Psychiatric News

Newspaper of the AMERICAN PSYCHIATRIC ASSOCIATION

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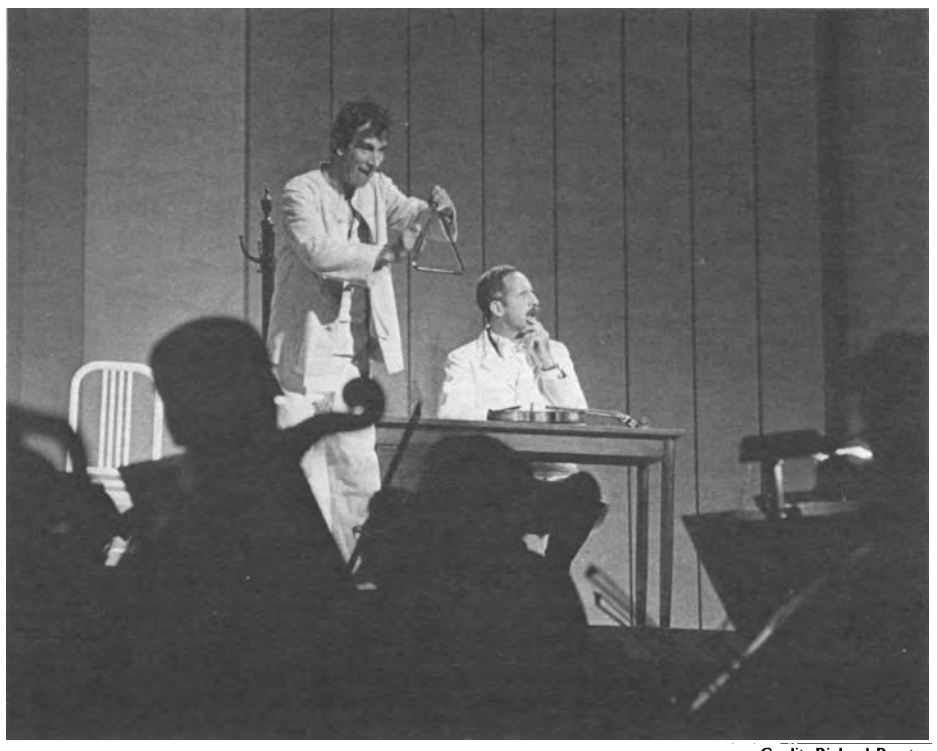

Credit: Richard Braaten

Tom Stoppard's new play, *Every Good Boy Deserves Favour*, details the Soviet use of psychiatry as a tool of political oppression. A review by Clarissa K. Wittenberg is on page 28.

Marmor Examines Value In Newer Therapies

SPEAKING with admirable candor to an audience that would have challenged anything less, Judd Marmor, M.D., told a group of science writers gathered at a recent research symposium that the burgeoning experiential therapies are effective for some people, although any system offering a panacea for all comers should be viewed dimly. Further, he said that members of all mental health disciplines have been trained in some form of psychotherapy that is effective for some patients and that there has been a class bias in providing one-to-one psychotherapy.

Marmor, an APA past president who is Franz Alexander Professor of Psychiatry in the psychiatry department of the University of Southern California School of Medicine, described for the writers attending the conference on "Research Perspectives on Treating Mental Illness" what he terms three revolutions in psychotherapy. The first, he said, was the advent of Freudian analysis, which initiated a scientific approach to psychotherapy. "The main emphasis was cognitive," he explained. "If we could understand the difficulties, we could enable the patient to overcome them." The second revolution, the behavioral, began 25 to 30 years ago and was based on animal psychology. It rejected cognitive, subjective therapeutic concepts and focused on

See "Marmor," page 7

Eisenberg Hits Fiscal Constraints

WHILE MOST of the speakers at the 30th Institute on Hospital & Community Psychiatry struggled to work within the confines of the conferences theme, "Quality Amidst Constraints: the Creative Use of Limited Resources," Harvard Professor Leon Eisenberg, M.D., opened his provocative speech with a blistering attack on the title itself, branding it "a capitulation to the conservative political consensus on the limits of government responsibility for health care. . . ."

"Insofar as we take the words 'constraints' and 'limited resources' to be no more than descriptors of current resource allocations for mental health services, they are visibly true. Insofar as we slip into accepting them as implying appropriate social policy decisions or as reflecting immutable economic forces, we mistake what is for what must be," he declared.

Taking on the words "quality" and "creativity" as well, Eisenberg flatly stated that "no matter how imaginative and dedicated, the state hospital psychiatrist with 100 patients to manage" or "the welfare worker with 50 abused children to supervise" simply cannot fulfill professional responsibilities. And, he argued, after a certain point "continuing to lend one's professional name to a badly understaffed agency contributes to the perpetuation of a fraud by conjuring up the appearance of quality when there really isn't any."

The Massachusetts psychiatrist did not deny the need to make the most of resources at hand or the necessity of justifying empirically pleas for more funds. But, he underscored, federal expenditures for social programs have been quite miniscule in relation to the size of the problems they have been "thrown" at. He contended that the "biggest government handouts have gone to the haves rather than the have nots. Mortgage interest and property tax exemptions on the income tax available to middle- and upper-class home owners like me—subsidize their housing in an amount three and a half times the federal investment in public housing."

Eisenberg dissected the problem into three parts, trying to answer the

See "Eisenberg," page 8

News Digest

Highlights of the Kansas City H&CP Institute are *on page 9.*

* * *

Views of the current status of the state mental hospital are *on page 10.*

* * *

A recent study has challenged the idea that incest is uniformly harmful. *Story on page 26.*

* * *

The *Bulletin* *of the Hampstead Clinic* began publication recently. *Story on page 30.*

* * *

A Yale pediatrician has predicted that it will take at least another ten years before the puzzle of phenylketonuria will be unraveled. *Story on page 32.*

* * *

A New York psychologist has found that 20 percent of 500 male psychotherapists responding to his survey feel there are "exceptions" to the rule against physician-patient sexual relations. *Story on page 40.*

Special Feature

This issue of *Psychiatric News* contains the text of proposed constitutional amendments drafted by the Joint Conference Committee on the Key Conference. Readers are urged to study the document, which begins on page 11.

Second-class postage paid at Washington, D.C. and at additional mailing offices

A Look at Health Systems Agencies

Upon this gifted age, in its dark hour, rains from the sky a meteoric shower of facts. . . . They lie unquestioned, uncombined. Widsom enough to leech us of our ills is daily spun, but there exists no loom to weave it into fabric. . . .

Edna St. Vincent Millay

By B. S. Herrington

Second of Two Articles

"I SUBMIT CONGRESS has legislated a loom, but it needs all the help it can get," commented Rosalyn D. Bass, M.A., of the National Institute of Mental Health, during a conference last year. She drew on the above quote to characterize the state of health planning evolving from the regionalized structure legislated in 1974 through the National Health Planning and Resources Development Act, which aimed at getting a firmer grip on costs and supplying services before the advent of any national health insurance system.

A basic part of this loom, the local regional planning bodies, or, more formally, the Health Systems Agencies (HSAs), are in preliminary stages, some still awaiting final approval from the Department of Health, Education, and Welfare (HEW), many designing just the bare framework of their five-year goals and yearly implementation plans. Instructed to amass facts and figures on such things as how services are used and what are needed, operating with skeleton staffs and volunteer boards, they need many knowledgeable "weavers" to select and combine the unending strands of information into cohesive patterns.

In terms of the loom metaphor, the state of the art in mental health planning in central Maryland is almost a textile mill. From all reports, this HSA, whose territory encompasses two million persons in Baltimore City and five surrounding counties, has the help of one of the most tightly organized and effective mental health coalitions in the country. Kent E. Robinson, M.D., the only psychiatrist on the governing board of the Central Maryland HSA, explained at APA's annual meeting just how this was accomplished.

The approach taken by Robinson and others was a variation on that famous admonishment to hang together

See "Planning," page 16

Letters

Psychiatric News invites readers to send letters, preferably not more than 500 words in length. Submission of a letter implies consent for publication unless otherwise indicated. All letters are subject to customary editing to meet style, clarity, and space requirements. Receipt of letters is not ordinarily acknowledged.

ERA Vote (Cont'd.)

THE ERA REFERENDUM results were disheartening and dishonored our Association as well. Regardless of the mixed motives in overriding the decision to withdraw our annual meeting from New Orleans—those having to do with New Orleans as a desirable place to meet, anger at what seemed to be a repudiation of a previous referendum, or being against boycott as strategy—it was an apparent vote *against* supporting ERA. Nearly 150 organizations have voted to hold no meetings in the unratified states, including those organizations representing all other mental health professionals. Our organization is conspicuous in not standing among these ranks. We, who should be aware of the adverse psychological effect of discrimination and who should be taking a leadership position on issues affecting the psychological well-being of people, instead have taken a position that lends support to our critics. It may very well be that the great majority of psychiatrists support ERA, yet by either not voting at all or not considering this referendum a vote on ERA, they have put our organization in this position of dishonor.

We face two major problems as a result of this vote: *a*) Our position as an organization appears to be sexist, discriminatory, and repressive by implication. *b*) Women psychiatrists who have been active within APA, contributing time and effort to the organization, are feeling saddened and angry by the vote and now must decide what to do in response. If lessened involvement or staying away from New Orleans results, both APA and the individual women will experience loss.

What to do to heal the wounds within our organization and to restore our moral and professional leadership outside are the problems to be faced. Going to New Orleans with women as the theme has been talked about as one way of addressing both problems. At this point, New Orleans is three years away, giving us time, hopefully, to do something about the mess created by this referendum.

Jean Shinoda Bolen, M.D.
San Francisco, Calif.

10B-10

I AM CHAGRINED to hear that the referendum vote was such that the 1981 convention will be held in New Orleans after all. The first ERA referendum, despite obfuscation on behalf of critics, asked merely *when* and *at what risk* the American Psychiatric Association wished to start the convention boycott that the Board of Trustees had already [said it would] initiate "as soon as possible."

I am afraid that this latter referendum says that APA clearly does not support any boycott, even when the risk is quite minimal. There remains an important task of education about the importance and impact of ERA on the psychiatric health of women and men. Hopefully, others with more optimism and energy than I have right now can perform that task.

I cannot in conscience attend the 1979 Chicago convention or the 1981 New Orleans convention and will be joining friends and colleagues who also could not in conscience attend this year's Atlanta meeting because none of these states has ratified ERA. In the next few years, I will be planning to invest my continuing education dollars in convention attendance of related organizations that do observe the ERA boycott, such as the American Orthopsychiatric Association, the American Psychological Association, and the American Academy of Psychoanalysis.

Such a move to boycott our APA as an individual in terms of convention attendance will in no way injure our APA, as we pay APA no fee for convention attendance. It will, however, withhold subsidy for the hotels and restaurants in Chicago and New Orleans. I would urge other APA members and their spouses to join me in this kind of movement.

Ann L. Chappell, M.D.
San Francisco, Calif.

10B-20

IT IS GRATIFYING that the membership has ratified the position endorsed by the Louisiana Psychiatric Association with regard to the cancellation by the Board of the 1981 APA meeting in New Orleans. The issue was not a geographical one but a constitutional one, that is, how much voice would the membership have in the decision-making process.

In my years as a deputy representative, I quite often saw the Assembly and the Board of Trustees adopt positions and pass resolutions that in my opinion were not supported, or worse, were in conflict with the desires and hopes of the membership. I feel that the controversy created by the Board's decision to disregard the first referendum has been a healthy one. For the first time in years, the members have shown openly their vital interest in APA and their desire to have a more active role and voice in shaping its future. We need now to direct this energy in a constructive and positive direction. If LPA or I can be of any help in this endeavor or in closing any wounds that might have been opened during this debate, we stand ready to help.

F. A. Silva, M.D., President
Louisiana Psychiatric Association
Baton Rouge, La.

10B-9

Chodoff/Masserman

AS A MEMBER of the Board of Amnesty International USA, as chairman of the Task Force Against the Political Abuse of Psychiatry of the Massachusetts Psychiatric Society, and as a member of the Medical Advisory Board of the International Executive Committee of Amnesty International, I feel that I have had some sufficient experience to make some brief comments on the two important letters published in the September 15 issue of *Psychiatric News* from Dr. Paul Chodoff and Dr. Jules Masserman.

On the matter of human rights, they do not differ in substance. They do differ in what they consider is effective action.

This is a crucial debate and does not only affect the two protagonists, but affects what we, as professionals, and more importantly what we as a *body of professionals* should do about such questions as the political abuse of psychiatry in the Soviet Union on the one hand and the persecution of psychiatrists (among others) in Argentina on the other.

Dr. Chodoff speaks for public statements (which he infers is action, and Dr. Masserman describes as velleity). Dr. Masserman speaks for quiet diplomacy and *friendly* professional and personal influences.

In my experience, both approaches are better than no approach. Both approaches together are better than either singly. But if one must choose one (and there is no reason to do this), it is far more effective to choose the public approach. By this, I do not mean the public approach of individuals but of individuals representing bodies of their colleagues.

Why do I say this? For a number of reasons.

The first is that what we are trying to influence is not the individual physician or psychiatrist but the political system, the government of the country in which he works—whether it be the authoritarian regime of the right of Argentina or the totalitarian regime of the left of the Soviet Union. The second is that both types of regime, and others, are extremely sensitive to their world image, to what is said of them in the world press, and to comments on their ideologies. In fact, it is only because of this sensitivity (part of the battle for mens' minds) that Amnesty International has been effective at all. Amnesty does not work with anything except careful documented information and publicity. Is

See "Letters," page 20

Correction

IN ITS SEPTEMBER 1 issue, *Psychiatric News* described a study reported in the August 8 issue of *ADAMHA News* on the use of the drug clonidine to treat opiate addiction in humans and animals. Unfortunately, the dosage of the drug cited by *ADAMHA News* and picked up by *Psychiatric News* was incorrect. Each addict participating in the study received five μg (micrograms) per kg of clonidine (not five mg as was reported) twice daily for a week on an outpatient basis.

For additional information on this research, see the article titled, "Clonidine and Opiate Withdrawal," by Gold et al. in the Volume I, 1978, issue of *Lancet*. 10B-2

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Cost Containment— Numerous Methods

By Margaret C. McDonald

First of Two Parts

ALTHOUGH the health care policy of the Carter Administration is not yet in clear focus, one certainty is that any plan issued or approved by the White House will include a vigorous cost containment measure.

Total health care expenditures in the United States increased by two-and-a-half times from 1970 to 1977, according to a recent article in the *National Journal* by John K. Iglehart: from $62.5 billion to $163 billion. Not only did total spending rise dramatically, but the public share of the total—that derived from federal, state, and local taxes—likewise increased from 34 percent to 43 percent. So the public is paying a larger and larger share of an already substantial expenditure and is getting little more for its money. The Carter mandate is that such spending must be controlled. The question is how.

One way is by voluntary measures, which, for the moment, seem to be working fairly well for in-hospital care, which accounts for the lion's share of expenditures. Data from the American Medical Association and the American Hospital Association show that the increase in hospital costs has been held down over the past few months. Last January, there was a 13.5 percent increase in costs, followed by figures of 13.1 percent for February, 12.4 percent in March, and 11.8 percent for April (monthly projected annual rate of increase)—all compared to a 15-plus percent increase in 1977.

