and have demonstrated experience in Mental Health and Substance Abuse settings. NYS M.D. license required, along with proven oral/written communication skills. This position also serves as the Discipline Head for the Psychiatrists of the Department.

We offer competitive salary and a comprehensive benefits package. Please forward resume, with salary requirements to: Interfaith Medical Center, Dr. Weisenfreund, Director of Psychiatry, 555 Prospect PL, Brooklyn, NY 11238. We are an equal opportunity employer.

PSYCHIATRIST for Psychiatric clinic in Brooklyn, NY. Responsible for diagnosing and treating patients with mental, emotional, behavioral disorders, organizing data obtained from patients, relatives, other sources concerning patients' symptoms, family and medical history. Examining patients to determine general physical condition, following standard medical procedures, ordering laboratory and other special diagnostic tests, evaluating data obtained. Determining nature and extent of mental disorders. Russian and Hebrew fluency a must. 40 hrs/wk, 3 years experience, \$104,700/year. Send letter and resume to: Dr. Stern, 1049 Fordham Lane, Woodmere, NY 11598.

PSYCHIATRIC NEWS - The First Choice
for Psychiatric Recruitment
Call (202) 682-6250 for advertising information

NEW YORK STATE

PSYCHIATRISTS—Full-time opportunities throughout New York for qualified psychiatrists. Inpatient/outpatient settings. Work as much or as little as you like, and enjoy competitive rates, paid travel, housing, malpractice insurance, and access to health insurance. Short-term, long-term, and permanent positions available. Call Laura at CompHealth for more information: 800-328-3035, or fax CV to 801-264-6464.

MEDICAL DIRECTORSHIP for newly created Child and Adolescent Psychiatrist in beautiful Catskill/Adirondack resort area. Salary and generous income guarantee available. Work is either Inpatient or Outpatient, your choice. Easy call schedule. Call (610) 889-4850 for details. Many other opportunities available nationwide.

CHIEF, C&L PSYCHIATRY SERVICE—University Hospital, Stony Brook. Excellent opportunity in major academic Medical Center. Established Fellowship Program. Faculty appointment commensurate with experience. Competitive salary and benefits.

Send CV to: Mark I. Sedler, M.D., Acting Chairman, Dept. of Psychiatry, HSC, T-10, SUNY at Stony Brook, New York 11704; (516) 444-2399. SUNY Stony Brook is an EEO/AA Employer and Educator.

PSYCHIATRIST—Bassett Healthcare, a regional referral and teaching center affiliated with Columbia University, seeks a 4th BC/BE psychiatrist to provide inpatient/outpatient care as part of a 150-member multispecialty practice group. The candidate should have eclectic interests and skills in a variety of treatment modalities including treatment methods within an HMO. Opportunities exist for subspecialty development. We offer a competitive salary with excellent benefits, including malpractice coverage, relocation expenses, and academic appointment. Located in Cooperstown, New York, a rural, four season resort village with excellent schools and unusual cultural and recreation opportunities. Contact Celeste A. John, M.D., Acting Psychiatrist-in-Chief, Bassett Healthcare, One Atwell Rd., Cooperstown, NY 13326; (607) 547-3500, FAX (607) 547-6550.

Buffalo—Senior academic position, associate or full professor, in the Department of Psychiatry at the SUNY at Buffalo. Candidate would serve as the Clinical Director of Psychiatry at the Erie County Medical Center (ECMC) with responsibilities for the psychiatric medical staff of the Center's inpatient units, consultation liaison service and outpatient programs. The ECMC is a major teaching hospital in the SUNYAB system. The Department's main offices are located there. Seeking someone with national prominence in clinical care and research for a Department that is expanding its research and clinical service focus dramatically. Candidates with research in schizophrenia preferred; neuroimaging capabilities excellent. Candidate should be able to provide junior faculty with support for academic development and be able to work closely with the Chair of the Department in program planning, development and implementation. Board certification in Psychiatry and eligibility for NYS medical licensure required.

Women and minorities encouraged to apply. The SUNY at Buffalo is an Affirmative Action/Equal Opportunity employer. Send CV to Susan V. McLeer, M.D., Chairwoman, Department of Psychiatry, SUNYAB, 221 Cary Hall, 3435 Main St., Buffalo, NY 14214-3005.

NORTH CAROLINA

CHARTER MEDICAL CORPORATION **SEE OUR AD ON PAGE 33**

BEST OF BOTH WORLDS—Enjoy the best of rural North Carolina, less than 25 minutes from downtown Charlotte. Join a sophisticated medical community with strong ties to Duke, while living in an outdoor recreational paradise. Positions for both adult and child psychiatrists. Call St. John Associates at (800) 737-2001, or fax CV to (812) 332-2727.

ACADEMIC CHILD & ADOLESCENT PSYCHIATRY: Bowman Gray School of Medicine—Unexpected, immediate opening for Director of Outpatient Child Guidance Services, Assistant to Associate Professor level. Teaching and administrative responsibilities in addition to clinical care. Opportunity for research. United Way clinic in Medical School. Active Board. Inquiries should be directed to Burton V. Reifler, M.D., M.P.H., Chairman, Department of Psychiatry and Behavioral Medicine, Bowman Gray

tainment with large lakes of 1,000 miles of shoreline, scuba, boating, fishing, hunting, amusement parks, water parks, 5,000 caves, canoeing, wineries and Branson with over 50 musical shows. One of the top schools in Missouri. Call (800) 255-4419.

St. Louis—Psychiatrist positions are available now at Malcolm Bliss Mental Health Center, providing services for the mentally ill in the St. Louis metropolitan area. Recruiting for Staff Psychiatrists, Board Certified or Eligible, faculty appointment with Washington University School of Medicine with research opportunities available. Salaries are \$110,076-\$123,900 based on years of experience special training (e.g., for ECT), and board certification. Excellent benefit package including health, life and long-term disability insurance plan, 3 weeks vacation, 12 holidays, 3 weeks sick leave per year, no on-call responsibilities, short-term leave for professional workshops and deferred compensation plan.

We are located in a stable middle class residential neighborhood with excellent living facilities within walking distance. We are within 15 minutes of downtown St. Louis, the Gateway Arch, Union Station and St. Louis Centre. We have major league sports, excellent schools, the Art Museum, St. Louis Symphony. The Fox Theater and summer open air theater. If you are interested in working in a high quality Mental Health setting, please send resumes to Lori DeRosear, D.O., Clinical Director, Malcolm Bliss Mental Health Center, 5400 Arsenal St., Mailstop 152, St. Louis, MO 63139.

MONTANA

MEDICAL DIRECTORSHIP for 18-bed Child and Adolescent Unit in hospital-based program with 7 F/T Psychiatrists. Salary or income guarantee in excess of 140K. Call (610) 889-4850 for details. Many other opportunities available nationwide.

Butte—Seeking PT/FT Psychiatrist for Inpatient/Outpatient work in Child/Adolescent environment. Excellent compensation and benefit package. Outstanding mountain region offers unlimited outdoor activities and quality lifestyle. For confidential consideration, please call David Lassiter at (800) 844-0080 or send your CV to:

Vendell Healthcare, Inc.
3401 West End Ave., Suite 500
Nashville, TN 37203
CALL (800) 844-0080
FAX (615) 269-7525

Southwestern Montana—Position for psychiatrist on a 20-bed acute care unit (average length of stay 40 days). Join the six psychiatrists serving this 200-bed state hospital. Excellent outdoor opportunities. Mountains surround the area. Excellent skiing, hunting, fishing and hiking. Trout stream less than one mile from hospital. Salary \$90,291 - \$104,500, based on experience. Send CV or inquiries to Carl L. Keener, M.D., Medical Director, Montana State Hospital, Warm Springs, MT 59756; (406) 693-7008. EOE.

NEVADA

Reno—The Department of Psychiatry and Behavioral Sciences at the University of Nevada School of Medicine is seeking a BC/BE psychiatrist for clinical academic appointment at the Nevada Mental Health Institute. Salary \$108,781, malpractice, and excellent faculty retirement plan and benefits. Located in the Reno area, the Institute is a licensed, JCAHO accredited, HCFA certified inpatient facility (average census 40-50) with an active outpatient medicine clinic, staffed by six psychiatrists. Other services include an on grounds residential care program and case management services. This public sector program features a progressive multidisciplinary approach with focus on alternatives to hospitalization, continuity of care, quality services. Teaching on site includes medical, nursing, psychology, social work, pharmacy, recreational therapy, medical students and psychiatric residents. Facility site accessible, attractive grounds in progressive, convenient metropolitan area. Good locale for family, excellent schools and university, shopping, world class entertainment daily. Year round sports include fishing, hiking, camping and skiing. Setting is the beautiful Sierra Nevada mountain range with Lake Tahoe, Sacramento, Napa, and San Francisco easily accessible. Contact Barry Cole, MD, Director, Nevada Mental Health Institute, 480 Galletti Way, Sparks, NV 89431; (702) 688-2011. The position will remain open until filled. AA/EEO.

CLASSIFIEDS

School of Medicine, Medical Center Blvd., Winston-Salem, NC 27157-1087. AA/EOE.

Charlotte—Kaiser Permanente has opportunities for BE/BC Adult and Child Psychiatrists. Psychopharmacology and experience in short-term therapy required. Responsibilities include outpatient and inpatient care, as well as call coverage. Comprehensive salary and benefits package. Call (800) 277-2764 or send CV to Jennie Judd, Professional Recruitment, Dept. AD022, The Carolina Permanente Medical Group, P.A., 3120 Highwoods Blvd., Raleigh, NC 27604. AA/EOE.

Durham—The Duke Division of Child and Adolescent Psychiatry offers child and adolescent psychiatry residencies in the full continuum-of-care of services for children/adolescents, parents, and families. Closely supervised, individualized career tracking is emphasized. In addition to achieving the basic clinic competencies, fellows may pursue tracks in biological and clinical research, academic teaching, admin., private practice, substance abuse services, and community child psychiatry. Psychobiologic and psychodynamic perspectives are synthesized. Adult and child psychoanalytic trainings are available. Contact Charles Keith, M.D., Dir. of Trng., Div. of Child and Adol. Psychiatry, Box 2906, Duke Univ. Med. Ctr., Durham, NC 27710; (919) 684-3044. AA/EOE.

OHIO

CHILD PSYCHIATRIST—Private behavioral health care corporation in East Central Ohio has openings for board eligible psychiatrists due to recent expansion. Located in designated health physician shortage area (HPSA) MUA/MUP. Responsibilities include quality improvement, in-service training and direct patient care, involving evaluations, consultation/liaison to health care facilities and psychopharmacology. License to practice medicine in Ohio required. Interest or experience in community psychiatry and a willingness to practice in a managed care environment preferred. Salary starting at \$150K but negotiable based upon experience. Liberal benefits package including fully paid malpractice insurance. Send letter of interest and CV to: SCI, 830 Orchard St., Room 90, Zanesville, OH 43701-3722. EOE.

PSYCHIATRIST—General Psychiatrist, BC/BE, needed to develop a practice in conjunction with local community, 231-bed hospital with the largest mental health system in the region, one hour from Pittsburgh, PA. This Ohio opportunity has attractive compensation, medical directorships, private, group and salaried opportunities, very attractive family lifestyle with the best of both a big city and a small town atmosphere. For more information, call (800) 443-9346 or send CV to: Richard L. Shrum, Vice President, Diamond Healthcare Corporation, 700 East Main St., Suite 900, Richmond, VA 23219.

STAFF PSYCHIATRIST—FT BC/BE—Excellent opportunity awaits you to serve our nation's veterans at the VA Medical Center in scenic Chillicothe, Ohio, 45 minutes from Columbus, 90 minutes from Dayton and 2 hours from Cincinnati. This medical center is affiliated with The Ohio State University College of Medicine. Beginning salary \$103,941 and higher based on qualifications; 30 days vacation and excellent retirement benefits. Please send inquiries and CV to Rajani Thangavelu, M.D., VA Medical Center (116A), 17273 State Route 104, Chillicothe, OH 45601; (614) 773-1141, x-7897. EOE.

Cincinnati—Group practice is seeking BC Adult Psychiatrist with excellent skills in outpatient and inpatient psychiatry. Salary \$100,000 to \$130,000. Please send CV to Madelon Hartford, M.D., 10550 Montgomery Rd., Cincinnati, OH 45242, or call (513) 984-1441.

PENNSYLVANIA

PSYCHIATRISTS

KidsPeace National Hospital is seeking psychiatrists to work with child and adolescent patients in our inpatient facility. Part-time positions are available in our Allentown area facility.

Board eligibility or certification in child and/or adolescent psychiatry is preferred, but not essential if you have experience working with this age group.

KidsPeace provides high quality treatment for emotionally disturbed youth from around the state and nation. The children you would work with range from 5 to 18 years old with a wide variety of psychiatric problems.

Send CV to: Candace Herrman, Director, National Hospital for Kids In Crisis, 5300 KidsPeace Dr., Orefield, PA 18069. EOE M/F.

PHYSICIAN SCIENTIST POSITIONS for psychiatrists interested in substance abuse research at University of Pennsylvania. Faculty level salaries available in multidisciplinary research center with the aim of developing new independent researchers. Salaries are secure for up to five years in a rich academic environment so that a new researcher can develop a research program and obtain independent research funding. Preclinical and clinical research in the area of substance abuse will be encouraged through mentoring and assistance with pilot projects. Wide range of faculty mentors active in psychotherapy research, psychopharmacology, epidemiology or basic research are eager to help new colleagues launch a research career. Apply C.P. O'Brien, M.D., Ph.D., University of Pennsylvania, 3900 Chestnut St., Philadelphia, PA 19104-6178. EOAAE.

MEDICAL DIRECTORSHIP/CHAIRMAN OF DEPARTMENT OF PSYCHIATRY—Position available in 300 plus bed Medical/Surgical Facility in Western, PA. Only 1.5 hours from Pittsburgh; great family and recreational community! Generous salary and income guarantee in an underserved community. Call (610) 889-4850 for details.

CHARTER MEDICAL CORPORATION
SEE OUR AD ON PAGE 33

Kittanning—FT BE/BC Psychiatrist needed for an outpatient position at a CMHC in a beautiful rural area of Western PA. Evening hours 1-2/week. Experience with children and adolescents required. Teaching and academic affiliation with WPIC, University of Pittsburgh. Send CV to David Shaeffer, Ph.D., Family Counseling Center of Armstrong County, 150 S. Jefferson St., Kittanning, PA 16201.

Philadelphia Area—Board Certified/Eligible. Outpatient, private practice group. Part-time for medication evaluations, med checks and psychotherapy; (215) 997-9585.

Pottsville—INSTITUTE FOR BEHAVIORAL HEALTH. BE/BC Adult/Adolescent/Geriatric Psychiatrist to expand team of mental health professionals in psychiatrically underserved area. D&A experience a plus. Humanism and interpersonal kindness necessary. Small town with safe and sane quality of life. Good schools. Easy drive to Philadelphia, Princeton, NYC. 246-bed community hospital. Excellent relationship with county MH/MR. Coverage: 1 in 4. Competitive and flexible salary/benefits. Contact Joseph T. Marconis, M.D., Vice President/Medical Affairs, The Pottsville Hospital and Warne Clinic, 420 South Jackson St., Pottsville, PA 17901; (717) 621-5115.

RHODE ISLAND

MEDICAL DIRECTOR

South Shore Mental Health Center, Inc., seeks a board certified psychiatrist with seven to ten years of clinical and administrative experience to assume responsibility for all aspects of medical care. The successful candidate will join the senior management team, supervise three staff psychiatrists and spend a portion of time in direct care.

South Shore Mental Health Center serves adults with severe and persistent mental illness, emotionally and behaviorally disordered children, substance abusers and the general outpatient population in a variety of settings and locations.

Located in a southern Rhode Island resort community, the Center is less than one hour to the metropolitan Providence area, and within 90 minutes of Boston, MA or Hartford, CT.

Position available July 1. Excellent fringe benefits; salary negotiable based on experience. Send resume to: Director Human Services, South Shore Mental Health Center, Inc., 4701A Old Post Rd., Route 1A South, Charlestown, RI 02813.

SOUTH CAROLINA

CHILD AND GENERAL PSYCHIATRISTS—Excellent opportunity for private practice in a large multidisciplinary group with multiple locations in the Charleston area and expanding into the coastal South Carolina region. Guaranteed income is available for the first year. Must be

Board Eligible/Board Certified. For more information contact James E. Jenkins, M.D., or Louis Storen at (803) 572-0900 or send resume to Westwood Psychiatric and Psychological Associates, 9329 Medical Plaza Dr., Charleston, SC 29406.