In addition, various national medical organizations have been forming committees, preparing reports, and making policy statements on the question of cost control. AMA's National Commission on the Cost of Medical Care issued a summary report last December calling for "strengthening price consciousness in the health care marketplace" as one of the chief of its many recommendations. AMA has also joined with AHA and the Federation of American Hospitals to organize a national steering committee of hospital people, physicians, insurers, and consumers to develop goals and mechanisms to voluntarily reduce the rate of increase in hospital costs and in health care costs in general. The national committee's guidelines are intended to be used as screens to identify those institutions to be reviewed by committees designated by state hospital associations and medical societies. AMA has urged each state medical association to begin meeting with its joint state level steering committee; and a letter has been sent to board chairmen, chief executive officers, and chiefs of medical staff in every U.S. hospital asking for support of the voluntary cost containment program. Hospital boards are also being asked to plan budgets for the next fiscal year which are consistent with these cost-containment goals.

The nation's foremost accreditation body, the Joint Commission on the Accreditation of Hospitals (JCAH), has also adopted a cost control policy, which it is publicizing. This is significant in light of the fact that although the commission is a private, nonprofit organization, JCAH accreditation is a

See "Cost," page 22

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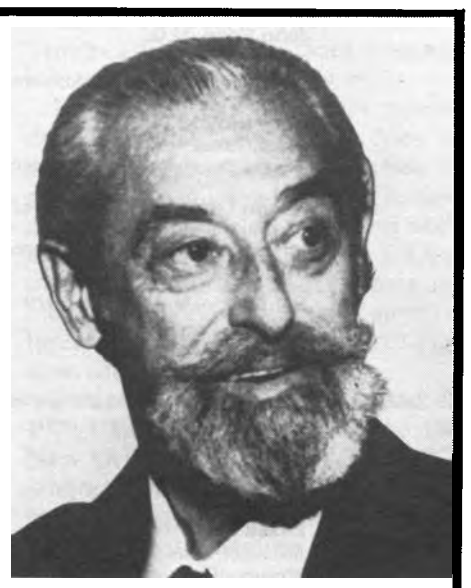

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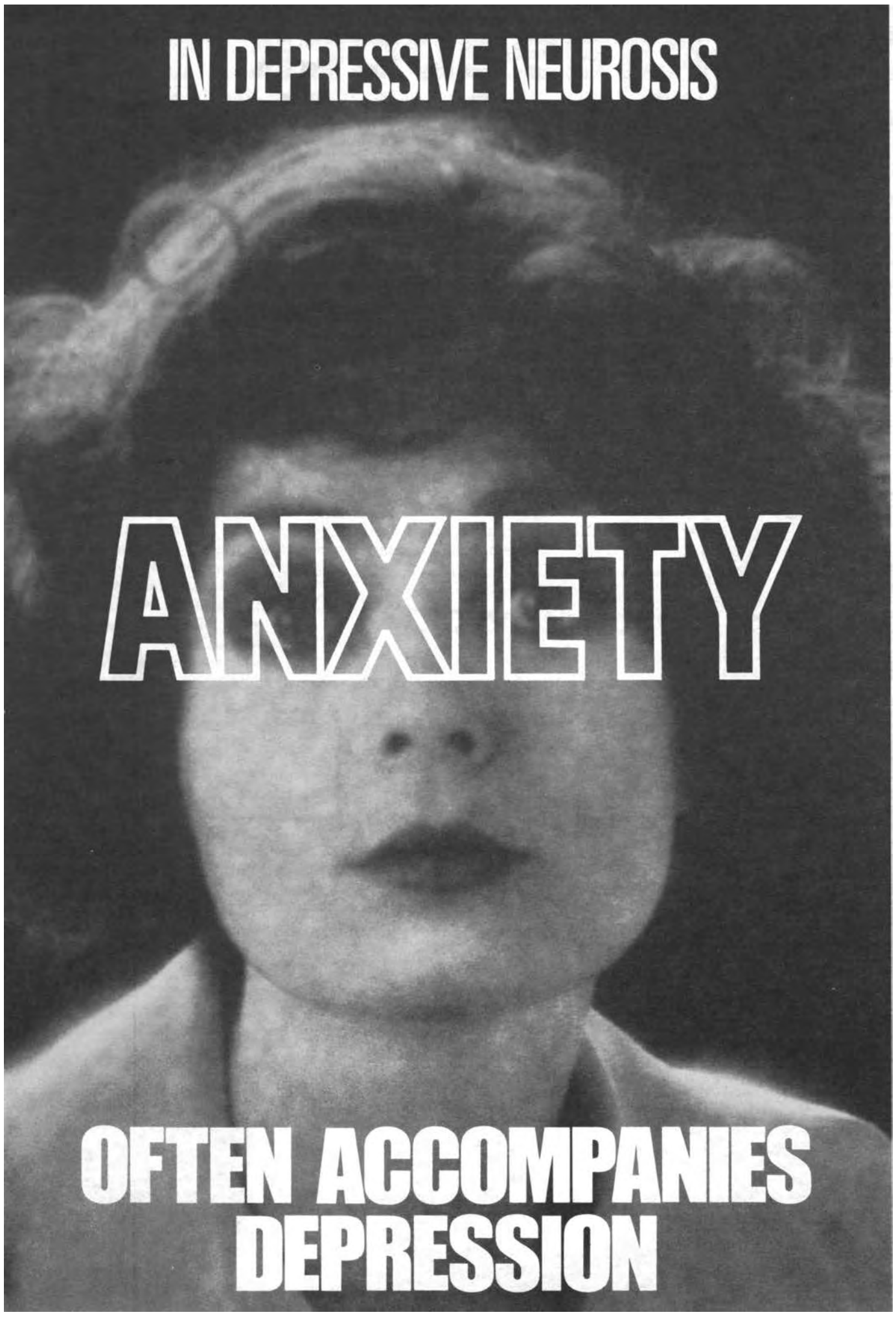

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Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy, observed primarily in patients receiving larger than recommended doses, is characterized by diminution of visual acuity, brownish coloring of vision, and impairment of night vision; the possibility of its occurrence may be reduced by remaining within recommended dosage limits. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving), and increase dosage gradually. Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension since phenothiazines may induce a reversed epinephrine effect on occasion. Daily doses in excess of 300 mg should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; rarely, nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—ECG changes (see *Cardiovascular Effects* below). *Other*—Rare cases described as parotid swelling.

It should be noted that efficacy, indications and untoward effects have varied with the different phenothiazines. It has been reported that old age lowers the tolerance for phenothiazines; the most common neurologic side effects are parkinsonism and akathisia, and the risk of agranulocytosis and leukopenia increases. The following reactions have occurred with phenothiazines and should be considered whenever one of these drugs is used. *Autonomic Reactions*—Miosis, obstipation, anorexia, paralytic ileus. *Cutaneous Reactions*—Erythema, exfoliative dermatitis, contact dermatitis. *Blood Dyscrasias*—Agranulocytosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplastic anemia, pancytopenia. *Allergic Reactions*—Fever, laryngeal edema, angioneurotic edema, asthma. *Hepatotoxicity*—Jaundice, biliary stasis. *Cardiovascular Effects*—Changes in terminal portion of electrocardiogram, including prolongation of Q-T interval, lowering and inversion of T-wave, and appearance of a wave tentatively identified as a bifid T or a U wave have been observed with phenothiazines, including Mellaril (thioridazine); these appear to be reversible and due to altered repolarization, not myocardial damage. While there is no evidence of a causal relationship between these changes and significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients showing characteristic electrocardiographic changes while taking the drug. While proposed, periodic electrocardiograms are not regarded as predictive. Hypotension, rarely resulting in cardiac arrest. *Extrapyramidal Symptoms*—Akathisia, agitation, motor restlessness, dystonic reactions, trismus, torticollis, opisthotonus, oculogyric crises, tremor, muscular rigidity, and akinesia. *Persistent Tardive Dyskinesia*—Persistent and sometimes irreversible tardive dyskinesia, characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements) and sometimes of extremities may occur on long-term therapy or after discontinuation of therapy, the risk being greater in elderly patients on high-dose therapy, especially females; if symptoms appear, discontinue all antipsychotic agents. Syndrome may be masked if treatment is reinstituted, dosage is increased, or antipsychotic agent is switched. Fine vermicular movements of tongue may be an early sign, and syndrome may not develop if medication is stopped at that time. *Endocrine Disturbances*—Menstrual irregularities, altered libido, gynecomastia, lactation, weight gain, edema, false positive pregnancy tests. *Urinary Disturbances*—Retention, incontinence. *Others*—Hyperpyrexia; behavioral effects suggestive of a paradoxical reaction, including excitement, bizarre dreams, aggravation of psychoses, and toxic confusional states; following long-term treatment, a peculiar skin-eye syndrome marked by progressive pigmentation of skin or conjunctiva and/or accompanied by discoloration of exposed sclera and cornea; stellate or irregular opacities of anterior lens and cornea; systemic lupus erythematosus-like syndrome.

Dosage: Dosage must be individualized according to the degree of mental and emotional disturbance, and the smallest effective dosage should be determined for each patient. In adults with depressive neurosis the usual starting dosage is 25 mg t.i.d. and the dosage ranges from 10 mg b.i.d. to q.i.d. in milder cases to 50 mg t.i.d. or q.i.d. for more severely disturbed patients; the total daily dose ranges from 20 mg to a maximum of 200 mg.

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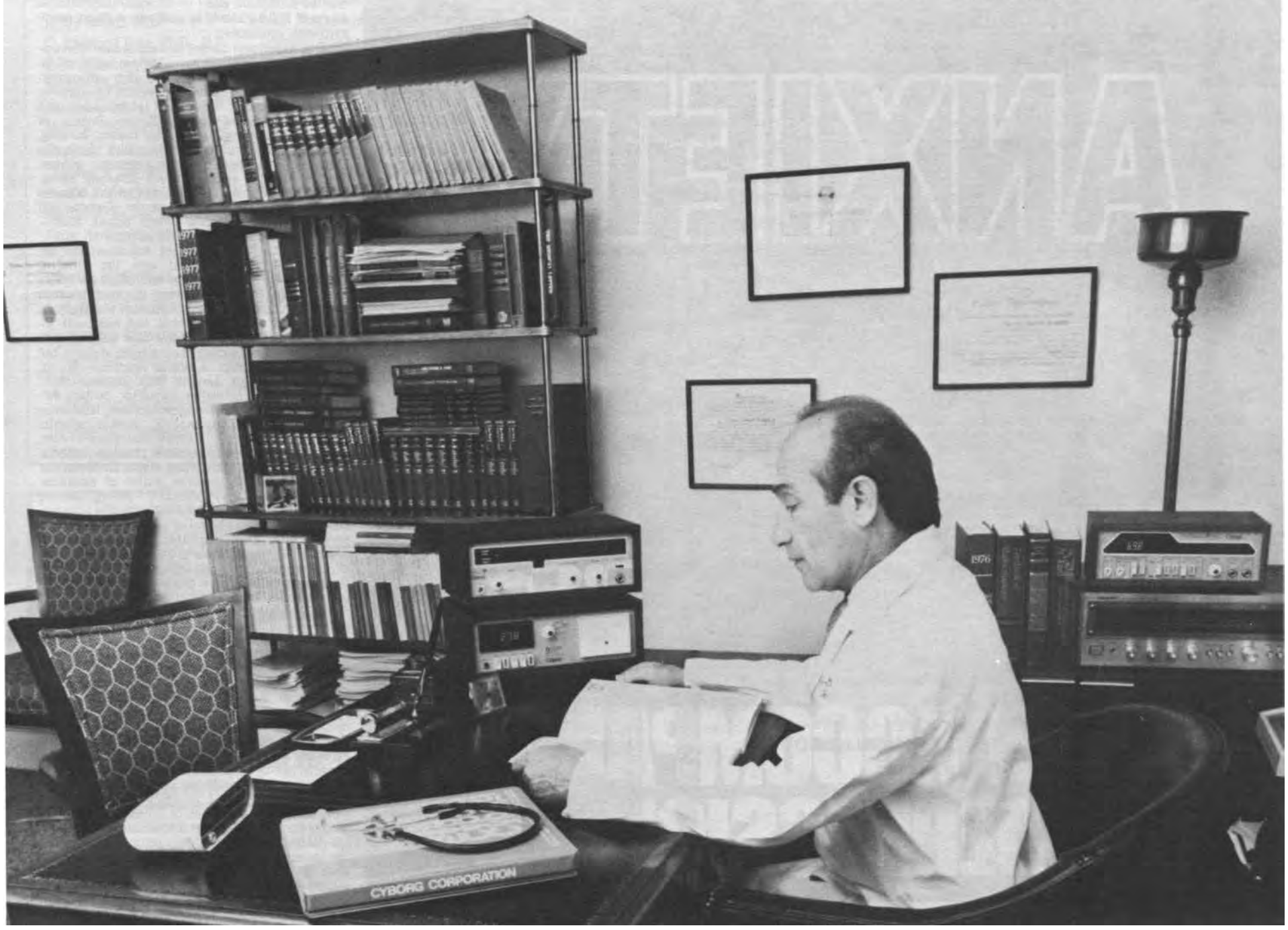

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Marmor

Continued from page 1

observing behavior and modifying it. "Lately, however, the cognitive and behavioral schools have been converging somewhat," he said.

The third and newest approach, the experiential therapies, reject both the cognitive and behavioral schools. The experiential therapies are eclectic, explained Marmor, having no common thread "except a rejection of mechanistic approaches. Rather, they attempt to 'find the true self,' 'reach repressed emotion,' and 'merge oneself with the cosmos.' " The question to be asked about these therapies, which have been the dominant emergence in psychotherapy in recent years, is whether they work, if so how, and whether they are relevant to the more scientific psychotherapies?

"The new therapies must be seen socially and historically," he said. "They reflect a deepening revulsion against scientific technology and what it has brought" in terms of both physical and psychological depletions of the environment. "In general, there is an anti-intellectualism and loss of faith in conventional values and the materialism inherent in the scientific and technological establishment—a distrust of and rebellion against authority, feelings of loneliness within a crowd, loss of a sense of community, and a search for things beyond the material world." For those who are feeling these dissatisfactions the new therapies seem to offer some enticing answers: Self-acceptance without self-change, a cure without dealing with the reality of life, and synthetic and instant intimacy as a cure for loneliness, attractive promises to someone who is dissatisfied with the general social tone.

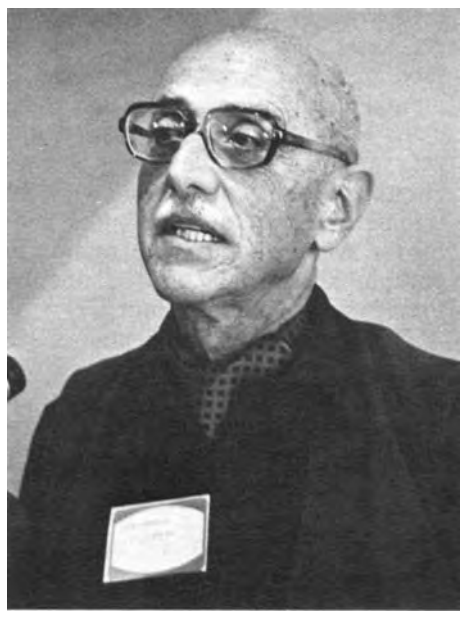
Although researchers would like to know what makes people change, said Marmor, the question is how to test the efficacy of therapy. It is hard to compare approaches, he acknowledged, although there have been some complex and objective studies.