CHARTER MEDICAL CORPORATION
SEE OUR AD ON PAGE 33

SOUTH DAKOTA

CHILD AND ADOLESCENT FACULTY—BE/BC Child and Adolescent Psychiatrist, Univ. of South Dakota Sch. of Medicine, Sioux Falls. Attractive living in prosperous, growing city that is regional medical center for large rural area. Accredited child and adolescent psychiatry residency program now in second year recruiting additional faculty. Presently four bd.-cert. faculty. Major teaching duties include supervision of residents doing outpatient and C/L at integrated pediatric/child psychiatry site. Contact Mark W. Mahnke, M.D., (605) 367-5960, Fax CV (605) 330-0807.

CHARTER MEDICAL CORPORATION
SEE OUR AD ON PAGE 33

TENNESSEE

CHARTER MEDICAL CORPORATION
SEE OUR AD ON PAGE 33

MEDICAL DIRECTOR—With strong leadership skills needed to direct a very busy 34-bed (expanding to 49 in June '95) inpatient behavioral medicine program at University Medical Center in Lebanon, Tennessee. Programs in adult and geriatric psychiatry as well as dual diagnosis and partial hospitalization in place. Conveniently located 30 minutes east of NASHVILLE, Lebanon offers a very high quality of life as well as an excellent professional environment. For details please contact Maureen Corrigan, Vice President, Recruitment, Specialty Healthcare Management, Inc., 3060 Williams Dr., Suite 200, Fairfax, VA 22031; FAX (703) 205-7690.

(800) 388-6449
APA Booth #1034

Chattanooga—Positions available for BE/BC Psychiatrists who enjoy inpatient practice. Moccasin Bend Mental Health Institute is a 200-bed facility with full JCAHO accreditation and programs that range from adult acute care to child and adolescent to psychogeriatric. A creative experiment with a 12-bed Admissions Unit staffed by Psychiatrists and Social Workers in addition to Nursing 24 hours/day, 7 days a week is in development. The hospital is sited on over 300 acres on the Tennessee River, 5 minutes from downtown Chattanooga. Chattanooga is a vigorous city of 250,000 with an enchanting blend of Civil War tradition and modern and progressive community. Salary for a 37.5 hour work week is BE up to \$120,000 and up to \$131,000 for BC. Opportunities for moonlighting abound both within the hospital with on-call or outside in Tennessee, Georgia and/or Alabama. We are moving rapidly into TQM. Staff are empowered and supported for work to be both challenging and personally rewarding. Contact: Donald D. Gold, Jr., M.D., Clinical Director, Moccasin Bend Mental Health Institute, 100 Moccasin Bend Rd., Chattanooga, TN 37405; Phone (615) 785-3344.

Nashville—An exciting opportunity for a Board Certified (or planning to become certified within two years) psychiatrist is now available. A rapidly expanding, multidiscipline, mental health group is currently looking for a second psychiatrist. Must be comfortable with managed care philosophy of treatment. If interested, please send a curriculum vitae or your inquiries to Aliene Varner, RN, 109 Hazel Path, Suite 2, Hendersonville, TN 37075.

TEXAS

CHARTER MEDICAL CORPORATION
SEE OUR AD ON PAGE 33

TEXAS WANTS YOU!! The Texas Mental Health and Mental Retardation System (TXMHMR) is recruiting psychiatrists and other medical specialists for clinical and clinic administrative positions. Many positions offer appointments at one of Texas's eight medical schools,

with opportunities for public-academic liaison in teaching and/or research. TXMHMR is committed to caring for people with serious mental illness and MR/DD, in both communities and institutional settings. Our needs are as diverse as our geography, offering qualified physicians freedom to choose how and where to put their expertise to work. **Annual compensation up to \$143,000**, plus benefits, depending on location and qualifications. The Department can assist you in the Texas licensing process. **Recent changes in the state's licensure requirements now make it easier to come to Texas.** Write or call William H. Reid, M.D., M.P.H. Medical Director (512) 206-4502 or the Physician Recruitment Coordinator (800) 833-MHMR, P.O. Box 12668, Austin, TX 78711-2668. EOE

CLINICAL DIRECTOR

Perform highly responsible clinical management functions for a 380-bed JCAHO accredited state hospital. Provide leadership and direction for psychiatric and medical services as well as supervising all medical and other clinical professional staff. Must be board eligible or certified in psychiatry and be able to obtain or have Texas medical license.

Wichita Falls is a city of 100,000, 2 1/2 hours from Dallas, good schools plus a university. No state income tax, low cost of living. Generous employee benefits. Contact:

Richard M. Bruner, Superintendent
Wichita Falls State Hospital
P.O. Box 300
Wichita Falls, Texas 76307
Telephone (817) 689-5213

Amarillo—Seeking BC/BE child and general psychiatrists Full-time academic appointment with establishment of clinical practice, on-call rotation, and the teaching of medical students and rotating residents. Salary plus excellent fringe benefits. Big city amenities; small town atmosphere. Send CV to Mitchell Jones, M.D., Chairman, Dept. of Psychiatry, Texas Tech Univ HSC, 1400 Wallace Blvd., Amarillo, TX 79106; (806) 354-5542.

Huntsville—State correctional system seeking BC/BE unit psychiatrist for inpatient facilities in Amarillo, Gatesville, Rusk. Full-time and part-time with attractive salaries. Contact (409) 291-4030 or CV to: TDCJ Psych Services, 1650 7th St., Huntsville, TX 77340.

San Antonio—CHAIRPERSON, DEPARTMENT OF PSYCHIATRY, THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT SAN ANTONIO, SAN ANTONIO, TEXAS. UTHSCSA has begun a search for a Chair of the Department of Psychiatry. We seek an established, nationally recognized, academic psychiatrist with demonstrated leadership and management skills in order to take the department forward to the 21st century. The Department has 83 faculty members and 38 residents and provides the clinical psychiatric services at University Hospital and the Audie Murphy VA Hospital, as well as the San Antonio State Hospital and several outpatient clinics in the community mental health program. Please send letters of interest and a curriculum vitae to Stewart R. Reuter, M.D., Chairman, Psychiatry Search Committee, Department of Radiology, The University of Texas Health Science Center at San Antonio, 7703 Floyd Curl Dr., San Antonio, TX 78284-7800. The University of Texas Health Science Center at San Antonio is an equal employment opportunity/affirmative action employer.

VERMONT

PRIVATE PRACTICE OPPORTUNITY VERMONT

Private practice group is seeking a general psychiatrist to complete its clinical team. The members of the practice, two doctoral level and three masters level clinicians, are all well-established in the practice community. We are hoping to find an experienced general psychiatrist who enjoys being part of an interdisciplinary team. Psychiatric/medication evaluation a requirement with psychotherapy services defined by the interests of the candidate selected. The Rutland Region is a beautiful area for hiking, skiing, and boating. We are 70 miles from the University of Vermont Medical School in Burlington and 65 miles from the Dartmouth Medical School in Hanover, NH. This is an excellent opportunity for someone interested in joining an established practice in a semi-rural area with much natural beauty. Please send CV to John J. Pekar, Ph.D., Allen Commons Associates in Psychotherapy, One Commons St., Rutland, VT 05701.

CLASSIFIEDS

VIRGINIA

CHARTER MEDICAL CORPORATION **SEE OUR AD ON PAGE 33**

ADULT AND/OR CHILD PSYCHIATRIST—

Excellent opportunity with a growing multispecialty private group practice in Virginia Beach, VA. Includes inpatient/outpatient treatment, diagnostic assessment, medication management, consultation and psychotherapy. Affiliation with local psychiatric hospital. For confidential consideration, send CV to *Psychiatric News*, Box P-233, APA, PSD, 1400 K St., NW, Washington, DC 20005.

ADULT PSYCHIATRIST—Carilion Psychiatric Services has a position available for a BE/BC psychiatrist to join the staff of Saint Albans Psychiatric Hospital in Radford, Virginia. Responsibilities include providing direct clinical services for inpatients and outpatients. Opportunities to provide contractual services with the community mental health centers and to develop an integrated care delivery system with primary care physicians. Located in the heart of the New River Valley, this college town of 16,000 offers a high quality of living at a low cost. Radford is 25 miles from Roanoke, a community of 250,000. Selected candidates can expect strong compensation package and excellent benefits. Call Paul Hlusko, M.D., at (703) 633-4538 or send your CV to P.O. Box 3608, Radford, VA 24143-3608; Fax (703) 633-4559.

CHILD PSYCHIATRIST

Board Eligible or Board Certified to join group practice in Richmond area. Competitive salary with partnership availability. Send CV to *Psychiatric News*, Box P-232, APA, PSD, 1400 K St., NW, Washington, DC 20005.

ADULT PSYCHIATRIST FACULTY POSITION

The Department of Psychiatry and Behavioral Sciences of the Eastern Virginia Medical School has an opening for a clinical psychiatrist with academic interests and background to direct an inpatient teaching service within a tertiary care general hospital environment. Responsibilities include the clinical supervision and teaching of medical students and psychiatry residents as well as provision and direction of clinical care activities. The successful candidate must qualify for academic appointment and be strongly committed to undergraduate and graduate medical education in psychiatry. Eastern Virginia Medical School is a rapidly growing community-based school of 303 full-time faculty, 410 medical students, and 325 residents and fellows. Salary and faculty rank commensurate with experience and qualifications. Send curriculum vitae and cover letter to: Jerry H. Morewitz, M.D., Chair, Adult Psychiatry Search Committee, Eastern Virginia Medical School, Department of Psychiatry and Behavioral Sciences, 825 Fairfax Ave., Hofheimer Hall, Norfolk, VA 23507. Telephone (804) 446-5888. The Eastern Virginia Medical School is an Affirmative Action/Equal Opportunity Employer.

Charlottesville—Department of Psychiatric Medicine, University of Virginia, Charlottesville is recruiting M.D. faculty for its academic program. Candidates must be BC/BE in psychiatry. Salary and academic rank to be negotiated. Send CV to Patricia B. Porterfield, Chair, Faculty Selection Committee, Drawer D, Blue Ridge Hospital, Charlottesville, VA 22901. U Va is an Equal Opportunity/Affirmative Action Employer.

Petersburg—An excellent opportunity for BC/BE, private practice seeking a psychiatrist experienced in C&A, A&G. Share with 2 other psychiatrists providing inpatient and outpatient services. Salary negotiable. Send CV and salary requirements to: Southside Psychiatric, 4338 S. Sycamore St., Petersburg, VA 23803; phone (804) 861-2600, Fax (804) 861-5401.

VIRGINIA—Child Psychiatrist sought for large facility in metropolitan coastal Virginia. Predominantly outpatient. Excellent support staff. Endless recreational and cultural opportunities including symphony, opera, and numerous championship golf courses. Contact: Donna Herzog, AM Care Physician Search, Department J, P.O. Box 2816, Durham, NC 27715; (800) 477-0600.

WASHINGTON

Private Practice in Puget Sound—Well-established psychology practice expanding to include child psychiatrist. Preferred areas of specialization: adolescents and sexually abused children. Send vita to Elizabeth Robinson, Ph.D., 3020

Rucker Ave., #308, Everett, WA 98201 or FAX (206) 252-4778.

Just North of Seattle—Seeking Adult or Child Psychiatrist for multi-specialty practice in large outpatient Medical Center FT/PT M.D. who has expertise in medication management and therapy. Send Vita to: T. Reisenauer, 3020 Rucker #305, Everett, WA 98201; (206) 258-4649.

Vancouver—Busy psychiatric practice for sale in beautiful Vancouver, WA. Physician with full patient load relocating to new state. Completely furnished offices with furniture, computers and software. Wonderful business opportunity for motivate provider. Please direct inquiries to David Peter, M.D., by telephone (360) 253-4450 or fax (360) 253-2104.

WISCONSIN

CHILD/ADOLESCENT PSYCHIATRIST

Appleton, Wisconsin-based group of 3 general and 2 child/adolescent psychiatrists seeks a 3rd child/adolescent psychiatrist. Need is based on rapid community growth. Practice serves population of 400,000 and the inpatient units of two major area hospitals. Opportunity for development of services is great, including potential within practice subspecialization.

Compensation: Salary guarantee of \$120K plus production incentives and full benefits package. Full partnership after 18 months.

Community: Appleton is family-oriented with excellent schools, abundant recreation and cultural opportunities, and affordable homes in safe, attractive neighborhoods. Within 1 1/2 hours of Milwaukee and 3 hours of Chicago. Strong business and industry economic base.

Call Mary Shawn Cowles, Manager of Physician Recruitment at (800) 236-7772 for further information.

Lakeshore Area—Lakeshore Mental Health, Inc., a rapidly growing practice association of independent mental health providers, uniquely positioned as primary providers for larger local physician and hospital network, seek one or two BE/BC General or Specialist, (with general interest) Psychiatrists for unique independent private practice opportunity. Expect a warm welcome and rapid practice development. Clinics located in Sheboygan and Manitowoc, both Lake Michigan shoreline communities, serving a three county area with population of 300,000. Clinic staff now composed of 1.5 Psychiatrists, 2 Ph.D.s, 12 MSWs, 2 AODA and 2 educational therapists. Share weekend on-call with 4-6 area Psychiatrists. Very favorable percentage (low overhead), Signing Bonus, Medical and contracted clinical options all available. Additional administrative, business, and limited partnership options also available. At full-time expect \$150-\$200K annual income level within 3-6 months. Degree of FT, Vacation, and benefits entirely up to candidate. The Lakeshore area, consisting of Sheboygan, Manitowoc and Calumet counties, is rapidly growing, diversified economically, boasts high employment, and a well-insured market. Outstanding trailing spouse opportunities available. Various small to medium size communities, or rural housing options available. I-43 provides ready and low stress access to Milwaukee, Green Bay, and Door County. Motivated, well-recommended individuals may call Brian J. Eggen, M.D., at (414) 683-9906 (day) or (414) 684-0948 (eve/weekend), or send CV to Lakeshore Mental Health, Inc., P.O. Box 637, Manitowoc, WI 54221-0637.

Madison—Progressive, expanding multidisciplinary private practice seeking a child/adolescent psychiatrist to join our group as a full-time partner. We are located in lovely Madison, WI, the state capitol and home to a major university. Both inpatient and outpatient opportunities available. Please contact us for more information. Capitol Square Associates, 660 W. Washington, Suite 305, Madison, WI 53705; (608) 256-5176.

FOREIGN

NEW ZEALAND—Work and live in a country the size and beauty of California but with 27 million fewer people. Immediate and future opportunities for BE/BC psychiatrists. Locums, one-to-two year, and indefinite placements in a variety of geographic settings. Ski in August and sunbathe at Christmas. Visit our booth at the APA meeting in Miami. Send or fax CV to: Jacob W. Mates, M.D., New Zealand Psychiatric Workforce

Development, 236 West Portal Ave., Suite 342, San Francisco, CA 94127 or FAX (415) 566-1878.

FELLOWSHIPS

FELLOWSHIP TRAINING IN INTENSIVE PSYCHOANALYTICALLY-ORIENTED PSYCHOTHERAPY IN AN OPEN HOSPITAL SETTING

The Austen Riggs Center is accepting applications for a two-year fellowship in intensive, psychoanalytically-oriented psychotherapy with deeply troubled individuals in an open hospital setting for advanced (PGY-IV year) psychiatric residents and post-residency psychiatrists. The ACGME has accredited the first year of the fellowship for one year of advanced psychiatric residency training (the PGY-IV year). All applicants must have completed at least the PGY-I through PGY-III years in a fully accredited program and be eligible to obtain a Massachusetts medical license prior to their application.

The basic training experience is intensive, individual psychotherapeutic work. The average case load is four psychotherapy patients, each seen four times a week for 50-minute sessions. Patients are ordinarily admitted to the Center's inpatient program and then step down to less intensively staffed programs according to clinical need. The intensive psychotherapy continues through all programs. The psychotherapeutic work is augmented and integrated with appropriate use of psychoactive medications and work with families, as indicated. Training is provided in negotiating with third parties for support of such care and in integrating the meaning of resource limitations into the individual psychotherapeutic work. Fellows also have an opportunity to participate in and study group process in a sophisticated therapeutic community program. The psychotherapeutic work with each patient is supervised by a member of the senior staff of the Center.

Other aspects of the education program at the Center include an active seminar and guest lecture program. These are organized around various aspects of psychoanalytic theory and technique, as well as clinical and research topics related to work pursued at the Center.

The training program provides fellows with an opportunity for a personal psychoanalysis as part of their educational experience. The Center bears a major portion of the cost of the analysis for the first two years.

Opportunities to extend the fellowship beyond the designated two years are available depending on the fellow's interest and institutional need.

For application form and additional information, please call or send a letter of interest and CV to:

James L. Sacksteder, M.D.
Director, Psychiatric Residency Training Program
The Austen Riggs Center
25 Main Street
Stockbridge, MA 01262
(413) 298-5511

FELLOWSHIP—Beginning July 1995. PGY-5. Addiction Psychiatry. Acquire expertise in addictions. Norman Miller, M.D., Division Chief, Inpatient, outpatient and CL in University and VA hospital setting. Research and teaching expected. Resume: C. Kimsey, UIC-Dept. of Psychiatry (m/c 913), 912 S. Wood St., Chicago, IL 60612. The University of Illinois at Chicago is an AA/EOE.