He outlined seven basic elements of all therapeutic approaches that provide the core of the ability to help another:

- The therapist-patient relationship, which Marmor called "the crucial matrix within which progression or regression will take place. There are variables with the therapist, the patient, and with their interaction," he commented, "and therapists are not interchangeable. Transference and reality elements do matter."
- Reduction of emotional tension at the beginning of therapy with the expectation of getting help.
- Cognitive learning, which enables the patient to understand what is wrong, how, and how to get rid of it.
- Some degree of reshaping habits, which can be called "conditioning" and which occurs "through the implicit or explicit approval or disapproval of the therapist." Also involved in reshaping is what Marmor called the "corrective emotional experience"—reliving an experience in which the therapist behaves and responds more appropriately than past authority figures in the patient's life have done.
- Some degree of identification with the therapist.
- A degree of suggestion and persuasion, even if it is a focus on what should be changed.
- A certain amount of reality testing and rehearsal. "Knowledge from the therapist is translated into the ability to cope with life more effectively."

All seven elements, Marmor stressed, must occur within the context of emotional support and encouragement.

He clarified that the three major types of therapy are not mutually exclusive but may overlap and may occur in either a one-to-one or group situation. In fact, he said, psychiatrists perhaps have not taken full advantage of the possibilities of group therapy. The members of the group have a common problem to which they can all relate and provide mutual support; plus, they have the possible advantage of seeing their own problem mirrored in others. Self-help groups, he said, are especially useful for those who for some reason have a distrust of authority but share a common motivation. In California, he said, most self-help groups are being used as an extension of therapy by a trained therapist. "Our only concern," he added, "is adequate screening to assure that only those who can indeed benefit from the group experience are included. I look with a dim eye on anyone with the 'cure-all' for every problem. There is no single gimmick applicable to all human difficulties. We must question therapies marketed for everything which take all comers. They may have potential dangers for some people."



Judd Marmor, M.D.

On the other hand, when asked whether the experiential therapies are effective, he responded, "There is no question that many people get a transitory lift; the new therapies involve many of the qualities basic to therapy already noted. But whether they work? Psychiatrists do not dismiss them all as quackery, as the popular press often implies. Rather they look at them and study them. The question is one of 'working' in what sense—immediately? long-term?"

Also, he continued, we must question whether there is danger in these approaches. "Psychiatrists think there is some," Marmor affirmed. "Hard-sell marketing without screening diagnostically those who would benefit and those who would be vulnerable to harm should be avoided. There are serious outcomes on some occasions. The therapies may promote a degree of narcissism not altogether healthy—Tom Wolfe's 'me generation.' And we must also question the romantic notion that the internal lift will change the external reality." He described a scientific-therapeutic approach to understanding a therapeutic modality: "It involves a commitment to understanding what

See "Marmor," page 44

Eisenberg

Continued from page 1

three corresponding questions that he raised.

First, he contended that the cap on resources for mental health "reflects political priorities rather than immutable external forces.

"When the Congress votes $2 billion for a nuclear powered aircraft carrier, even though the President contends that it is unnecessary, at the same time that it cuts back on funding for ADAMHA, it is expressing its values," he argued.

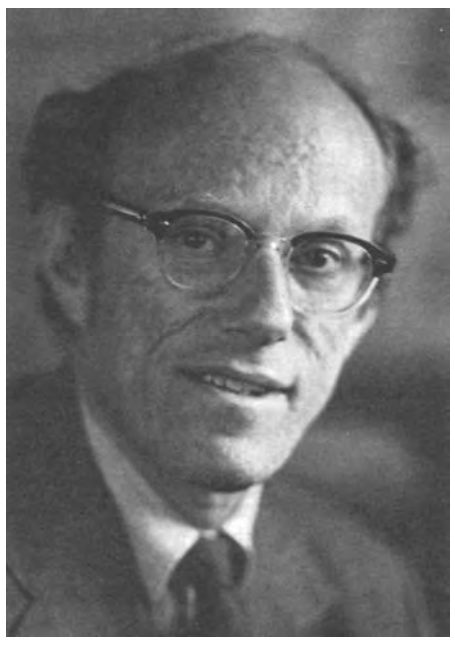
Fortifying his statements with facts, he pointed out that while the U.S. gross national product per capita "still exceeds that of most other countries, our rate of taxation is lower than many and our system of social welfare benefits is far from the most comprehensive. Consequently, it is clear that Americans could decide to do more, much more, than we are now doing. We may not wish to, but it is misleading to pretend that we cannot."

Moving to a second question of why professionals are taken for "special pleaders," Eisenberg replied that, in fact, they often are. He criticized all mental health professionals and physicians for too often serving self interests rather than patient needs, not exempting psychiatrists, who, he said, "sometimes act as if what is good for the APA is good for the nation, to paraphrase the late and unlamented President of General Motors."

The other part of the answer, he said, lies in public cynicism, so well justified by the government's fabrications about foreign and domestic policy that "the citizen who believes what he is told must be a visitor from Mars."

Yet the expert professional has a large contribution to make in attacking the problems ahead, he asserted. And when mental health workers request more services for the ill, "what is important to examine is the efficacy of those services, whether or not the providers enjoy added status."

Efficacy is the point. In asking the public to judge by the facts, Eisenberg said, professionals are obligated to



Leon Eisenberg, M.D.

make only realistic claims for services they provide. "In the past, we have issued far too many promissory notes we were unable to redeem. Where there is evidence that we do make a difference, we have a responsibility to say so and to lobby for universal access to effective services."

Taking a public health vantage to determine how resources can best be used to lighten the burden of illness, Eisenberg said that the priority assigned to an intervention should turn on three factors: prevalence of the illness, disability and mortality, and the success of known treatment to alter its course.

Relying on this framework, he said, programs now should concentrate on a full range of services for psychotic patients, the reintegration of mental health into general medical care, and the development of comprehensive maternal and child health programs. He described in greater detail how each of these programmatic thrusts fulfilled the public health criteria.

Assessing the net impact of mental disorders on the health of Americans, Eisenberg cited 1975 data by Dorothy Rice and co-workers that showed of all the major disease categories listed in the *International Classification of Diseases*, mental disorders "led the list" in days of hospitalization: 260 million making up just under 30 percent of the total from all causes for admission. They ranked third as a reason for social security disability, ninth as a cause of physician office visits, and tenth in days of work loss. Gathered under the rubric of economic costs, it totalled $19.3 billion or about eight percent of all health costs and was sixth on the list, according to Eisenberg.

Excluded in these estimates are mental problems that masquerade as physical ailments: patients who respond to stress with somatic symptoms or with such self-destructive behavior as is seen in the alcoholic patient hospitalized for cirrhosis, Eisenberg noted. Research also suggests that persons with strong interpersonal networks are at less risk for mortality and have fewer functional complaints and neurotic symptoms, he observed.

Moreover, Eisenberg continued, specific treatments combining psychological, social, and biomedical intervention have been shown to diminish this cumulative burden. For example, maintenance phenothiazines and participation in a day care program reduce relapse rates for psychotic patients returning to emotionally charged families but offer no benefits to patients from more neutral homes. With depressed patients, anti-depressive drugs are clearly superior to placebo or psychotherapy alone; but, Eisenberg stressed, "the social effectiveness of the formerly depressed patients six months later is considerably greater following psychotherapy plus drug than after drug alone." It is here, he said, that psychiatrists belong, not in treating the only mildly disturbed.

He conceded that there remains a "sizeable residue of patients with chronic psychotic disorders" who require a costly array of support services but contends that providing these "is the least any society which professes to be civilized owes to its most handicapped citizens."

Moving on to his second programmatic recommendation, Eisenberg pointed out that statistics from the National Institute of Mental Health show that more than half the care of patients diagnosed by their own physicians as suffering from psychological disorders is delivered by nonpsychiatric physicians, the quality of which is unknown. Averring that the numbers are too great to be absorbed by the mental health establishment and that it is better to treat them with-

See "Eisenberg," page 44

H&CP Institute Meets In Kansas City

By B. S. Herrington

WHILE APA's Atlanta meeting dwelt on the amorphous and all encompassing theme, "Time, Age, and Timelessness," its yearly fall interdisciplinary institute got down to the nuts-and-bolts of wringing the most from shrinking resources. The 30th Institute on Hospital & Community Psychiatry drew some 800 attendees from all parts of the country to Kansas City, Missouri, hoping to draw as well on their collective expertise to devise some creative solutions to the economic crunch being felt in every sector.

There were a few who took issue with some of the assumptions of the theme itself—"Quality Amidst Constraints: Creative Use of Limited Resources"—notably Harvard Professor Leon Eisenberg, M.D., who argued that the resources are there but the priorities are misplaced (see story on page 1). Robert Daly, M.D., Pennsylvania Commissioner of Mental Health, also questioned the inadequacy of manpower and other resources, hypothesizing instead that social and political trends have helped to dissolve the medical model, leading to an inefficiently administered mental health delivery system. Daly concurred with Lawrence Kubie's advice of decade ago that "the structure of a comprehensive community mental health delivery system would need to be developed by the intensive eclectic training of mature psychiatrists and other non-medical but clinical behavioral scientists," rather than human service generalists.

On a more positive note, he related that there is "much creative action by brilliant investigators" to solve these problems. "We are beginning to move rapidly to advance the technology in mental health planning, evaluation, management information, needs assessment, cost-benefit analysis, and manpower development."

On the whole, however, most participants peered through a pragmatic lens at the constraints they face on three levels: family support, programmatic, and administrative. In many of the workshops, the faculty explained their own innovative models. For example, Maureen E. Rooney, clinical director of the Bushwick Ridgewood Community Mental Health Service in New York, explained how they continue their work therapy program even though they cannot afford to pay their patients the minimum wage decreed by a recent court ruling. Their solution is to give patients working in the garden a share in the harvest and to offer boutique clerks small percentages of the profits.

On a different level, Thomas A. Coughlin III, Commissioner of the New York State Office of Mental Retardation and Developmental Disabilities, told of how they handled new compliance regulations for Title XIX funds issued by HEW several years ago for upgrading the physical plant by offering a counter proposal of their own to improve only facilities that would be needed in 1982 following deinstitutionalization. It was accepted, and they "completely turned about the system without any legislative input," he pointed out. Coughlin used this as a basis for arguing against an integrated legislated system that bogs down programs. The system now, he contends, allows a competent adminstrator much flexibility to use various parts to the clients' best advantage.

On the familial level, William Mello, M.S.S.W., described how the Home and Community Treatment Program of the Mendota Mental Health Institute in Madison, Wisconsin, keeps emotionally or behaviorally disturbed children from three to ten years old out of expensive residential treatment by sending teams out to the home to work with the family. Using a behavioral approach, they work with the parents and sometimes teachers to teach them how to ignore the negative aspects of the child's behavior while reinforcing the positive. Although funding ran out midway during their ten-year long-term study of results, Mello says they have prevented some 75 percent of the children from being "extruded," children whose diagnoses ranged from non-compliance to psychosis or autism.

More importantly, however, there was evidence at the conference that national calls for objective evaluations

Allan Beigel, M.D.

of the effectiveness of a plethora of treatments—the federal version of the old Missouri maxim of "show me"—is beginning to filter down to the front lines in the field. Wrap-up speaker Allan Beigel, M.D., underscored this in his final speech, noting, "Subjective evaluation is not sufficient; objective evaluation is necessary. Evaluation of content is not sufficient; examination of process is mandatory."

More and more service deliverers indicated an awareness that they need to do more evaluation and more research, particularly to justify requests for funds.

At a workshop on partial hospitalization, Raymond F. Luber, M.D., assistant professor of clinical psychiatry and director of the Adult Partial Hospitalization Service of the Western Psychiatric Institute in Pittsburgh, Pennsylvania, called on his colleagues to do research "whether we like it or not." Although he mentioned some research data regarding the effectiveness of partial hospitalization which has been accumulated in some areas, he said that many questions remain unanswered. Among these are what the effective and active ingredients are in a partial program; whether specific treatment approaches are more effective than others; whether partial is more effective with particular diagnostic categories than

See "H&CP," page 45

State Hospitals— Problems and Solutions

By John Wykert

PROFOUNDLY TROUBLED and yet unwilling to change, in a state of desuetude yet deemed essential, the state hospital is rapidly assuming a curiously paradoxical position in society. Seven speakers from six of the country's more populated states addressed themselves to the dilemma facing these institutions during the present period of changing expectations for mental illness care.

The leadoff speaker at the APA's annual meeting session, "State Hospitals: Problems and Solutions," was John A. Talbott, M.D., associate medical director of the Payne Whitney Psychiatric Clinic and associate professor of psychiatry at Cornell University Medical College. Talbott briefly summarized the problems of state mental hospitals. In New York State, these facilities are part of a formidable mental illness establishment that is endowed with large real estate holdings and huge and often outdated plants; a smaller patient population than before (mostly readmissions); and some 60,000 employees statewide, most of them unionized and with powerful political allies in the legislature. The total budget is a formidable $900 million. Yet, the staff of state hospitals "tends to reflect the low status and civil service mentality prevalent in state service," while treatment consists of "reliance on drugs and quasi-therapeutic milieus . . . as opposed to full-day involvement in active psychotherapy, socialization, and rehabilitation activities."

A major problem of the state hospital is politics, that of the state's department of mental hygiene, the service system, other state departments and agencies, the legislature, the 156 agencies that have authority to monitor and inspect hospitals in New York State, and—possibly most crucial—the lack of political clout. The mentally ill lack a constituency, and advocates as much as the hospitals lack funds. What is needed badly are changes in professional and societal attitudes, funding priorities and mechanisms, administrative structures and procedures, and program planning and implementation. Even then, the options are four-fold: to close, to stay as they are now, to institute radical reforms, or alter the state hospitals' present function.

"Alteration in functioning seems to be the easiest, the most likely, and the most feasible option open to the state hospitals. Such a solution would not endanger jobs, threaten local businesses, or eliminate entrenched bureaucracies," Talbott concludes. "Instead, it would retain the existing buildings, staff, and administrative structures, while altering the task performed.

"Several roles have been suggested for the state facility in the future: that of community mental health center, tertiary care facility, domiciliary care facility, and multi-purpose mental health service which would accommodate to the gaps in service as part of a comprehensive, unified network of services."

J. Frank James, M.D., deputy director of health and mental health program chief of the Fresno County Department of Health in Fresno, California, debated the advisability of replacing state hospitals. He pointed out that from his county, with a population of almost 500,000, the state hospital census is as high as 600 at one time. Although alternative programs have been developed, "there have been at any one time between five and eight extremely difficult-to-manage patients for whom we have still had to use the state hospital. There is constant pressure to admit more patients from the private sector and from clinic staff. Only strict criteria and a dedicated social service staff prevent the state hospital from being used inappropriately and much more frequently. So long as the state hospital exists, the pressure will be there to use it. Communities are reluctant to take on the responsibility for state hospital-type patients; but when the actual numbers of patients that are truly difficult to manage are identified, we may find that resources can be developed to take care of them. . . . For the use of the same mental health dollar, we do know in Fresno County that the $2 million budget in 1969 paid for 73,000 patient-days in the state hospital, while approximately the same budget in 1973 paid for 116,000 local community services."

In California, there has been an almost 90 percent reduction of state hospital patients, from 37,000 in 1955 to 4,000 in 1978. This is a reality that state hospital proponents must face, James pointed out. In his community, there is a clinically appropriate alternative, established in 1972 by the transfer of the state community social service staff to mental health. A program, called "Advocare" now assists the patient to keep them within the system. In 1977, the staff initiated a "high-risk team" that "carries a smaller caseload of the more difficult patients and placed themselves on 24-hour call for these patients. For those who are considering a similar case management approach, you will find that priorities must be established for their valuable skills. The case manager, by any name, is more than ever required as part of the replacement system for the state hospitals. We can anticipate that communities will need this track, if they are going to succeed and if they are going to be accountable for their patients."