SUBSTANCE ABUSE FELLOWSHIPS—Funded by NIDA at the University of Pennsylvania are designed to develop future leaders in substance abuse treatment and research. The program provides clinical and research training for physicians and postdoctoral students who wish to become qualified in substance abuse treatment research. Postdoctoral fellows will be fully trained in current behavioral, psychological and pharmacological substance abuse treatment techniques and will also learn how to evaluate new treatments and to conduct their own research. A unique aspect of this program is that it combines supervised clinical experience with direct participation in ongoing research projects. All fellows will have supervised clinical training with a heterogeneous population of alcohol, cocaine and opiate abusing patients. Research experience is supplemented by clinical seminars, coursework and mentoring by faculty preceptors leading to development of an independent research project. Applications for VA Fellowships are encouraged. Interested applicants should contact Joseph R. Volpicelli, M.D., Ph.D., Fellowship Co-Director,

Treatment Research Center, 3900 Chestnut St., Philadelphia, PA 19104. EOAAE.

FELLOWSHIP WOMEN'S MENTAL HEALTH AND POST-TRAUMATIC STRESS DISORDER IN WOMEN

The Women's Health Sciences Division of the National Center for Post-traumatic Stress Disorder at the Boston VA Medical Center announces a new full-time clinical and research fellowship in psychiatry. The Women's Health Sciences Division of the National Center for PTSD is a Congressionally mandated center designed to study Post-traumatic Stress Disorder in women. The Division also provides mental health consultation and treatment to the Women's Health Center, a primary care setting for women veterans. This fellowship is divided into half-time clinical and half-time research opportunities that include: 1) psychopharmacology treatment of women with PTSD and other trauma related disorders; 2) consultation-liaison to the Women's Health Center and; 3) design and implementation of an independent research project on PTSD in women. The fellow can expect to acquire distinct skills in the psychopharmacology of PTSD, assessment and psychological treatment of traumatized women, and advanced research methods in PTSD. The applicant must be at PGY IV level or beyond. Interested applicants should contact Glenn Saxe, M.D., Women's Health Sciences Division, National Center for PTSD, VAMC (116B-3), 150 S. Huntington Ave., Boston, MA 02130; telephone (617) 232-9500, ext. 5993.

GERIATRIC PSYCHIATRY AND CONSULTATION-LIAISON PSYCHIATRY FELLOWSHIP

The Department of Psychiatry at Dartmouth Medical School, offers a unique opportunity for combined fellowship training in Geriatric Psychiatry and C-L Psychiatry, for those considering an academic career or specialization in the psychiatry of the medically ill and/or elderly. Fellows train and supervise residents and medical students providing care to older patients in a general hospital. Training experiences also include outpatient dementia evaluations, different models of nursing home C-L, and home visits. Research opportunities include social support, cancer, neuroimaging, health services delivery, and drug trials. One or two years. Includes appointment at rank of Instructor of Psychiatry. For further information contact Thomas E. Oxman, M.D., Director, Geriatric Psychiatry and Consultation-Liaison Psychiatry, Dartmouth-Hitchcock Medical Center, 1 Medical Ctr. Dr., Lebanon, NH 03756; (603) 650-6147.

WAYNE STATE UNIVERSITY FELLOWSHIP—Department of Psychiatry is recruiting physicians and clinical psychologists for fellowships (12 to 24 months) in Chemical Dependence. The department has a division specializing in addictive disorders, with significant interaction between basic and clinical research components. Fellowship training involves clinical experience with alcohol and other drug abusing patients using multiple modalities in a variety of community and academic settings. Fellows in the 24-month academic track participate in research and teaching programs. Candidates must have a minimum of two years postdoctoral training. Please send CV, three letters of reference and relevant reprints to: Dr. Thomas W. Uhde, Chairperson, Department of Psychiatry and Behavioral Neurosciences, c/o Drs. C.R. Schuster and E.P. Schoener, University Psychiatric Center, 2751 East Jefferson, Detroit, MI 48207; (313) 993-3406, FAX (313) 993-3421. Wayne State University is an equal opportunity/affirmative action employer. All buildings, structures and vehicles at Wayne State University—People working together to provide quality service.

FELLOWSHIP TRAINING IN GERIATRIC PSYCHIATRY—UMDNJ-New Jersey's University of the Health Sciences offers a one or two year fellowship in the Div. of Geriatric Psychiatry, Dept. of Psychiatry-Robert Wood Johnson Medical School, CMHC at Piscataway, Comprehensive Services on Aging (COPSA). We have multidisciplinary dementia and geropsychiatric clinical and academic outpatient services. Curriculum topics include Geropsychiatry, Applied Neuroscience, and Neurobehavior. Fellows participate in clinical consultations, outpatient, individual, and family therapy. Research opportunities are available. Applicants must have completed PGY 3 or 4 in an accredited psychiatry program and be able to obtain a NJ medical license. Contact Hilary Hanchuk, M.D., Director of Geriatric Psychiatry Training, RWJ Medical School, COPSA, 667 Hoes Lane, PO Box 1392, Piscataway, NJ 08855-1392; (908) 235-5640.

CLASSIFIEDS

CHILD AND ADOLESCENT PSYCHIATRY FELLOWSHIP

Child Fellowship position is available at University of California, Irvine. Located in coastal Southern California this program offers an outstanding opportunity. In addition to balanced basic training, fellows may participate in a wide range of well established specialty areas. These extend from psychoanalytic play therapy to participation in the University's acclaimed neurobiologic research center and include infant psychiatry, autism, and child abuse; all with close supervision by renowned experts. The University of California is an Equal Opportunity, Affirmative Action Employer, "Rooted in education, enriched by diversity".

Please contact: Kenneth W. Steinhoff, M.D., Director, Child and Adolescent Psychiatry Training, UCIMC, Bldg. 3, Rt. 88, 101 City Dr., orange, CA 92668; or call (714) 753-7703.

GERIATRIC PSYCHIATRY FELLOWSHIPS

Applications are being accepted from applicants for the 1995-96 Geriatric Psychiatry Fellowship Program, Department of Psychiatry & Behavioral Neurobiology, University of Alabama at Birmingham. Interested and qualified individuals may contact F. Cleveland Kinney, Ph.D., M.D., Interim Director, Division of Geriatric Psychiatry, or Terri S. Steele, M.D., Fellowship Program Director, at (205) 934-6054, or in writing to: 1713 6th Avenue South, CPM 253, Birmingham, AL 35294-0018. AA/EOE.

NEW HAVEN, Connecticut—Yale University School of Medicine Department of Psychiatry has an opening at the level of PGY IV or PGY V in the Outpatient Psychiatry Clinic of Yale-New Haven Hospital. Opportunity to work with a multidisciplinary team to provide intensive ambulatory psychiatric consultation to primary care medicine. Consultation and liaison with the heart/lung transplant program and other specialty medical clinics is also available. Additional responsibilities could include supervision and teaching of residents and psychology interns, as well as pursuit of research interests. Yale-New Haven Hospital is a 900-bed teaching hospital within short walking distance to Yale University campus, theaters and shops. Interested individuals should contact Claudia Bemis, M.D., Yale-New Haven Hospital, Room 2046 CB, 20 York St., New Haven, CT 06504; telephone (203) 785-4628.

RESIDENCIES

TULANE UNIVERSITY Department of Psychiatry and Neurology—Unexpected opening for first year child psychiatry resident position available July 1, 1995. Applicants must have completed PGY-3 training in general psychiatry. Program is university academic medical center hospital based. Inpatient and outpatient rotations at university hospital and community mental health center, forensic, school, pediatric consultation-liaison rotations provide full range of didactic and experiential training in contemporary child psychiatry. Intense supervision offered by full-time academic faculty. Contact Betty Muller, M.D., Director of Child Psychiatry Residency Training, Department of Psychiatry and Neurology, Tulane University School of Medicine, 1430 Tulane Ave. SL23, New Orleans, LA 70112; telephone (504) 588-5401; Fax (504) 587-4264. EO/AA Employer.

7/1/95 PGY 2. Unexpected opening. Georgetown Univ. Hosp. Dept. of Psychiatry. Closely supervised inpatient and outpatient experiences. Seminar program and clinical conference. Nathan Billig, M.D., Dept. of Psychiatry, Georgetown Univ. Hosp., Washington, DC 20007-2197; (202) 687-8537.

UNIVERSITY OF MICHIGAN MEDICAL CENTER, Department of Psychiatry, has unexpected openings for PGY-II level residents beginning July 1st, 1995. Send universal application, personal application, CV and three reference letters to:

Michelle Riba, M.D., Director Resident and Fellow Education, University of Michigan Medical Center, Department of Psychiatry, 1500 E. Medical Center Drive, Ann Arbor, MI 48109-0704. Phone: (313) 764-6875. Fax: (313) 936-1130.

The University of Michigan Medical Center is an equal opportunity employer.

PGY-4 position available at Univ. of Illinois at Chicago for new Primary Care Program beginning July '95. Resident will be trained to consult with primary care team in general medicine; teach medicine residents and other health pro-

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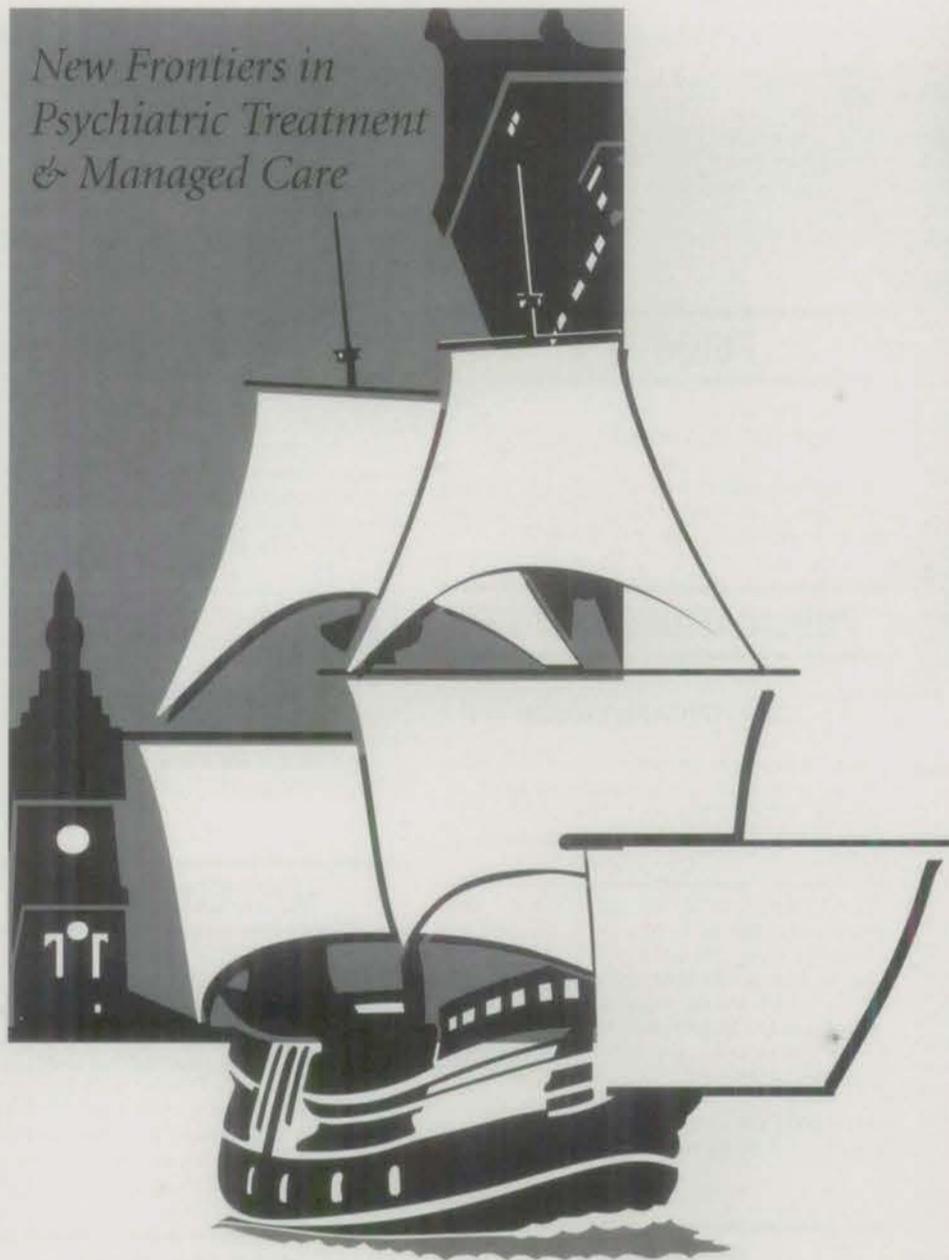
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BRIEF SUMMARY

ZOLOFT® (sertraline HCl)

INDICATIONS AND USAGE: ZOLOFT (sertraline hydrochloride) is indicated for the treatment of depression.