In disagreement with this approach were Henry Brill, M.D., formerly deputy and first deputy commissioner of mental hygiene in New York State, and James T. Barter, M.D., professor of psychiatry, University of Cincinnati College of Medicine. Brill held that "it has already been demonstrated that it is possible to virtually abolish the state hospital system in several large jurisdictions, but it has not been proved that it is the best alternative for all cases. We now know we were misled in hoping that modern methods would reduce chronicity to the vanishing point. What remains to be determined is what proportion of persons have a better quality of life in state hospital-type accommodation and what proportion will do better in some type of community settings. It also remains to be determined what will be the relative cost of adequate care in both settings. Since it will always be possible to decommission these services—but difficult or impossible to reestablish them once they are

See "Hospital," page 24

Proposed Amendments To APA Constitution and Bylaws

IN DECEMBER 1977, the APA Board of Trustees voted to present amendments to the Constitution and Bylaws as proposed by the Joint Conference Committee on the Key Conference Recommendations to the membership at the annual meeting in 1978 so that the amendments could appear on the 1979 ballot. The Constitution and Bylaws Committee reviewed the amendments to ensure that they are in proper order and the Secretary reported official receipt of the amendments within the required 60 days before the opening of the annual meeting in 1978, where they were presented.

In keeping with the constitutional requirement that such amendments must be further disseminated to the entire membership (before January 1, 1979), the full text is presented below.

In May 1978, the Assembly established a task force to educate the membership as to the issues involved in the constitutional changes proposed by JCC. The task force was charged to recommend to the Assembly an educational program for APA members as to the advisability of the change in governance embodied in the constitutional amendments prepared by the JCC. The task force has this representation from each geographic APA Area: Warren Williams (VII) and James Trench (I) (co-chairpersons), Harvey Bluestone (II), Oscar Legault (III), Anne Seiden (IV), Pete Palastoa (V), and Robert Bittle (IV) (all M.D.s). The task force will report to the Assembly at its meeting October 13–15, 1978.

APA encourages district branches to discuss the proposed amendments before the ballots are mailed in February 1979. It has been suggested that district branch meetings in January 1979 be devoted to that discussion.

The proposed revision is published below without commentary at this time. However, *Psychiatric News* intends to publish commentaries in future issues.

Additional copies of the following pages, as a separate document, are available in reasonable quantities for the use of APA members of district branches. Write to *Psychiatric News,* stating quantity desired. Allow four weeks for delivery.

The first column is a reproduction of the present Constitution and Bylaws. The second lists changes/additions/deletions proposed by JCC. The third column is the proposed new Constitution and Bylaws with additions denoted by underlining and deletions denoted by brackets.

Amendments, unrelated to those below, have been proposed by the APA Committee on Constitution and Bylaws. Those proposals appear in the October *American Journal of Psychiatry*.

PRESENT APA CONSTITUTION (as amended in April 1977)	CHANGES PROPOSED	PROPOSED NEW CONSTITUTION
Article I. Name	**Article I. Name**	**Article I. Name**
The name of this corporation shall be the American Psychiatric Association. It was first designated as such in 1921 and incorporated in that name under the laws of the District of Columbia in 1927. This organization was founded in 1844 as the Association of Medical Superintendents of American Institutions for the Insane. From 1892 to 1921 it was known as the American Medico-Psychological Association.	NO CHANGE PROPOSED.	The name of this corporation shall be the American Psychiatric Association. It was first designated as such in 1921 and incorporated in that name under the laws of the District of Columbia in 1927. This organization was founded in 1844 as the Association of Medical Superintendents of American Institutions for the Insane. From 1892 to 1921 it was known as the American Medico-Psychological Association.
Article II. Objectives and Stipulations	**Article II. Objectives and Stipulations**	**Article II. Objectives and Stipulations**
1. The objectives of the Association are: (a) to improve the treatment, rehabilitation, and care of the mentally ill, the mentally retarded, and the emotionally disturbed; (b) to promote research, professional education in psychiatry and allied fields, and the prevention of psychiatric disabilities; (c) to advance the standards of all psychiatric services and facilities; (d) to foster the cooperation of all who are concerned with the medical, psychological, social, and legal aspects of mental health and illness; (e) to make psychiatric knowledge available to other practitioners of medicine, to scientists in other fields of knowledge, and to the public; and (f) to promote the best interests of patients and those actually or potentially making use of mental health services.	NO CHANGE PROPOSED.	1. The objectives of the Association are: (a) to improve the treatment, rehabilitation, and care of the mentally ill, the mentally retarded, and the emotionally disturbed; (b) to promote research, professional education in psychiatry and allied fields, and the prevention of psychiatric disabilities; (c) to advance the standards of all psychiatric services and facilities; (d) to foster the cooperation of all who are concerned with the medical, psychological, social, and legal aspects of mental health and illness; (e) to make psychiatric knowledge available to other practitioners of medicine, to scientists in other fields of knowledge, and to the public; and (f) to promote the best interests of patients and those actually or potentially making use of mental health services.
2. No substantial part of the activities of the Association shall be the carrying on of propaganda or otherwise attempting to influence legislation, and the Association shall not participate or intervene in (including the publishing or distribution of statements) any political campaign of any candidate for public office.	2. NO CHANGE PROPOSED.	2. No substantial part of the activities of the Association shall be the carrying on of propaganda or otherwise attempting to influence legislation, and the Association shall not participate or intervene in (including the publishing or distribution of statements) any political campaign of any candidate for public office.
Article III. Members	**Article III. Members**	**Article III. Members**
There shall be the following categories of membership: Life Fellows; Fellows; Life Members; General Members; Associate Members; Members-in-Training; Provisional Members; Distinguished Fellows; Honorary Fellows; Corresponding Fellows; Corresponding Members; Inactive Fellows; and Inactive Members, as defined in the By-Laws.	NO CHANGE PROPOSED.	There shall be the following categories of membership: Life Fellows; Fellows; Life Members; General Members; Associate Members; Members-in-Training; Provisional Members; Distinguished Fellows; Honorary Fellows; Corresponding Fellows; Corresponding Members; Inactive Fellows; and Inactive Members, as defined in the By-Laws.
Article IV. Board of Trustees	**Article IV. Assembly and the Executive Board**	**Article IV. [Board of Trustees] Assembly and the Executive Board**
There shall be a Board of Trustees as defined in the By-Laws. This Board of Trustees will hereinafter be referred to as the Board.	1. There shall be an Assembly as defined in the By-Laws, that shall be the governing body of the Association. 2. There shall also be an Executive Board as defined in the By-Laws. The Executive Board will hereafter be referred to as the Board.	1. There shall be [a Board of Trustees] an Assembly as defined in the By-Laws [.], that shall be the governing body of the Association. [This Board of Trustees will hereinafter be referred to as the Board.] 2. There shall also be an Executive Board as defined in the By-Laws. The Executive Board will hereafter be referred to as the Board.
Article V. Officers	**Article V. Officers**	**Article V. Officers**
The Officers of the Association shall be a President, a President-Elect, two Vice-Presidents, a Secretary, and a Treasurer.	The Officers of the Association shall be a President, a President-Elect, a Vice-President from each geographical Area of the Association, a Secretary, and a Treasurer. The Officers of the Assembly shall be a Speaker, Speaker-Elect and a Recorder.	The Officers of the Association shall be a President, a President-Elect, [two Vice-Presidents,] a Vice-President from each geographical area of the Association, a Secretary, and a Treasurer. The Officers of the Assembly shall be a Speaker, Speaker-Elect and a Recorder.
Article VI. District Branches and the Assembly	**Article VI. District Branches**	**Article VI. District Branches [and the Assembly]**
1. District Branches and the Assembly shall be established as provided for in the By-Laws. 2. Categories of membership in District Branches shall be consistent with Article III.	1. District Branches shall be established as provided for in the By-Laws. 2. Categories of membership in District Branches shall be consistent with Article III.	1. District Branches [and the Assembly] shall be established as provided for in the By-Laws. 2. Categories of membership in District Branches shall be consistent with Article III.
Article VII. Committees	**Article VII. Committees**	**Article VII. Committees**
1. There shall be the following Constitutional Committees: Executive, Ethics, Membership, Nominating, Constitution and By-Laws, Budget, Tellers and Reference; with functions and procedures as defined in the By-Laws or by the Board. 2. Other organizational components of the Association may be established as determined by the Board.	1. There shall be the following Constitutional Committees: Ethics, Membership, Nominating, Constitution and By-Laws, Budget, Tellers and Reference; with functions and procedures as defined in the By-Laws and in the Operations Manual. 2. Other organizational components of the Association may be established as authorized in the By-Laws.	1. There shall be the following Constitutional Committees: [Executive,] Ethics, Membership, Nominating, Constitution and By-Laws, Budget, Tellers and Reference; with functions and procedures as defined in the By-Laws [or by the Board.] and in the Operations Manual. 2. Other organizational components of the Association may be established as [determined by the Board.] authorized in the By-Laws.
Article VIII. Annual Meeting and Annual Business Meeting	**Article VIII. Annual Meeting and Annual Business Meeting**	**Article VIII. Annual Meeting and Annual Business Meeting**
A general meeting of the Association, including a Business Meeting, shall be held annually at such time and place as the Board shall determine.	NO CHANGE PROPOSED.	A general meeting of the Association, including a Business Meeting, shall be held annually at such time and place as the Board shall determine.
Article IX. Amendments	**Article IX. Amendments**	**Article IX. Amendments**
1. Proposals to amend the Constitution may originate either: (a) by a petition signed by 50 or more voting members, or (b) by resolution of the Board.	1. Proposals to amend the Constitution may originate either (a) by a petition signed by 50 or more voting members, or (b) by resolution of the Assembly.	1. Proposals to amend the Constitution may originate either (a) by a petition signed by 50 or more voting members, or (b) by resolution of the [Board.] Assembly.

PRESENT APA CONSTITUTION
(as amended in April 1977)

2. Proposed amendments to the Constitution shall be received by the Secretary at least 60 days before the Annual Meeting.

3. A proposed amendment shall be presented at the Annual Meeting and thereafter disseminated to the entire membership not later than January 1 of the following year. The proposed amendment shall be voted on by the eligible voting membership by secret mail ballot. Approval by two-thirds of at least 40 percent of the eligible voting members of the Association shall be required for adoption of the proposed amendment. If adopted, the amendment shall become effective upon certification by the Committee of Tellers to the Board unless a later effective date is specified on the ballot.

Article X. Distribution of Assets on Dissolution

In the event of the termination, dissolution, or the winding up of the affairs of the Association in any manner or for any reason whatsoever, its remaining assets, if any, shall be distributed to (and only to) one or more organizations described in Section 501(c)(3) of the Internal Revenue Code.

PRESENT APA BY-LAWS

Chapter One. Members

1. Adoption of this Constitution and By-Laws shall not change the membership status of present members at the time of adoption.

2. An applicant for membership shall be a resident of a country of North America, Central America, the Caribbean Islands or a dependency of such.

3. To maintain membership in good standing all members are required to participate in continuing education according to the standards of the Association.

4. (a) Provisional Members shall be physicians who are in their first year of an approved psychiatric residency training program, or approved internship preparatory to entering such an approved psychiatric residency training program. Provisional Membership shall not include voting privileges. (b) Members-in-Training shall be physicians who have completed one year of an approved psychiatric residency training program and remained enrolled therein. Member-in-Training status shall not exceed five years, and upon completion of approved residency training, Members-in-Training shall be advanced to General Membership. If approved residency training is not completed within five years, Members-in-Training shall be transferred to Associate Membership.

5. Associate Members shall be physicians who have completed at least one year of acceptable full-time training or experience in psychiatry but are not eligible for Membership-in-Training or General Membership categories. Associate Members must either have a valid license to practice medicine or hold an academic, research, or governmental position that does not require licensure.

6. General Members shall be physicians who have at least three years of acceptable training and who have either a valid license to practice medicine or hold an academic, research, or governmental position that does not require licensure.

7. Fellows shall have been General Members for at least five years and shall have made significant contribution to the field of psychiatry. At its discretion the Board, upon recommendation of the Membership Committee, may waive the requirement for five years as a General Member. The criteria and procedures for selection and nomination of General Members for Fellowship shall be established by the Board and the Membership Committee and shall apply uniformly for all District Branches.

8. Life Members and Life Fellows shall be those in their respective categories who have had 30 years of active membership in the Association.

9. Distinguished Fellows shall be physicians who have made significant contributions to psychiatry or related fields.

10. Honorary Fellows shall be persons other than physicians who have rendered signal service in the promotion of mental health and psychiatry.

11. Corresponding Fellows and Members shall be physicians living outside the jurisdiction of the Association who would otherwise be qualified for membership.

12. Inactive Members or Fellows shall be those whom the Board has, for sufficient reason, excused from paying dues.

Chapter Two. Membership Processing

1. Admission to membership shall require valid election by the appropriate District Branch approved to process membership applications with certification that the constitutional requirements for membership have been met.

An applicant for membership may be refused election or promotion to more advanced membership, or transfer to another District Branch, on the basis of the provisions of Chapter One of the By-Laws or on the basis of criteria of ethical and professional suitability established by the Board and the Membership Committee and applied by the appropriate District Branch. A rejected applicant must be informed by the District Branch of the right to appeal through the Recorder to the Assembly for adjudication.

If the local District Branch is not approved by the Board to process membership applications the District Branch shall forward the application with its recommendation to the Membership Committee of the Association.

An applicant for membership who does not live or practice within the jurisdiction of a District Branch may apply through the Secretary of the Association.

The Board shall be the final judge of the acceptability of all candidates for membership.

2. Advancement to Member-in-Training from Provisional Member, and to General Member from Member-in-Training or Associate Member shall be by the same process as for election to membership.

3. Fellows shall be chosen by the Board from among General Members upon recommendation of the Membership Committee.

4. Advancement to Life Membership or Life Fellowship shall be upon the Secretary's certification that the Member or Fellow has been an active member in good standing for 30 years.

5. Honorary or Distinguished Fellows may be elected by the Board upon recommendation of the Membership Committee. Any voting member may nominate a person for consideration.

6. Application for inactive status shall be directed to the Membership Committee. Recommendations shall be made to the Board for action.

7. Application for Corresponding Membership may be directed to the Membership Committee, which shall forward its recommendations to the Board. Corresponding Members or applicants for such status who have made distinguished contributions to psychiatry may be designated by the Board as Corresponding Fellows, upon recommendation of the Membership Committee.

8. When a member of a District Branch establishes practice in the jurisdictional area of another District Branch, his or her membership shall be transferred to the latter branch unless he or she is exempted, deferred, or rejected by that District Branch. An appeal from the decision of the District Branch may be made to the Assembly through the Recorder. A member may not hold voting membership in more than one District Branch.

Chapter Three. Board of Trustees

1. The primary function of the Board shall be to formulate and implement the policies of the Association.

2. The voting members of the Board shall consist of the six Officers of the Association, its three immediate Past Presidents, the Speaker of the Assembly, three Trustees elect-

CHANGES PROPOSED

2. NO CHANGE PROPOSED.

3. A proposed amendment shall be presented at the Annual Meeting and thereafter disseminated to the entire membership not later than January 1 of the following year. The proposed amendment shall be voted on by the eligible voting membership by secret mail ballot. Approval by a two-thirds vote, with at least 40 percent of the eligible voting members of the Association voting, shall be required for adoption of the proposed amendment. If adopted, the amendment shall become effective upon certification by the Committee of Tellers to the Board unless a later effective date is specified on the ballot.

Article X. Distribution of Assets on Dissolution

NO CHANGE PROPOSED.

Article XI. (New)

No provision of the By-Laws shall be inconsistent with any provisions of the Constitution. The Assembly shall have the authority to interpret the provisions of the Constitution and By-Laws.