CONTRAINDICATIONS: None known. **WARNINGS:** Cases of serious reactions have been reported in patients receiving ZOLOFT in combination with a monoamine oxidase inhibitor (MAOI). The symptoms have included mental status changes such as memory changes, confusion and irritability, chills, pyrexia and muscle rigidity. In patients receiving another serotonin reuptake inhibitor drug in combination with a monoamine oxidase inhibitor (MAOI), there have been reports of serious, sometimes fatal, reactions including hyperthermia, rigidity, myoclonus, autonomic instability with possible rapid fluctuations of vital signs, and mental status changes that include extreme agitation progressing to delirium and coma. These reactions have also been reported in patients who have recently discontinued that drug and have been started on an MAOI. Some cases presented with features resembling neuroleptic malignant syndrome. Therefore, it is recommended that ZOLOFT (sertraline hydrochloride) not be used in combination with an MAOI, or within 14 days of discontinuing treatment with an MAOI. Similarly, at least 14 days should be allowed after stopping ZOLOFT before starting an MAOI. **PRECAUTIONS General:** **Activation of Mania/Hypomania**—During premarketing testing, hypomania or mania occurred in approximately 0.4% of ZOLOFT (sertraline hydrochloride) treated patients. Activation of mania/hypomania has also been reported in a small proportion of patients with Major Affective Disorder treated with other marketed antidepressants. **Weight Loss**—Significant weight loss may be an undesirable result of treatment with sertraline for some patients, but on average, patients in controlled trials had minimal, 1 to 2 pound weight loss, versus smaller changes on placebo. Only rarely have sertraline patients been discontinued for weight loss. **Seizure**—ZOLOFT has not been evaluated in patients with a seizure disorder. These patients were excluded from clinical studies during the product's premarket testing. Accordingly, like other antidepressants, ZOLOFT should be introduced with care in epileptic patients. **Suicide**—The possibility of a suicide attempt is inherent in depression and may persist until significant remission occurs. Close supervision of high risk patients should accompany initial drug therapy. Prescriptions for ZOLOFT should be written for the smallest quantity of tablets consistent with good patient management, in order to reduce the risk of overdose. **Weak Urinary Effect**—ZOLOFT is associated with a mean decrease in serum uric acid of approximately 7%. The clinical significance of this weak uricosuric effect is unknown, and there have been no reports of acute renal failure with ZOLOFT. **Use in Patients with Concomitant Illness**—Clinical experience with ZOLOFT in patients with certain concomitant systemic illness is limited. Caution is advisable in using ZOLOFT in patients with diseases or conditions that could affect metabolism or hemodynamic responses. ZOLOFT has not been evaluated or used to any appreciable extent in patients with a recent history of myocardial infarction or unstable heart disease. Patients with these diagnoses were excluded from clinical studies during the product's premarket testing. However, the electrocardiograms of 774 patients who received ZOLOFT in double-blind trials were evaluated and the data indicate that ZOLOFT is not associated with the development of significant ECG abnormalities. ZOLOFT is extensively metabolized by the liver. In subjects with mild, stable cirrhosis of the liver, the clearance of sertraline was decreased, thus increasing the elimination half-life. A lower or less frequent dose should be used in patients with cirrhosis. Since ZOLOFT is extensively metabolized, excretion of unchanged drug in urine is a minor route of elimination. However, until the pharmacokinetics of ZOLOFT have been studied in patients with renal impairment and until adequate numbers of patients with severe renal impairment have been evaluated during chronic treatment with ZOLOFT, it should be used with caution in such patients. **Interference with Cognitive and Motor Performance**—In controlled studies, ZOLOFT did not cause sedation and did not interfere with psychomotor performance. **Hypotension**—Several cases of hypotension have been reported. The hypotension appeared to be reversible when ZOLOFT was discontinued. The majority of these occurrences have been in elderly individuals, some in patients taking diuretics or who were otherwise volume depleted. **Platelet Function**—There have been rare reports of altered platelet function and/or abnormal results from laboratory studies in patients taking ZOLOFT. While there have been reports of abnormal bleeding or purpura in several patients taking ZOLOFT, it is unclear whether ZOLOFT had a causative role. **Information for Patients:** Physicians are advised to discuss the following issues with patients for whom they prescribe ZOLOFT. Patients should be told that although ZOLOFT has not been shown to impair the ability of normal subjects to perform tasks requiring complex motor and mental skills in laboratory experiments, drugs that act upon the central nervous system may affect some individuals adversely. Patients should be told that although ZOLOFT has not been shown in experiments with normal subjects to increase the mental and motor skill impairments caused by alcohol, the concomitant use of ZOLOFT and alcohol in depressed patients is not advised. Patients should be told that while no adverse interaction of ZOLOFT with over-the-counter (OTC) drug products is known to occur, the potential for interaction exists. Thus, the use of any OTC product should be initiated cautiously according to the directions of use given for the OTC product. Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during therapy. Patients should be advised to notify their physician if they are breast-feeding an infant. **Laboratory Tests:** **None.** **Drug Interactions: Potential Effects of Coadministration of Drugs Highly Bound to Plasma Proteins**—Because sertraline is tightly bound to plasma protein, the administration of ZOLOFT (sertraline hydrochloride) to a patient taking another drug which is tightly bound to protein (e.g., warfarin, digoxin) may cause a shift in plasma concentrations potentially resulting in an adverse effect. Conversely, adverse effects may result from displacement of protein-bound ZOLOFT by other highly bound drugs. In a study comparing prothrombin time AUC (0-120 hr) following dosing with warfarin (0.75 mg/kg) before and after 21 days of dosing with either ZOLOFT (50-200 mg/day) or placebo, there was a mean increase in prothrombin time of 8% relative to baseline for the ZOLOFT group compared to a 1% decrease for placebo (p<0.02). The normalization of prothrombin time for the ZOLOFT group was delayed compared to the placebo group. The clinical significance of this change is unknown. Accordingly, prothrombin time should be carefully monitored when ZOLOFT therapy is initiated or stopped. **Cimetidine**—In a study assessing disposition of ZOLOFT (100 mg) on the second of 8 days of cimetidine administration (800 mg daily), there were increases in ZOLOFT mean AUC (50%), C_{max} (24%) and half-life (26%) compared to the placebo group. The clinical significance of these changes is unknown. **CNS Active Drugs**—In a study comparing the disposition of intravenously administered diazepam before and after 21 days of dosing with either ZOLOFT (50 to 200 mg/day escalating dose) or placebo, there was a 32% decrease relative to baseline in diazepam clearance for the ZOLOFT group compared to a 19% decrease relative to baseline for the placebo group (p<0.03). There was a 23% increase in t_{1/2} for desmethyldiazepam in the ZOLOFT group compared to a 20% decrease in the placebo group (p<0.03). The clinical significance of these changes is unknown. In a placebo-controlled trial in normal volunteers, the administration of two doses of ZOLOFT did not significantly alter steady-state lithium levels or the renal clearance of lithium. Nonetheless, at this time, it is recommended that plasma lithium levels be monitored following initiation of ZOLOFT therapy with appropriate adjustments to the lithium dose. The risk of using ZOLOFT in combination with other CNS active drugs has not been systematically evaluated. Consequently, caution is advised if the concomitant administration of ZOLOFT and such drugs is required. There is limited controlled experience regarding the optimal timing of switching from other antidepressants to ZOLOFT. Care and prudent medical judgment should be exercised when switching, particularly from long-acting agents. The duration of an appropriate washout period which should intervene before switching from one selective serotonin reuptake inhibitor (SSRI) to another has not been established. **Drugs Metabolized by P450 2D6**—Many antidepressants, e.g., the SSRIs, including sertraline, and most tricyclic antidepressants inhibit the biochemical activity of the drug-metabolizing isozyme cytochrome P450 2D6 (debrisoquin hydroxylase), and, thus, may increase the plasma concentrations of co-administered drugs that are metabolized by P450 2D6. The drugs for which this potential interaction is of greatest concern are those metabolized primarily by 2D6 and which have a narrow therapeutic index, e.g., the tricyclic antidepressants and the Type 1C antiarrhythmics propafenone and flecainide. The extent to which this interaction is an important clinical problem depends on the extent of the inhibition of P450 2D6 by the antidepressant and the therapeutic index of the co-administered drug. There is variability among the antidepressants in the extent of clinically important 2D6 inhibition, and in fact sertraline at lower doses has a less prominent inhibitory effect on 2D6 than some others in the class. Nevertheless, even sertraline has the potential for clinically important 2D6 inhibition. Consequently, concomitant use of a drug metabolized by P450 2D6 with ZOLOFT may require lower doses than usually prescribed for the other drug. Furthermore, whenever ZOLOFT is withdrawn from co-therapy, an increased dose of the co-administered drug may be required. **Hypoglycemic Drugs**—In a placebo-controlled trial in normal volunteers, administration of ZOLOFT for 22 days (including 200 mg/day for the final 13 days) caused a statistically significant 16% decrease from baseline in the clearance of tolbutamide following an intravenous 1000 mg dose. ZOLOFT administration did not noticeably change either the plasma protein binding or the apparent volume of distribution of tolbutamide, suggesting that the decreased clearance was due to a change in the metabolism of the drug. The clinical significance of this decrease in tolbutamide clearance is unknown. **Atenolol**—ZOLOFT (100 mg) when administered to 10 healthy male subjects had no effect on the beta-adrenergic blocking ability of atenolol. **Digoxin**—In a placebo-controlled trial in normal volunteers, administration of ZOLOFT for 17 days (including 200 mg/day for the last 10 days) did not change serum digoxin levels or digoxin renal clearance. **Microsomal Enzyme Induction**—Preclinical studies have shown ZOLOFT to induce hepatic microsomal enzymes. In clinical studies ZOLOFT was shown to induce hepatic enzymes minimally as determined by a small (5%) but statistically significant decrease in antipyrine half-life following administration of 200 mg/day for 21 days. This small change in antipyrine half-life reflects a clinically insignificant change in hepatic metabolism. **Electroconvulsive**