CHANGES PROPOSED

Chapter One. Members

NO CHANGES PROPOSED.
(Sections 1 thru 6)

7. The criteria and procedures for selection and nomination of General Members for Fellowship shall be established by the Assembly and shall apply uniformly for all District Branches.

NO CHANGES PROPOSED.
(Sections 8 thru 12)

Chapter Two: Membership

1. Admission to membership shall require valid election by the appropriate District Branch, approved by the Assembly to process membership applications, with subsequent certification by the Membership Committee that the Constitutional requirements for membership have been met.

An applicant for membership may be refused election or promotion to more advanced membership, or transfer to another District Branch, on the basis of the provisions of Chapter One of the By-Laws or on the basis of criteria of ethical and professional suitability established by the Assembly and applied by the appropriate District Branch. A rejected applicant must be informed by the District Branch of the right to appeal through the Recorder to the Assembly for adjudication.

If the local District Branch is not approved by the Assembly to process membership applications, the District Branch shall forward the application with its recommendation to the Membership Committee of the Association.

An applicant for membership who does not live or practice within the jurisdiction of a District Branch may apply through the Secretary of the Association.

The Assembly shall be the final judge of the acceptability of all candidates for membership.

2. NO CHANGE PROPOSED.

3. Fellows shall be chosen by the Assembly from among General Members upon recommendation of the Board.

4. NO CHANGE PROPOSED.

5. Honorary or Distinguished Fellows may be elected by the Assembly upon recommendation of the Board. Any voting member may nominate a person for consideration.

6. NO CHANGE PROPOSED.

7. Application for Corresponding Membership may be directed to the Membership Committee, which shall forward its recommendations to the Board. Corresponding Members or applicants for such status who have made distinguished contributions to psychiatry may be designated by the Assembly as Corresponding Fellows, upon recommendation of the Board.

8. NO CHANGE PROPOSED.

Chapter Three. Executive Board

1. The primary function of the Board shall be to implement the policies of the Association.

2. The voting members of the Board shall consist of the Officers of the Association, and the immediate Past President. Past Presidents, after serving a one-year term, shall

PROPOSED NEW CONSTITUTION

2. Proposed amendments to the Constitution shall be received by the Secretary at least 60 days before the Annual Meeting.

3. A proposed amendment shall be presented at the Annual Meeting and thereafter disseminated to the entire membership not later than January 1 of the following year. The proposed amendment shall be voted on by the eligible voting membership by a secret mail ballot. Approval by a two-thirds [of] vote, with at least 40 percent of the eligible voting members of the Association voting, [members of the Association] shall be required for adoption of the proposed amendment. If adopted, the amendment shall become effective upon certification by the Committee of Tellers to the Board unless a later effective date is specified on the ballot.

Article X. Distribution of Assets on Dissolution

In the event of the termination, dissolution, or the winding up of the affairs of the Association in any manner or for any reason whatsoever, its remaining assets, if any, shall be distributed to (and only to) one or more organizations described in Section 501(c)(3) of the Internal Revenue Code.

Article XI.

No provision of the By-Laws shall be inconsistent with any provisions of the Constitution. The Assembly shall have the authority to interpret the provisions of the Constitution and By-Laws.

PROPOSED NEW BY-LAWS

Chapter One. Members

1. Adoption of this Constitution and By-Laws shall not change the membership status of present members at the time of adoption.

2. An applicant for membership shall be a resident of a country of North America, Central America, the Caribbean Islands or a dependency of such.

3. To maintain membership in good standing all members are required to participate in continuing education according to the standards of the Association.

4. (a) Provisional Members shall be physicians who are in their first year of an approved psychiatric residency training program, or approved internship preparatory to entering such an approved psychiatric residency training program. Provisional Membership shall not include voting privileges.
(b) Members-in-Training shall be physicians who have completed one year of an approved psychiatric residency training program and remained enrolled therein. Member-in-Training status shall not exceed five years, and upon completion of approved residency training, Members-in-Training shall be advanced to General Membership. If approved residency training is not completed within five years, Members-in-Training shall be transferred to Associate Membership.

5. Associate Members shall be physicians who have completed at least one year of acceptable full-time training or experience in psychiatry but are not eligible for Membership-in-Training or General Membership categories. Associate Members must either have a valid license to practice medicine or hold an academic, research, or governmental position that does not require licensure.

6. General Members shall be physicians who have at least three years of acceptable training and who have either a valid license to practice medicine or hold an academic, research, or governmental position that does not require licensure.

7. Fellows shall have been General Members for at least five years and shall have made a significant contribution to the field of psychiatry. At its discretion the Board, upon recommendation of the Membership Committee, may waive the requirement for five years as a General Member. The criteria and procedures for selection and nomination of General Members for Fellowship shall be established by the [Board and the Membership Committee] Assembly and shall apply uniformly for all District Branches.

8. Life Members and Life Fellows shall be those in their respective categories who have had 30 years of active membership in the Association.

9. Distinguished Fellows shall be physicians who have made significant contributions to psychiatry or related fields.

10. Honorary Fellows shall be persons other than physicians who have rendered signal service in the promotion of mental health and psychiatry.

11. Corresponding Fellows and Members shall be physicians living outside the jurisdiction of the Association who would otherwise be qualified for membership.

12. Inactive Members or Fellows shall be those whom the Board has, for sufficient reason, excused from paying dues.

Chapter Two. Membership [Processing]

1. Admission to membership shall require valid election by the appropriate District Branch, approved by the Assembly to process membership applications, with subsequent certification by the Membership Committee that the constitutional requirements for membership have been met.

An applicant for membership may be refused election or promotion to more advanced membership, or transfer to another District Branch, on the basis of the provisions of Chapter One of the By-Laws or on the basis of criteria of ethical and professional suitability established by the [Board and the Membership Committee] Assembly and applied by the appropriate District Branch. A rejected applicant must be informed by the District Branch of the right to appeal through the Recorder to the Assembly for adjudication.

If the local District Branch is not approved by the [Board] Assembly to process membership applications, the District Branch shall forward the application with its recommendation to the Membership Committee of the Association.

An applicant for membership who does not live or practice within the jurisdiction of a District Branch may apply through the Secretary of the Association.

The [Board] Assembly shall be the final judge of the acceptability of all candidates for membership.

2. Advancement to Member-in-Training from Provisional Member, and to General Member from Member-in-Training or Associate Member shall be by the same process as for election to membership.

3. Fellows shall be chosen by the [Board] Assembly from among General Members upon recommendation of the [Membership Committee.] Board.

4. Advancement to Life Membership or Life Fellowship shall be upon the Secretary's certification that the Member or Fellow has been an active member in good standing for 30 years.

5. Honorary or Distinguished Fellows may be elected by the [Board] Assembly upon recommendation of the [Membership Committee.] Board. Any voting member may nominate a person for consideration.

6. Application for inactive status shall be directed to the Membership Committee. Recommendations shall be made to the Board for action.

7. Application for Corresponding Membership may be directed to the Membership Committee, which shall forward its recommendations to the Board. Corresponding Members or applicants for such status who have made distinguished contributions to psychiatry may be designated by the [Board] Assembly as Corresponding Fellows, upon recommendation of the [Membership Committee.] Board.

8. When a member of a District Branch establishes practice in the jurisdictional area of another District Branch, his or her membership shall be transferred to the latter branch unless he or she is exempted, deferred, or rejected by that District Branch. An appeal from the decision of the District Branch may be made to the Assembly through the Recorder. A member may not hold voting membership in more than one District Branch.

Chapter Three. [Board of Trustees] Executive Board

1. The primary function of the Board shall be to [formulate and] implement the policies of the Association.

2. The voting members of the Board shall consist of the [six] Officers of the Association, [its three] and the immediate Past [Presidents, the Speaker of the Assembly, three

PRESENT APA BY-LAWS	CHANGES PROPOSED	PROPOSED NEW BY-LAWS
ed at large, and one Trustee elected by the membership of each geographical area defined by the Assembly. Past Presidents, after serving a three-year term, shall continue as members of the Board without a vote.	continue as members of the Board without vote. The Speaker, Speaker-Elect and the Medical Director shall be ex officio members of the Board without a vote.	Trustees elected at large, and one Trustee elected by the membership of each geographical area defined by the Assembly.] President. Past Presidents, after serving a [three-year] one-year term, shall continue as members of the Board without a vote. The Speaker, Speaker Elect and the Medical Director shall be ex officio members of the Board without a vote.
3. Each year two Area Trustees and one Trustee-at-Large will be elected for three-year terms, until such time as the number of areas may be increased. Candidates for Trustee-at-Large will be nominated by procedures established by the Board. Area Trustees shall be nominated and elected by procedures established by the Assembly. An appointed Trustee who fills an unexpired term is eligible for election to a full term. An elected Trustee, following a three-year term, may succeed himself or herself. Following two full terms, a Trustee becomes eligible for election again only after an interval of three years.	3. Each year two or three Vice-Presidents shall be elected for three-year terms, until such time as the number of areas may be increased. An appointed Vice-President who fills an unexpired term is eligible for election to a full term. An elected Vice-President, following a three-year term, may succeed himself or herself. Following two full terms, a Vice-President becomes eligible for election again to the same office only after an interval of three years.	3. Each year two [Area Trustees and one Trustee-at-Large will] or three Vice-Presidents shall be elected for three-year terms, until such time as the number of areas may be increased. [Candidates for Trustee-at-Large will be nominated by procedures established by the Board. Area Trustees shall be nominated and elected by procedures established by the Assembly.] An appointed [Trustee] Vice-President who fills an unexpired term is eligible for election to a full term. An elected [Trustee,] Vice-President, following a three-year term, may succeed himself or herself. Following two full terms, a [Trustee] Vice-President becomes eligible for election again to the same office only after an interval of three years.
4. A majority of the voting members of the Board shall constitute a quorum.	4. NO CHANGE PROPOSED.	4. A majority of the voting members of the Board shall constitute a quorum.
5. The Board shall meet during the time of the Annual Meeting of the Association and at such other times as the President may decide. By petition, one-third of its voting members may call a special meeting of the Board.	5. NO CHANGE PROPOSED.	5. The Board shall meet during the time of the Annual Meeting of the Association and at such other times as the President may decide. By petition, one-third of its voting members may call a special meeting of the Board.
6. The Executive Committee of the Board shall consist of the Officers of the Association, the Speaker of the Assembly, and two Trustees designated by the Board at the Annual Meeting.	6. DELETED	[6. The Executive Committee of the Board shall consist of the Officers of the Association, the Speaker of the Assembly, and two Trustees designated by the Board at the Annual Meeting.]
7. In the intervals between Board meetings, the Executive Committee shall exercise the powers of the Board. All actions of the Executive Committee shall be reported to the Board at its next meeting for ratification.	7. DELETED	[7. In the intervals between Board meetings, the Executive Committee shall exercise the powers of the Board. All actions of the Executive Committee shall be reported to the Board at its next meeting for ratification.]
8. The Board shall exercise all the powers of the Association that are not otherwise assigned. The responsibilities of the Board shall include: (a) Interpreting the provisions of the Constitution and By-Laws. (b) Presenting an annual report on the finances of the Association to the business session of the Annual Meeting. (c) Establishing dues and assessments for the several categories of membership. (d) Controlling the funds of the Association and designating its depositories. (e) Authorizing expenditures from the funds of the Association to implement its goals and purposes. (f) Administering special funds, grants, and awards. (g) Reviewing applications for District Branch charters after the Assembly has taken appropriate action, and approving recommendations for redistricting geographical areas. (h) Acting upon matters referred from the Assembly. (i) Publishing *The American Journal of Psychiatry* and appointing its editor and editorial board or publication committee. (j) Providing for the production of other publications useful in carrying out the aims of the Association. (k) Appointing a Medical Director who shall function as the full-time administrator of the Association in order to carry out its purposes and resolves. (l) Appointing or authorizing the appointment of administrative staff personnel under the immediate authority of the Medical Director to assist in carrying out the purposes and resolves of the Association. (m) Appointing and employing professional auditors and others to assist in carrying out the purposes and resolves of the Association. (n) Establishing salaries for the Medical Director and staff, and determining compensation for services rendered or to be rendered by others. (o) Preparing an Operations Manual as a guide to the implementation of the purposes and resolves of the Association. (p) Dissolving or modifying any council, commission, nonconstitutional committee, or other appointed organizational entity. (q) Performing all other acts consistent with the Constitution and By-Laws that may be needed to carry out the purposes and resolves of the Association.	8. *renumbered* 6. 6. The Board shall exercise all the powers of the Association in the interim between meetings of the Assembly. All actions of the Board shall be reported to the Assembly at its next meeting for ratification. The Board shall prepare an Operations Manual for approval by the Assembly. The Board shall be governed by the Operations Manual which shall serve as a guide to the implementation of the purposes of the Association. (NEW SECTIONS) 7. The Board shall have the authority to delay implementation of an Assembly decision for reconsideration at the next meeting of the Assembly. If the decision is reaffirmed the Board shall implement the decision without further dealy. 8. In emergencies the President, the Speaker of the Assembly and the Medical Director acting jointly have authority to take necessary actions on behalf of the Association. All actions taken under this authority shall be reported to the next meeting of the Board or the Assembly for ratification.	[8.] 6. The Board shall exercise all the powers of the Association [that are not otherwise assigned. The responsibilities of the Board shall include: (a) Interpreting the provisions of the Constitution and By-Laws. (b) Presenting an annual report on the finances of the Association to the business session of the Annual Meeting. (c) Establishing dues and assessments for the several categories of membership. (d) Controlling the funds of the Association and designating its depositories. (e) Authorizing expenditures from the funds of the Association to implement its goals and purposes. (f) Administering special funds, grants, and awards. (g) Reviewing applications for District Branch charters after the Assembly has taken appropriate action and approving recommendations for redistricting geographical areas. (h) Acting upon matters referred from the Assembly. (i) Publishing *The American Journal of Psychiatry* and appointing its editor and editorial board or publication committee. (j) Providing for the production of other publications useful in carrying out the aims of the Association. (k) Appointing a Medical Director who shall function as the full-time administrator of the Association in order to carry out its purposes and resolves. (l) Appointing or authorizing the appointment of administrative staff personnel under the immediate authority of the Medical Director to assist in carrying out the purposes and resolves of the Association. (m) Appointing and employing professional auditors and others to assist in carrying out the purposes and resolves of the Association. (n) Establishing salaries for the Medical Director and staff, and determining compensation for services rendered or to be rendered by others. (o) Preparing an Operations Manual as a guide to the implementation of the purposes and resolves of the Association. (p) Dissolving or modifying any council, commission, nonconstitutional committee, or other appointed organizational entity. (q) Performing all other acts consistent with the Constitution and By-Laws that may be needed to carry out the purposes and resolves of the Association.] in the interim between meetings of the Assembly. All actions of the Board shall be reported to the Assembly at its next meeting for ratification. The Board shall be governed by the Operations Manual which shall serve as a guide to the implementation of the purposes of the Association. 7. The Board shall have the authority to delay implementation of an Assembly decision for reconsideration at the next meeting of the Assembly. If the decision is reaffirmed the Board shall implement the decision without further delay. 8. In emergencies the President, the Speaker of the Assembly and the Medical Director acting jointly have authority to take necessary actions on behalf of the Association. All actions taken under this authority shall be reported to the next meeting of the Board or the Assembly for ratification.
Chapter Four. Officers	**Chapter Four. Officers**	**Chapter Four. Officers**
1. The President shall be the chief executive officer of the Association and shall carry out all orders and resolves of the Board and the membership.	1. The President shall be the chief executive officer of the Association and shall carry out all orders and resolves of the Assembly and the membership.	1. The President shall be the chief executive officer of the Association and shall carry out all orders and resolves of the [Board] Assembly and the membership.
2. The President shall preside at all general meetings of the Association, and at all meetings of the Board and of the Executive Committee. The President shall appoint the personnel of all councils, committees, commissions, and boards, and may establish and appoint the personnel of other special organizational entities.	2. The President shall preside at all general meetings of the Association, and at all meetings of the Board. The President shall appoint the personnel of all councils, committees, commissions, and boards, and may establish and appoint the personnel of other special organizational entities.	2. The President shall preside at all general meetings of the Association, and at all meetings of the Board [and of the Executive Committee]. The President shall appoint the personnel of all councils, committees, commissions, and boards, and may establish and appoint the personnel of other special organizational entities.
3. Each Vice-President shall perform the duties assigned or delegated by the President.	3. Each Vice-President shall perform the duties assigned or delegated by the President and shall be a voting member of his or her respective Area Council. Each Vice-President shall inform his or her Area Council of the actions of the Board.	3. Each Vice-President shall perform the duties assigned or delegated by the President [.] and shall be a voting member of his or her respective Area Council. Each Vice-President shall inform his or her Area Council of the actions on the Board.
4. The Secretary shall keep the records of the Association and perform all duties prescribed herein and those delegated by the Board.	4. NO CHANGE PROPOSED.	4. The Secretary shall keep the records of the Association and perform all duties prescribed herein and those delegated by the Board.
5. The Treasurer or his or her authorized agents shall receive, disburse, account for, and manage all monies of the Association under the general direction of the Board. The Treasurer shall submit a financial statement each year to the Board and to the Assembly at the Annual Meeting. The Treasurer and his or her authorized agents shall be bonded in an amount to be determined by the Board.	5. The Treasurer or his or her authorized agents shall receive, disburse, account for, and manage all monies of the Association under the policies established by the Assembly. The Treasurer shall submit a financial statement each year to the Board and to the Assembly at the Annual Meeting. The Treasurer and his or her authorized agents shall be bonded in an amount to be determined by the Board.	5. The Treasurer or his or her authorized agents shall receive, disburse, account for, and manage all monies of the Association under the [general direction of the Board.] policies established by the Assembly. The Treasurer shall submit a financial statement each year to the Board and to the Assembly at the Annual Meeting. The Treasurer and his or her authorized agents shall be bonded in an amount to be determined by the Board.
6. The President-Elect shall be installed as President during the Annual Meeting. All other Officers and newly elected Trustees of the Association shall assume their responsibilities at the same time.	6. The President-Elect shall be installed as President during the Annual Meeting. All other Officers of the Association shall assume their responsibilities at the same time.	6. The President-Elect shall be installed as President during the Annual Meeting. All other Officers [and newly elected Trustees] of the Association shall assume their responsibilities at the same time.
7. The President and Vice-Presidents are ineligible for reelection to the same office. The President shall hold office for one year. The Vice-Presidents shall be elected in alternate years and each shall hold office for two years. The Secretary and Treasurer shall be elected in alternate years and each shall hold office for two years.	7. The President is ineligible for reelection to the same office after serving one full term. The President shall hold office for one year. The Vice-Presidents shall hold office for three years. An appointed Vice-President who fills an unexpired term is eligible for election to a full term. An elected Vice-President, following a three-year term may succeed him/herself. Following two full terms, a Vice-President becomes eligible for election again to the same office only after an interval of three years. The Secretary and Treasurer shall be elected in alternate years and each shall hold office for two years.	7. The President [and Vice-Presidents are] is ineligible for relection to the same office [.] after serving one full term. The Vice-Presidents shall [be elected in alternate years and each hold office for two years.] hold office for three years. An appointed Vice-President who fills an unexpired term is eligible for election to a full term. An elected Vice-President, following a three-year term may succeed him/herself. Following two full terms, a Vice-President becomes eligible for election again to the same office only after an interval of three years. The Secretary and Treasurer shall be elected in alternate years and shall hold office for two years.
8. Vacancies (a) If the President becomes unable to function because of absence or illness, the Board shall select one of the Vice-Presidents to act for the President. In the event of the resignation or death of the President, the Board shall select one of the Vice-Presidents to become President for the remainder of the term. (b) If the position of President-Elect becomes vacant during the term, the Board shall select one of the Vice-Presidents to serve as President-Elect, and he or she shall be installed as President at the next Annual Meeting. (c) If any other office becomes vacant, the Board shall select any voting member of the Association to fill that office for the remainder of the term.	8. Vacancies (a) If, for any reason, the President becomes unable to function because of absence or illness, the President-Elect shall assume the duties of the office. (b) If any other office becomes vacant, the office may be filled by a special election.	8. Vacancies (a) If, for any reason, the President becomes unable to function because of absence or illness, the [Board shall select one of the Vice-Presidents to act for the President.] President-Elect shall assume the duties of the office. [In the event of the resignation or death of the President, the Board shall select one of the Vice-Presidents to become President for the remainder of the term.] (b) [If the position of President-Elect becomes vacant during the term, the Board shall select one of the Vice-Presidents to serve as President-Elect, and he or she shall be installed as President at the next Annual Meeting. (c) If any other office becomes vacant, the Board shall select any voting member of the Association to fill that office for the remainder of the term.] If any other office becomes vacant, the office may be filled by a special election.
Chapter Five. Seal	**Chapter Five. Seal**	**Chapter Five. Seal**
The Association shall have a Corporate Seal upon which shall be inscribed the name of the Corporation, the year of its organization, and the words "Corporate Seal, District of Columbia." The Association may alter the seal and prescribe its use.	NO CHANGE PROPOSED.	The Association shall have a Corporate Seal upon which shall be inscribed the name of the Corporation, the year of its organization, and the words "Corporate Seal, District of Columbia." The Association may alter the seal and prescribe its use.
Chapter Six. Councils, Committees, Boards, and Other Organizational Entities	**Chapter Six. Councils, Committees, Commissions, Boards, and Other Organizational Entities**	**Chapter Six. Councils, Committees, Commissions, Boards, and Other Organizational Entities**
1. The President, with the approval of the Board or the Executive Committee, shall establish or eliminate committees, councils, commissions, and boards as may be necessary to implement the objectives of the Association.	1. The President, with the approval of the Assembly shall establish or eliminate committees, councils, commissions, and boards as may be necessary to implement the objectives of the Association.	1. The President, with the approval of the [Board or the Executive Committee,] Assembly shall establish or eliminate committees, councils, commissions, and boards as may be necessary to implement the objectives of the Association.
2. Ad hoc committees, when appointed, shall act through the next Annual Meeting.	2. NO CHANGE PROPOSED.	2. Ad hoc committees, when appointed, shall act through the next Annual Meeting.
3. Unless otherwise specified by the President, with the approval of the Board or the Executive Committee, members of the Constitutional Committees established by Article VII, Section 1, of the Constitution shall be appointed for terms of three years. The terms of other committees, councils, commissions, boards, and other organizational entities shall be determined by the President, with the approval of the Board or the	3. Members of the Constitutional Committees established by Article VII, Section 1, of the Constitution shall be appointed for terms of three years unless otherwise specified by the President, with the approval of the Assembly. The terms of other committees, councils, commissions, boards, and other organizational entities shall be determined by the President, with the approval of the Assembly. Each year the President then in	3. [Unless otherwise specified by the President, with the approval of the Board or the Executive Committee, members] Members of the Constitutional Committees established by Article VII, Section 1, of the Constitution shall be appointed for terms of three years [.] unless otherwise specified by the President, with the approval of the Assembly. The terms of other committees, councils, commissions, boards, and other