Therapy—There are no clinical studies establishing the risks or benefits of the combined use of electroconvulsive therapy (ECT) and ZOLOFT. **Alcohol**—Although ZOLOFT did not potentiate the cognitive and psychomotor effects of alcohol in experiments with normal subjects, the concomitant use of ZOLOFT and alcohol in depressed patients is not recommended. **Carcinogenesis, Mutagenesis, Impairment of Fertility:** Lifetime carcinogenicity studies were carried out in CD-1 mice and Long-Evans rats at doses up to 40 mg/kg in mice (10 times on a mg/kg basis and the same on a mg/m² basis as the maximum recommended human dose) and at doses up to 40 mg/kg in rats (10 times on a mg/kg basis and 2 times on a mg/m² basis, the maximum recommended human dose). There was a dose-related increase in the incidence of liver adenomas in male mice receiving sertraline at 10-40 mg/kg. No increase was seen in female mice or in rats of either sex receiving the same treatments, nor was there an increase in hepatocellular carcinomas. Liver adenomas have a variable rate of spontaneous occurrence in the CD-1 mouse and are of unknown significance to humans. There was an increase in follicular adenomas of the thyroid in female rats receiving sertraline at 40 mg/kg; this was not accompanied by thyroid hyperplasia. While there was an increase in uterine adenocarcinomas in rats receiving sertraline at 10-40 mg/kg compared to placebo controls, this effect was not clearly drug related. Sertraline had no genotoxic effects, with or without metabolic activation, based on the following assays: bacterial mutation assay; mouse lymphoma mutation assay; and tests for cytogenetic aberrations in vivo in mouse bone marrow and in vitro in human lymphocytes. A decrease in fertility was seen in one of two rat studies at a dose of 80 mg/kg (20 times the maximum human dose on a mg/kg basis and 4 times on a mg/m² basis). **Pregnancy—Pregnancy Category B: Teratogenic Effects**—Reproduction studies have been performed in rats and rabbits at doses up to approximately 20 times and 10 times the maximum daily human mg/kg dose (4 to 4.5 times the mg/m² dose), respectively. There was no evidence of teratogenicity at any dose level. At doses approximately 2.5-10 times the maximum daily human mg/kg dose, sertraline was associated with delayed ossification in fetuses, probably secondary to effects on the dams. There are no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed. **Non-teratogenic Effects**—There was also decreased neonatal survival following maternal administration of sertraline at doses as low as approximately 5 times the maximum human mg/kg dose. The decrease in pup survival was shown to be most probably due to in utero exposure to sertraline. The clinical significance of these effects is unknown. **Labor and Delivery**—The effect of ZOLOFT on labor and delivery in humans is unknown. **Nursing Mothers**—It is not known whether, and if so in what amount, sertraline or its metabolites are excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when ZOLOFT is administered to a nursing woman. **Pediatric Use**—Safety and effectiveness in children have not been established. **Geriatric Use**—Several hundred elderly patients have participated in clinical studies with ZOLOFT. The pattern of adverse reactions in the elderly was similar to that in younger patients. **ADVERSE REACTIONS Commonly Observed:** The most commonly observed adverse events associated with the use of ZOLOFT (sertraline hydrochloride) and not seen at an equivalent incidence among placebo-treated patients were: gastrointestinal complaints, including nausea (26.1% vs 11.8%), diarrhea/loose stools (17.7% vs 9.3%) and dyspepsia (6% vs 2.8%); tremor (10.7% vs 2.7%); dizziness (11.7% vs 6.7%); insomnia (16.4% vs 8.8%); somnolence (13.4% vs 5.9%); increased sweating (8.4% vs 2.9%); dry mouth (16.3% vs 9.3%); and male sexual dysfunction (15.5% vs 2.2%), primarily ejaculatory delay. **Associated with Discontinuation of Treatment:** Fifteen percent of 2710 subjects who received ZOLOFT in pre-marketing multiple dose clinical trials discontinued treatment due to an adverse event. The more common events (reported by at least 1% of subjects) associated with discontinuation included agitation, insomnia, male sexual dysfunction (primarily ejaculatory delay), somnolence, dizziness, headache, tremor, anorexia, diarrhea/loose stools, nausea, and fatigue. **Other Events Observed During the Premarketing Evaluation of ZOLOFT (sertraline hydrochloride):** During its premarketing assessment, multiple doses of ZOLOFT were administered to approximately 2700 subjects. Events are further categorized by body system and listed in order of decreasing frequency according to the following definitions: frequent adverse events are those occurring on one or more occasions in at least 1/100 patients (only those not already listed in the tabulated results from placebo-controlled trials appear in this listing); infrequent adverse events are those occurring in 1/100 to 1/1000 patients; rare events are those occurring in fewer than 1/1000 patients. Events of major clinical importance are also described in the PRECAUTIONS section. **Autonomic Nervous System Disorders**—Infrequent: flushing, mydriasis, increased salivation, cold clammy skin; Rare: pallor. **Cardiovascular**—Infrequent: postural dizziness, hypertension, hypotension, postural hypotension, edema, dependent edema, periorbital edema, peripheral edema, peripheral ischemia, syncope, tachycardia; Rare: precordial chest pain, substernal chest pain, aggravated hypertension, myocardial infarction, varicose veins. **Central and Peripheral Nervous System Disorders**—Frequent: confusion; Infrequent: ataxia, abnormal coordination, abnormal gait, hyperesthesia, hyperkinesia, hypokinesia, migraine, nystagmus, vertigo; Rare: local anesthesia, coma, convulsions, dyskinesia, dysphonia, hyporeflexia, hypotonia, ptois. **Disorders of Skin and Appendages**—Infrequent: acne, alopecia, pruritus, erythematous rash, maculopapular rash, dry skin; Rare: bullous eruption, dermatitis, erythema multiforme, abnormal hair texture, hypertrichosis, photosensitivity reaction, follicular rash, skin discoloration, abnormal skin odor, urticaria. **Endocrine Disorders**—Rare: exophthalmos, gynecostoma. **Gastrointestinal Disorders**—Infrequent: dysphagia, eructation; Rare: diverticulitis, fecal incontinence, gastritis, gastroenteritis, glossitis, gum hyperplasia, hemorrhoids, hiccup, melena, hemorrhagic peptic ulcer, proctitis, stomatitis, ulcerative stomatitis, tenesmus, tongue edema, tongue ulceration. **General**—Frequent: asthenia; Infrequent: malaise, generalized edema, rigors, weight decrease, weight increase; Rare: enlarged abdomen, halitosis, otitis media, ophthalmostomatitis. **Hematopoietic and Lymphatic**—Infrequent: lymphadenopathy, purpura; Rare: anemia, anterior chamber eye hemorrhage. **Metabolic and Nutritional Disorders**—Rare: dehydration, hypercholesterolemia, hypoglycemia. **Musculoskeletal System Disorders**—Infrequent: arthralgia, arthrosis, dystonia, muscle cramps, muscle weakness; Rare: hernia. **Psychiatric Disorders**—Infrequent: abnormal dreams, aggressive reaction, amnesia, apathy, delusion, depersonalization, depression, aggravated depression, emotional lability, euphoria, hallucination, neuritis, paranoid reaction, suicide ideation and attempt, teeth-grinding, abnormal thinking; Rare: hysteria, somnambulism, withdrawal syndrome. **Reproductive**—Infrequent: dysmenorrhea (2), intermenstrual bleeding (2); Rare: amenorrhea (2), balanoposthitis (1), breast enlargement (2), leukorrhea (2), menorrhagia (2), atrophic vaginitis (2), (1)-(1) % based on male subjects only; 100S; (2) -% based on female subjects only; 170S. **Respiratory System Disorders**—Infrequent: bronchospasm, coughing, dyspnea, epistaxis; Rare: bradypnea, hyperventilation, sinusitis, stridor. **Special Senses**—Infrequent: abnormal accommodation, conjunctivitis, diplopia, earache, eye pain, xerophthalmia; Rare: abnormal lacrimation, photophobia, visual field defect. **Urinary System Disorders**—Infrequent: dysuria, face edema, nocturia, polyuria, urinary incontinence; Rare: oliguria, renal pain, urinary retention. **Laboratory Tests:** In men, asymptomatic elevations in serum transaminases (SGOT [or AST] and SGPT [or ALT]) have been reported infrequently (approximately 0.8%) in association with ZOLOFT administration. These hepatic enzyme elevations usually occurred within the first 1 to 9 weeks of drug treatment and promptly diminished upon drug discontinuation. ZOLOFT therapy was associated with small mean increases in total cholesterol (approximately 3%) and triglycerides (approximately 5%), and a small mean decrease in serum uric acid (approximately 7%) of no apparent clinical importance. **DRUG ABUSE AND DEPENDENCE Controlled Substance Class**—ZOLOFT (sertraline hydrochloride) is not a controlled substance. **Physical and Psychological Dependence**—ZOLOFT has not been systematically studied, in animals or humans, for its potential for abuse, tolerance, or physical dependence. However, the premarketing clinical experience with ZOLOFT did not reveal any tendency for a withdrawal syndrome or any drug-seeking behavior. As with any new CNS active drug, physicians should carefully evaluate patients for history of drug abuse and follow such patients closely, observing them for signs of ZOLOFT misuse or abuse (e.g., development of tolerance, incrementation of dose, drug-seeking behavior). **OVERDOSAGE Human Experience**—As of November, 1992, there were 79 reports of non-fatal acute overdoses involving ZOLOFT, of which 26 were overdoses of ZOLOFT alone and the remainder involved a combination of other drugs and/or alcohol in addition to ZOLOFT. In those cases of overdose involving only ZOLOFT, the reported doses ranged from 500 mg to 6000 mg. In a subset of 18 of these patients in whom ZOLOFT blood levels were determined, plasma concentrations ranged from <5 ng/mL to 554 ng/mL. Symptoms of overdose with ZOLOFT alone included somnolence, nausea, vomiting, tachycardia, ECG changes, anxiety and dilated pupils. Treatment was primarily supportive and included monitoring and use of activated charcoal, gastric lavage or cathartics and hydration. Although there were no reports of death when ZOLOFT was taken alone, there were 4 deaths involving overdoses of ZOLOFT in combination with other drugs and/or alcohol. Therefore, any overdose should be treated aggressively. **Management of Overdoses**—Establish and maintain an airway, insure adequate oxygenation and ventilation. Activated charcoal, which may be used with sorbitol, may be as or more effective than emesis or lavage, and should be considered in treating overdose. Cardiac and vital signs monitoring is recommended along with general symptomatic and supportive measures. There are no specific antidotes for ZOLOFT. Due to the large volume of distribution of ZOLOFT, forced diuresis, dialysis, hemoperfusion, and exchange transfusion are unlikely to be of benefit. In managing overdose, consider the possibility of multiple drug involvement. The physician should consider contacting a poison control center on the treatment of any overdose.

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