PRESENT APA BY-LAWS	CHANGES PROPOSED	PROPOSED NEW BY-LAWS
Executive Committee. Each year the President then in office shall designate the chairperson and members of each committee, council, commission, board, or other organizational entity from among the voting members. Members and nonmembers of the Association may be designated as advisors or consultants. The President, with the consent of the Board or Executive Committee, may replace any individual as a member of a committee, council, commission, board, or other appointed organizational entity, for good and sufficient reasons.	office shall designate the chairperson of each committee, council, commission, board, or other organizational entity from among the voting members and shall fill any vancancies therein. Members and nonmembers of the Association may be designated as advisors or consultants. The President, with the consent of the Board, may replace any individual as a member of a committee, council, commission, board, or other appointed organizational entity, for good and sufficient reasons.	organizational entities shall be determined by the President, with the approval of the [Board or the Executive Committee.] Assembly. Each year the President then in office shall designate the chairperson [and members] of each committee, council, commission, board, or other organizational entity from among the voting members [.] and shall fill any vacancies therein. Members and nonmembers of the Association may be designated as advisors or consultants. The President, with the consent of the Board [or Executive Committee], may replace any individual as a member of a committee, council, commission, board, or other appointed organizational entity, for good and sufficient reasons.
4. No member of the Association or organizational unit thereof shall speak in the name of or encumber the funds of the Association unless such power is specifically granted by a formal action of the Board.	4. No member of the Association or organizational unit thereof shall speak in the name of or encumber the funds of the Association unless such power is specifically granted by a formal action of the Assembly.	4. No members of the Association or organizational unit thereof shall speak in the name of or encumber the funds of the Association, unless such power is specifically granted by a formal action of the [Board] Assembly.
5. The Nominating Committee shall be appointed by the President within the first sixty days of his or her term of office and shall be comprised of a representative from each geographical area of the Assembly plus a chairperson. Each Area Council shall propose at least three candidates and the President shall appoint the members from among those candidates. The President may choose any voting member as chairperson of the Committee. The Committee shall nominate at least two candidates for each office and report its nomination to the Board by October 1 for immediate dissemination to the members.	5. NO CHANGE PROPOSED.	5. The Nominating Committee shall be appointed by the President within the first sixty days of his or her term of office and shall be comprised of a representative from each geographical area of the Assembly plus a chairperson. Each Area Council shall propose at least three candidates and the President shall appoint the members from among those candidates. The President may choose any voting member as chairperson of the Committee. The Committee shall nominate at least two candidates for each office and report its nomination to the Board by October 1 for immediate dissemination to the members.
6. The President, with the approval of the Board or the Executive Committee, is authorized to establish councils composed of five voting members. Each council shall have authority to create and eliminate task forces and to act, subject to the approval of the Board, within its area of interest to implement the objectives of the Association.	6. The President, with the approval of the Assembly, is authorized to establish councils composed of five voting members. Subject to the approval of the Board, each council may create and eliminate task forces and act within its area of interest to implement the objectives of the Association.	6. The President, with the approval of the [Board or the Executive Committee,] Assembly, is authorized to establish councils composed of five voting members. [Each council shall have authority to create and eliminate task forces and to act, subject] Subject to the approval of the Board, each council may create and eliminate task forces and act within its area of interest to implement the objectives of the Association.
7. A Reference Committee shall be established to act upon the concerns of the several councils and to refer matters to and from the Board. It shall be comprised of the President-Elect, who shall be the chairperson, the chairperson of each council, the Speaker-Elect of the Assembly, and the Medical Director.	7. A Reference Committee shall be established to act upon the concerns of the several councils and to refer matters to and from the Board and the Assembly. It shall be comprised of the President-Elect, who shall be the chairperson, the Speaker-Elect of the Assembly, the Medical Director, the chairperson of each council, and chairpersons of such other components as specified in the Operations Manual.	7. A Reference Committee shall be established to act upon the concerns of the several councils and to refer matters to and from the Board [.] and the Assembly. It shall be comprised of the President-Elect, who shall be the chairperson, [the chairperson of each council,] the Speaker-Elect of the Assembly, [and] the Medical Director [.], the chairperson of each council, and chairpersons of such other components as specified in the Operations Manual.
8. The Program Committee shall have the authority over the arrangements and content of the scientific program of the Annual Meeting subject to the approval of the Board.	8. NO CHANGE PROPOSED.	8. The Program Committee shall have the authority over the arrangements and content of the scientific program of the Annual Meeting subject to the approval of the Board.
9. The Ethics Committee shall consist of six voting members, at least one of whom shall be Past President of the Association. The terms of the members shall be adjusted so that each year two seats become vacant.	9. NO CHANGE PROPOSED.	9. The Ethics Committee shall consist of six voting members, at least one of whom shall be Past President of the Association. The terms of the members shall be adjusted so that each year two seats become vacant.
Chapter Seven. The Assembly and the District Branches	**Chapter Seven. The Assembly and the District Branches**	**Chapter Seven. The Assembly and the District Branches**
1. The Assembly shall be comprised of an elected representative and alternate representative from each District Branch.	1. The Assembly shall be comprised of elected Representatives and Deputy Representatives from each District Branch, the Speaker, Speaker-Elect, Recorder, an Area Representative and a Deputy Area Representative from each Area, and such other members, including representatives of underepresented groups, as may be designated in the Operations Manual.	1. The Assembly shall be comprised of [an] elected [representative] Representatives and [alternate representative] Deputy Representatives from each District Branch [.], the Speaker, Speaker-Elect, Recorder, an Area Representative, and a Deputy Area Representative from each Area, and such other members, including representatives of underrepresented groups, as may be designated in the Operations Manual.
2. The Assembly shall govern itself by its Procedural Code in a manner consistent with the Constitution and By-Laws of the Association.	2. The Assembly shall govern itself in accordance with the Operations Manual consistent with the Constitution and By-Laws of the Association.	2. The Assembly shall govern itself [by its Procedural Code in a manner] in accordance with the Operations Manual consistent with the Constitution and By-Laws of the Association.
	New 3.	
	3. Voting by the Assembly shall be according to voting strength on all substantive issues. Procedures for determining whether an issue is substantive shall be specified in the Operations Manual.	3. Voting by the Assembly shall be according to voting strength on all substantive issues. Procedures for determining whether an issue is substantive shall be specified in the Operations Manual.
3. District Branches shall be established, continued, or dissolved according to the Procedural Code of the Assembly.	3. *renumbered* 4. 4. District Branches shall be established, continued, or dissolved according to the Operations Manual of the Association.	[3.] 4. District Branches shall be established, continued, or dissolved according to the [Procedural Code of the Assembly.] Operations Manual of the Association.
4. The Assembly shall group contiguous District Branches into Areas, not exceeding a total of ten Areas, from which Area Trustees shall be elected under the provisions of Chapter Three, Section 3 of the By-Laws.	4. *renumbered* 5. 5. The Assembly shall group contiguous District Branches into Areas, not exceeding a total of ten Areas, from which Area Vice-Presidents shall be elected under the provisions of Chapter Nine, Section 1 of the By-Laws.	[4.] 5. The Assembly shall group contiguous District Branches into Areas, not exceeding a total of ten Areas, from which Area [Trustees] Vice-Presidents shall be elected under the provisions of Chapter [Three,] Nine, Section [3] 1 of the By-Laws.
5. The Officers of the Assembly shall be the Speaker, Speaker-Elect, and Recorder. The Speaker shall be the presiding officer at the Assembly.	5. *renumbered* 6. 6. NO CHANGE PROPOSED.	[5.] 6. The Officers of the Assembly shall be the Speaker, Speaker-Elect, and Recorder. The Speaker shall be the presiding officer at the Assembly.
6. The Assembly, by a majority vote, is authorized to submit referenda to the eligible voting membership of the Association. A proposed referendum accompanied by a statement of purpose shall be submitted to the Secretary of the Association for dissemination to the membership prior to the next mail ballot of the Association and it shall be voted on in that mail ballot. The ballot may carry the recommendation of the Board FOR or AGAINST the proposed measure. The adoption of a referendum shall require: (a) valid ballots from at least 40 percent of the membership; (b) a simple majority of those voting. After a referendum is approved by the Assembly, the Board or the Executive Committee shall review it to determine whether any conflict with the Constitution and By-Laws or with the legal status or established policy of the Association exists and shall formulate an opinion on any such conflicts before it is circulated to the members. The circulated referendum shall carry with it both the opinion of the Board and the opinion of those initiating the referendum.	6. *renumbered* 7. 7. The Assembly, by a majority vote, may submit referenda to the eligible voting membership of the Association. A proposed referendum accompanied by a statement of purpose shall be submitted to the Secretary of the Association for dissemination to the membership prior to the next mail ballot of the Association and it shall be voted on in that mail ballot. The adoption of a referendum shall require (a) valid ballots from at least 40 percent of the membership; (b) a simple majority of those voting.	[6.] 7. The Assembly, by a majority vote, [is authorized to] may submit referenda to the eligible voting membership of the Association. A proposed referendum accompanied by a statement of purpose shall be submitted to the Secretary of the Association for dissemination to the membership prior to the next mail ballot of the Association and it shall be voted on in that mail ballot. [The ballot may carry the recommendation of the Board FOR or AGAINST the proposed measure.] The adoption of a referendum shall require (a) valid ballots from at least 40 percent of the membership; (b) a simple majority of those voting. [After a referendum is approved by the Assembly, the Board or the Executive Committee shall review it to determine whether any conflict with the Constitution and By-Laws or with the legal status or established policy of the Association exists and shall formulate an opinion on any such conflicts before it is circulated to the members. The circulated referendum shall carry with it both the opinion of the Board and the opinion of those initiating the referendum.]
	New Section. 8. The primary function of the Assembly shall be the management and direction of the Association and the establishment of policies to carry out the purposes of the Association. In so doing, it may exercise or delegate any of the powers of the Association not otherwise assigned in the Constitution and By-Laws.	8. The primary function of the Assembly shall be the management and direction of the Association and the establishment of policies to carry out the purposes of the Association. In so doing, it may exercise or delegate any of the powers of the Association not otherwise assigned in the Constitution and By-Laws.
	New Section. 9. There shall be an Assembly Agenda Committee. It shall be composed of the Speaker, Speaker-Elect, Recorder, and an Area Representative or Deputy Representative from each Area of the Association. Its function shall be to facilitate the functioning of the Assembly. It shall not have any of the powers of the Assembly in the interim between meetings of the Assembly.	9. There shall be an Assembly Agenda Committee. It shall be composed of the Speaker, Speaker-Elect, Recorder, and an Area Representative or Deputy Representative from each Area of the Association. Its function shall be to facilitate the functioning of the Assembly. It shall not have any of the powers of the Assembly in the interim between meetings of the Assembly.
Chapter Eight. Privileges and Responsibilities	**Chapter Eight. Privileges and Responsibilities**	**Chapter Eight. Privileges and Responsibilities**
1. All members of the American Psychiatric Association shall be bound by the ethical code of the medical profession, specifically defined in the *Principles of Medical Ethics* of the American Medical Association.	1. NO CHANGE PROPOSED.	1. All members of the American Psychiatric Association shall be bound by the ethical code of the medical profession, specifically defined in the Principles of Medical Ethics of the American Medical Association.
2. The right to vote, to nominate candidates, to propose referenda and amendments to the Constitution and By-Laws, and to serve on a committee, council, commission, and board shall be limited to Fellows, Life Fellows, General Members, Life Members, and Members-in-Training in good standing.	2. NO CHANGE PROPOSED.	2. The right to vote, to nominate candidates, to propose referenda and amendments to the Constitution and By-Laws, and to serve on a committee, council, commission, and board shall be limited to Fellows, Life Fellows, General Members, Life Members, and Members-in-Training in good standing.
3. Any voting member may hold elected office, serve on councils, or serve as chairperson of committees, boards, and commissions.	3. NO CHANGE PROPOSED.	3. Any voting member may hold elected office, serve on councils, or serve as chairperson of committees, boards, and commissions.
4. Attendance at meetings of the Board, councils, committees, boards, and all other organizational components of the Association shall be open to all members of the Association except for the meetings of the Ethics Committee. All organizational components of the Association may go into Executive Session.	4. Attendance at meetings of the Assembly, the Board, councils, committees, boards, and all other organizational components of the Association shall be open to all members of the Association except for the meetings of the Ethics Committee. All organizational components of the Association may go into Executive Session.	4. Attendance at meetings of the Assembly, the Board, councils, committees, boards, and all other organizational components of the Association shall be open to all members of the Association except for the meetings of the Ethics Committee. All organizational components of the Association may go into Executive Session.
5. The voting membership may initiate referenda or change an action of the Board by the following procedure: A petititon signed by at least 200 voting members shall be submitted to the Secretary no later than December 15 to be voted on in the mail ballot in the following year. A statement from the petitioners setting forth the reasons for the action and a statement from the Board shall accompany the ballot. A simple majority of 40 percent of the eligible voting members shall be required for approval.	5. The voting membership may initiate referenda or change an action of the Assembly by the following procedure: A petititon signed by at least 200 voting members shall be submitted to the Secretary no later than December 1 to be voted on in the mail ballot in the following year. A statement from the petitioners setting forth the reasons for the action and a statement from the Assembly shall accompany the ballot. A simple majority with at least 40 percent of the eligible voting members voting shall be required for approval.	5. The voting membership may initiate referenda or change an action of the [Board] Assembly by the following procedure: A petition signed by at least 200 voting members shall be submitted to the Secretary no later than December [15] 1 to be voted on in the mail ballot in the following year. A statement from the petitioners setting forth the reasons for the action and a statement from the [Board] Assembly shall accompany the ballot. A simple majority [of] with at least 40 percent of the eligible voting members voting shall be required for approval.
6. Every Fellow, General Member, Associate Member, and Member-in-Training shall pay both dues and assessments as determined by the Board and the District Branches. All other categories of membership shall be exempt from paying dues to both the Association and its District Branches. Such dues will include amounts allocated to subscriptions for *The American Journal of Psychiatry* and for *Psychiatric News*. The membership application shall contain a provision for allocation of a specific portion of the dues to pay the cost of periodical subscriptions to these publications.	6. Every Fellow, General Member, Associate Member, and Member-in-Training shall pay both dues and assessments as determined by the Assembly and the District Branches. (No change proposed for the remainder of Section 6.)	6. Every Fellow, General Member, Associate Member, and Member-in-Training shall pay both dues and assessments as determined by the [Board] Assembly and the District Branches. All other categories of membership shall be exempt from paying dues to both the Association and its District Branches. Such dues will include amounts allocated to subscriptions for *The American Journal of Psychiatry* and for *Psychiatric News*. The membership application shall contain a provision for allocation of a specific portion of the dues to pay the cost of periodical subscriptions to these publications.
7. Any dues-paying member of the Association and/or its District Branches who fails to pay all dues and assessments may forfeit his or her memberships. Due notice of such failure shall be made to the member, the Treasurer of the Association, and the Board (after the member is in arrears for one full calendar year). Unless otherwise ordered by the Board, the Treasurer shall notify the member by registered mail that the member will forfeit his or her memberships if the arrearage is not paid in full by a specified date. (The letter from the Treasurer to the member shall inform the member of the conditions under which he or she may be exempted from payment of dues and assessments.) If payment in full or an appeal for exemption has not been received by the specified date, the Secretary of the Association shall notify the member of the loss of membership in the Association and the District Branch. Thereafter, such former members may apply for membership in accordance with Chapter Two of the By-Laws.	7. NO CHANGE PROPOSED.	7. Any dues-paying member of the Association and/or its District Branches who fails to pay all dues and assessments may forfeit his or her memberships. Due notice of such failure shall be made to the member, the Treasurer of the Association, and the Board (after the member is in arrears for one full calendar year). Unless otherwise ordered by the Board, the Treasurer shall notify the member by registered mail that the member will forfeit his or her memberships if the arrearage is not paid in full by a specified date. (The letter from the Treasurer to the member shall inform the member of the conditions under which he or she may be exempted from payment of dues and assessments.) If payment in full or an appeal for exemption has not been received by the specified date, the Secretary of the Association shall notify the member of the loss of membership in the Association and the District Branch. Thereafter, such former members may apply for membership in accordance with Chapter Two of the By-Laws.
8. Resignation or loss of membership in the Association or in the member's District Branch for any reason shall entail loss of membership in both.	8. NO CHANGE PROPOSED.	8. Resignation or loss of membersbip in the Association or in the member's District Branch for any reason shall entail loss of membership in both.

PRESENT APA BY-LAWS	CHANGES PROPOSED	PROPOSED NEW BY-LAWS
Chapter Nine. Voting	**Chapter Nine. Voting**	**Chapter Nine. Voting.**
1. Nominations for national office except that of Area Trustee shall be made by: (a) the Nominating Committee; or (b) by a petititon signed by 200 or more members eligible to vote. Nominations for Area Trustee shall be made by: (a) procedures established by the Assembly; or (b) by a petititon signed by 50 or more members of that Area who are eligible to vote. Nominating petitions must be filed with the Secretary before December 15 of the year immediately previous to the one in which the nominee would be elected.	1. Nominations for national office except that of Area Vice-President shall be made by (a) the Nominating Committee; or (b) by a petititon signed by 200 or more members eligible to vote. Candidates for Area Vice-President shall be nominated by an Area Nominating Committee composed of a member elected from each District Branch in the appropriate Area. The Committee shall select its own chairperson. It may nominate more than one candidate for the office. Additional candidates may be nominated by a petititon signed by at least two percent of the voting members in the Area. Election shall be by the same procedure as for national office. Nominating petititons must be filed with the Secretary before December 1 of the year immediately previous to the one in which the nominee would be elected.	1. Nominations for national office except that of Area [Trustee] Vice-President shall be made by (a) the Nominating Committee; or (b) by a petition signed by 200 or more members eligible to vote. [Nominations for Area Trustee shall be made by: (a) procedures established by the Assembly, or (b) by a petition signed by 50 or more members of that Area who are eligible to vote.] Candidates for Area Vice-President shall be nominated by an Area Nominating Committee composed of a member elected from each District Branch in the appropriate Area. The Committee shall select its own chairperson. It may nominate more than one candidate for the office. Additional candidates may be nominated by a petition signed by at least two percent of the voting members in the Area. Election shall be by the same procedure as for national office. Nominating petitions must be filed with the Secretary before December [15] 1 of the year immediately previous to the one in which the nominee would be elected.
2. A Tellers Committee consisting of three members shall be appointed by the President. This Committee shall be responsible, with the approval of the Board, for establishing procedures for equitable voting of the membership.	2. NO CHANGE PROPOSED.	2. A Tellers Committee consisting of three members shall be appointed by the President. This Committee shall be responsible, with the approval of the Board, for establishing procedures for equitable voting of the membership.
3. Voting shall be by secret ballot.	3. NO CHANGE PROPOSED.	3. Voting shall be by secret ballot.
4. All voting for the election of Officers, Trustees, amendments to the Constitution and By-Laws, and referenda shall be by mail ballot.	4. All voting for the election of Officers, amendments to the Constitution and By-Laws, and referenda shall be by mail ballot.	4. All voting for the election of Officers, [Trustees,] amendments to the Constitution and By-Laws, and referenda shall be by mail ballot.
5. Amendments to the Constitution and By-Laws shall be effective on the date of certification unless a later effective date is specified on the ballot.	5. NO CHANGE PROPOSED.	5. Amendments to the Constitution and By-Laws shall be effective on the date of certification unless a later effective date is specified on the ballot.
6. The Tellers Committee shall prepare a certificate of the results and a statistical summary of each membership vote, which shall be made available to members upon request to the Secretary.	6. NO CHANGE PROPOSED.	6. The Tellers Committee shall prepare a certificate of the results and a statistical summary of each membership vote, which shall be made available to members upon request to the Secretary.
7. The results of the voting shall be reported by the chairperson of the Tellers Committee to the Board and shall be announced to the membership at the Annual Meeting.	7. NO CHANGE PROPOSED.	7. The results of the voting shall be reported by the chairperson of the Tellers Committee to the Board and shall be announced to the membership at the Annual Meeting.
Chapter Ten. Complaint Procedure and Disciplinary Actions	**Chapter Ten. Complaint Procedure and Disciplinary Actions**	**Chapter Ten. Complaint Procedure and Disciplinary Actions**
1. A complaint concerning the behavior of a member of this Association shall be in writing, signed by the complainant, and filed with the Secretary. The Secretary shall refer it to the appropriate District Branch for investigation and action. The Secretary shall notify the accused member of the receipt of such a complaint and that it has been forwarded to the member's local District Branch and shall inform the accused member of his or her right to appeal any forthcoming action to the Board. The District Branch may appeal to the Board for relief from responsibility for considering any complaint. The member against whom the complaint was brought shall have the right of appeal to the Board for reconsideration of the decision of the District Branch.	1. NO CHANGE PROPOSED.	1. A complaint concerning the behavior of a member of this Association shall be in writing, signed by the complainant, and filed with the Secretary. The Secretary shall refer it to the appropriate District Branch for investigation and action. The Secretary shall notify the accused member of the receipt of such a complaint and that it has been forwarded to the member's local District Branch and shall inform the accused member of his or her right to appeal any forthcoming action to the Board. The District Branch may appeal to the Board for relief from responsibility for considering any complaint. The member against whom the complaint was brought shall have the right of appeal to the Board for reconsideration of the decision of the District Branch.
2. When the Board or Executive Committee receives a complaint that a member has engaged in unethical conduct or has brought discredit or dishonor on the Association and/or the practice of psychiatry it may: (a) dismiss the complaint; or (b) refer the complaint to the Ethics Committee for consideration and recommendation; or (c) suspend the member from membership privileges for not more than 90 days, pending completion of the following procedures contained in this chapter.	2. When the Board receives a complaint that a member has engaged in unethical conduct or has brought discredit or dishonor on the Association and/or the practice of psychiatry it may: (a) dismiss the complaint; or (b) refer the complaint to the Ethics Committee for consideration and recommendation; or (c) suspend the member from membership privileges, for not more than 90 days, pending completion of the following procedures contained in this chapter.	2. When the Board [or Executive Committee] receives a complaint that a member has engaged in unethical conduct or has brought discredit or dishonor on the Association and/or the practice of psychiatry it may: (a) dismiss the complaint; or (b) refer the complaint to the Ethics Committee for consideration and recommendation; or (c) suspend the member from membership privileges, for not more than 90 days, pending completion of the following procedures contained in this chapter.
3. In investigating a complaint, the Ethics Committee may designate two Fellows not on the Committee to serve as investigators. Any member under investigation shall be entitled to 30 days' notice in writing, advising him or her of the charges and the date and place of a hearing before the Ethics Committee. The member shall have the right to personal appearance and representation.	3. NO CHANGE PROPOSED.	3. In investigating a complaint, the Ethics Committee may designate two Fellows not on the Committee to serve as investigators. Any member under investigation shall be entitled to 30 days' notice in writing, advising him or her of the charges and the date and place of a hearing before the Ethics Committee. The member shall have the right to personal appearance and representation.
4. The Committee may: (a) determine the complaint to be without merit and recommend to the Board that it be dismissed; or (b) advise the Board that a complaint has been sustained and recommend that the member be admonished, reprimanded, suspended from membership for a specific period of time, or expelled from the Association in accordance with the recommendations of the District Branch.	4. NO CHANGE PROPOSED.	4. The Committee may: (a) determine the complaint to be without merit and recommend to the Board that it be dismissed; or (b) advise the Board that a complaint has been sustained and recommend that the member be admonished, reprimanded, suspended from membership for a specific period of time, or expelled from the Association in accordance with the recommendations of the District Branch.
5. The Board, by majority vote, may admonish, reprimand, or suspend, but a two-thirds vote shall be required to expel. The Secretary will promptly notify the member in writing of the action of the Board.	5. NO CHANGE PROPOSED.	5. The Board, by majority vote, may admonish, reprimand, or suspend, but a two-thirds vote shall be required to expel. The Secretary will promptly notify the member in writing of the action of the Board.
6. The records of the Ethics Committee and the pertinent minutes of the Board shall be filed with the permanent records of the Association. The name of the member involved will not be reported to the membership unless he or she so requests in writing.	6. NO CHANGE PROPOSED.	6. The records of the Ethics Committee and the pertinent minutes of the Board shall be filed with the permanent records of the Association. The name of the member involved will not be reported to the membership unless he or she so requests in writing.
7. A disciplined member may appeal to the membership by filing notice of such intent with the Secretary within 30 days after notification of the action of the Board. Expelled members shall be denied all membership privilege pending the appeal. All other penalties shall be suspended pending the appeal. Appeals shall be heard at the next Annual Meeting, at a session attended only by voting members and the necessary secretarial staff selected by the President. The member shall have the right to be heard and be represented. If two-thirds of those present vote, by secret written ballot, to reverse the Board's action, the complaint shall be dismissed.	7. NO CHANGE PROPOSED.	7. A disciplined member may appeal to the membership by filing notice of such intent with the Secretary within 30 days after notification of the action of the Board. Expelled members shall be denied all membership privileges pending the appeal. All other penalties shall be suspended pending the appeal. Appeals shall be heard at the next Annual Meeting, at a session attended only by voting members and the necessary secretarial staff selected by the President. The member shall have the right to be heard and be represented. If two-thirds of those present vote, by secret written ballot, to reverse the Board's action, the complaint shall be dismissed.
Chapter Eleven. Annual Business Meeting	**Chapter Eleven. Annual Business Meeting**	**Chapter Eleven. Annual Business Meeting**
1. At a previously announced time during the Annual Meeting, the President of the Association shall convene a Business Meeting composed of two consecutive sessions: (1) a meeting of the Assembly to act for the membership in responding to a report of the actions of the Board and the reports of the Speaker of the Assembly, the Medical Director, the Secretary, the Treasurer, and the chairpersons of the councils and constitutional committees, and (2) an Annual Forum for all voting members. Only voting members of the Association may attend this Business Meeting.	1. At a previously announced time during the Annual Meeting, the President of the Association shall convene a Business Meeting composed of two consecutive sessions: (1) a meeting of the Assembly during which it will respond to reports of the Speaker and Speaker-Elect of the Assembly, the Medical Director, the Secretary, the Treasurer, and the chairpersons of the councils, commissions, and constitutional committees, and (2) an Annual Forum for all voting members. Only voting members of the Association may attend this Business Meeting.	1. At a previously announced time during the Annual Meeting, the President of the Association shall convene a Business Meeting composed of two consecutive sessions: (1) a meeting of the Assembly [to act for the membership in responding to a report of the actions of the Board and the] during which it will respond to reports of the Speaker and Speaker-Elect of the Assembly, the Medical Director, the Secretary, the Treasurer, and the chairpersons of the councils, commissions, and constitutional committees, and (2) an Annual Forum for all voting members. Only voting members of the Association may attend this Business Meeting.
2. The Assembly may vote by simple majority on any matters before the Business Meeting except to reverse an action of the Board which will require a two-thirds majority vote of the Assembly.	2. DELETED.	[2. The Assembly may vote by simple majority on any matters before the Business Meeting except to reverse an action of the Board which will require a two-thirds majority vote of the Assembly.]
Chapter Twelve. Annual Forum	**Chapter Twelve. Annual Forum**	**Chapter Twelve. Annual Forum**
1. After the conclusion of the first session of the Business Meeting, at a reasonable point within the time allotted for the Business Meeting as a whole, the President shall convene the annual Forum session of the Business Meeting for all voting members.	1. NO CHANGE PROPOSED.	1. After the conclusion of the first session of the Business Meeting, at a reasonable point within the time allotted for the Business Meeting as a whole, the President shall convene the Annual Forum session of the Business Meeting for all voting members.
2. 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 an extraordinary vote and this shall require a mail ballot to be circulated 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 By-Laws.	2. Proposals for consideration by the Assembly about the affairs of the Association, or any old or new business, may be introduced by any member and passed by a two-thirds vote, except to reverse an action of the Assembly. To reverse an action of the Assembly, a two-thirds vote, with a minimum of 200 votes in favor, may call for an extraordinary referendum by mail ballot which shall be reported prior to the fall meeting of the Assembly. In matters other than an Assembly action, a majority vote, with a minimum of 200 votes in favor, may initiate the referendum process as defined in Chapter Eight, Section 5, of these By-Laws.	2. Proposals for consideration by the Assembly about the affairs of the Association, [and] or any old or new business, may be introduced [and voted on] by any member and passed by a two-thirds [majority of the voting members present] vote, 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] vote, with a minimum of 200 votes in favor, may call for an extraordinary [vote and this shall require a mail ballot to be circulated and] referendum by mail ballot which shall be reported prior to the fall meeting of the Assembly. In matters other than [a Board or] an Assembly action, a [simple majority of voting members present] majority vote, with a minimum of 200 votes in favor, may initiate the referendum process as [described] defined in Chapter [Seven] Eight, Section [6] 5, of these By-Laws.
3. After a referendum is approved by a two-thirds majority of the voting members present, the Board or Executive Committee shall review it to determine whether any conflict with the Constitution and By-Laws or with the legal status or established policy of the Association exists and shall formulate an opinion on any such conflicts before it is circulated to the members. The circulated referendum shall carry with it both the opinion of the Board tne the opinion of those initiating the referendum.	3. After a referendum is initiated by procedures in Chapter Twelve, Section 2, the Board shall ascertain whether any conflict with the Constitution and By-Laws or with the legal status or established policy of the Association exists and shall formulate an opinion on any such conflicts before it is circulated to the members. The circulated referendum shall carry with it the opinions of the Board, of the Assembly and of those initiating the referendum.	3. After a referendum is [approved by a two-thirds majority of the voting members present,] initiated by procedures in Chapter Twelve, Section 2, the Board [or Executive Committee] shall [review it to determine] ascertain whether any conflict with the Constitution and By-Laws or with the legal status or established policy of the Association exists and shall formulate an opinion on any such conflicts before it is circulated to the members. The circulated referendum shall carry with it [both the opinion] the opinions of the Board, of the Assembly and [the opinion] of those initiating the referendum.
4. The adoption of a referendum shall require: (a) valid ballots from at least 40 percent of the voting members, and (b) a simple majority of those voting.	4. NO CHANGE PROPOSED.	4. The adoption of a referendum shall require: (a) valid ballots from at least 40 percent of the voting members, and (b) a simple majority of those voting.
Chapter Thirteen. Affiliate Societies	**Chapter Thirteen. Affiliate Societies**	**Chapter Thirteen. Affiliate Societies**
1. No new affiliate societies will be designated. Any society that has been designated an Affiliate of the American Psychiatric Association prior to the promulgation of these By-Laws shall remain an Affiliate Society, subject to the provisions of Section 2 below.	1. NO CHANGE PROPOSED.	1. No new affiliate societies will be designated. Any society that has been designated an Affiliate of the American Psychiatric Association prior to the promulgation of these By-Laws shall remain an Affiliate Society, subject to the provisions of Section 2 below.
2. In every Affiliate Society, all members must be physicians, at least 75 percent of the members must be psychiatrists, and more than 50 percent of the Society members must be members in good standing of the American Psychiatric Association.	2. NO CHANGE PROPOSED.	2. In every Affiliate Society, all members must be physicians, at least 75 percent of the members must be psychiatrists, and more than 50 percent of the Society members must be members in good standing of the American Psychiatric Association.
3. No Affiliate Society shall speak in the name of, or encumber the funds of, the American Psychiatric Association.	3. NO CHANGE PROPOSED.	3. No Affiliate Society shall speak in the name of, or encumber the funds of, the American Psychiatric Association.
Chapter Fourteen. Amendments to the By-Laws	**Chapter Fourteen. Amendments to the By-Laws**	**Chapter Fourteen. Amendments to the By-Laws**
1. Proposed amendments to the By-Laws shall be handled in the same manner as are amendments to the Constitution (Article IX), except that approval by a majority of at least 40 percent of the eligible voting members shall be required for adoption.	1. NO CHANGE PROPOSED.	1. Proposed amendments to the By-Laws shall be handled in the same manner as are amendments to the Constitution (Article IX), except that approval by a majority of at least 40 percent of the eligible voting members shall be required for adoption.

Provisos:
1. All members of the existing Board of Trustees shall complete their elected terms as members of the new Executive Board.
2. The new Executive Board shall have the power to provide for orderly transition from the old to the new system of governance until the fall 1979 meeting of the Assembly.

Planning

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to avoid hanging separately. They realized from the outset, he said, that although psychiatrists had dominated the Mental Health Planning Council, they alone would have no influence. Instead, they set about forging an alliance with mental health providers and representatives from profit and voluntary related organizations in the area, including psychiatrists, psychologists, nurses, the local mental health association, and state mental health officials, and called themselves the Mental Health Coalition.

To create the HSA, the Citizens Health Council in July 1975 formed a Committee of One Hundred, its membership balanced slightly toward consumers and representing the widest possible range of provider and consumer groups. The coalition formed soon afterward, viewing its constituency as the mentally ill and substance-abusing people of the central Maryland area, rather than its component groups, and set about to prod the committee to seat as many mental health representatives on the governing body as possible and to staff the HSA with a mental health expert.

The mode of operation here was "constructive coercion": The coalition tactfully made it known prior to provisional accreditation of the HSA that unless its constituency got the attention it deserved, not only would its committee mental health providers resign as potential board members but all the mental health organizations in the coalition would withhold support from the HSA and forbid their members from serving. HEW would also be informed. Thus, in May 1976, when the Central Maryland HSA was provisionally accredited (it was fully accredited this year), there were six slots created for mental health providers, two on the executive committee, and a staff member hired.

Since then, the coalition has operated as an action arm and information resource for the HSA. It comments first on certification and review issues involving mental health, sparing the HSA staff from time-consuming site visits, and it or one of its subcommittees (such as the one on alcoholism) drafts a mental health plan before it reaches the HSA planning committee.

Its major achievements to date have been that it inserted in both the five-year and annual plans a provision that psychiatric units in general hospitals be urged to accept involuntary patients, thawed part of the state freeze on new hospital beds permitting conversion from general to psychiatic, and plugged the drain of state money into renovating a building that the coalition discovered was scheduled to close the following year.

It is fine for psychiatrists to get involved, says Robinson, "but there is no way the psychiatrist is going to be the sole voice for mental health." His experienced message is to form coalitions and "not neglect" patients. No matter who is actually sitting on the board—be it a psychologist, nurse, social worker, etc.—issues have to be referred to the coalition, he holds. And he contends that it is impossible for non-psychiatric representatives on the governing body to circumvent psychiatric concerns when the decision involves such medical concerns as physician staffing patterns on a new unit, after care programs, or neuroleptic prescriptions.

Working on the state level as the only psychiatrist (there are a few oth-

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er physicians) on the 70-member Massachusetts Statewide Health Coordinating Council, Lee Macht, M.D., shares Robinson's opinion about banding together with other mental health advocates, consumers as well as professionals. A former commissioner of mental health and president of the Massachusetts Psychiatric Society, Macht was appointed to the SHCC by the governor. The leader of the Massachusetts' coalition, an attorney and active community leader, was also appointed and, through what Macht terms a "very well-planned and hard-working political campaign," was elected chairman as well. "For us, it was a major achievement and insured mental health input and concern at the highest level of the organization," says Macht, because SHCCs hold final approval over state health plans and much federal funding.

This year, they pinpointed desired improvements in the mental health area. Although time considerations prevented HSA plans from adopting them this year, the comments were forwarded to the governor, and Macht hopes they will guide HSAs in formulating next year's plans.

The coalition itself, only three years old, has met with various levels of state government about budgets and policies and, according to Macht, has had "some real impact."

Macht advocates psychiatric involvement in the political process as an "opportunity," noting that besides specific expertise, psychiatrists can add "a dimension of humanism, total patient care emphasis, and comprehensiveness to the whole planning effort." He points out that for psychiatry, however, this means "translating what we know into broader conceptualizations of systems and policies, as well as shifting to a broader public function and activity with other disciplines and citizens and with a broader aspect to the role and functions of psychiatry." He recommends training psychiatrists "with all due speed" for these roles.

Other approaches vary with the state. Concerned that the local HSA board rejected a request to place a mental health representative on the board and that the planning body's top ten priorities excluded mental illness, psychiatrist Robert L. Zapalac in Texas, a member of APA's Committee on Comprehensive Health Planning, told *Psychiatric News* that his state district branch is gearing up for heavier impact. Its health planning committee, of which he is a member, assigned two of the state's 12 HSAs to each of its six members to monitor. Those who have responsibility then plan to "recruit, locate, find, cajole—whatever necessary—" local district branch members to lend a hand, Zapalac said. Already their persistence, coupled with an educational sweep through Texas by Rosalyn Carter and the President's Commission on Mental Health, won them a September hearing with the HSA board to lay out mental health concerns. In the formative stages as well is an effort to collaborate with the local Mental Health Association.

Plunging into the planning process with a personal perspective gained from several years of directing a mental health center, Bryce G. Hughett, M.D., who has put in more than two years chairing both the Montana HSA and SHCC, cautioned that his heavy involvement required much more time

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than he at first had anticipated. Although it originally seemed to absorb about 12 days a year in meetings, various reviews and orientations stretched this into 34. Only because he had a skilled center deputy director and a cadre of excellent private practice psychiatrists covering clinical areas, plus a supporting governing board, could he afford the loss in work days.

Psychiatrists can, however, tailor their involvement to the amount of time they have available, he said, offering a spectrum of ways from the least to most time consuming. These ranged from supplying mental health information at planning meetings of local medical societies or hospital staff or commenting on the mental health, psychiatric bed, or alcohol and drug part of a health systems plan to becoming a full-fledged member of one of the federally designated planning bodies, subcommittees, or coalitions. At this more involved level, Hughett advises participants to have "patience and modest expectations," since much time is devoted to non-psychiatric health matters. Draft and final copies of any plans are usually available from a local general hospital administrator, a medical society secretary, or public library and, before final adoption, must have a public hearing, he noted. Additionally, he said, the HSA or State Health Planning Agency can report on the current status.

Sounding an encouraging note, Hughett says the intent of the law is beginning to take shape. Diverse special interest groups are beginning to reach reasonable consenses. In Montana, a coalition of APA members and the State Council of Mental Health Centers successfully petitioned a change in the HSA bylaws to designate a mental health representative. The state also contributed close to a third of more than 50,000 letters and telegrams pouring into Congress and HEW which successfully parried a move to close low-occupancy rural hospitals, boosting rural citizens' sagging confidence in their ability to influence Washington.

Another ready-made opportunity for involvement is through links with professional standards review organizations. These organizations are already collecting facts and figures crucial to decisions by HSAs, which have been told to use outside sources whenever possible, according to Arnold Milstein, M.D., M.P.H., of HEW.

For instance, he pointed out at APA's annual meeting, routinely collected PSRO data, such as those on patient diagnosis and age, average length of stay, and entry and exits of patients, would help HSAs analyze the strengths and gaps in the mental health care system. Especially gathered information could, for instance, pinpoint how a dearth of aftercare facilities lengthens hospital stays or how failures in the treatment system lead to hospitalization. Utilization data could also check the success of new strategies, measuring, for example, the number of suicide admittals in areas where crisis clinics had recently started. This exchange of information is limited only by the imagination, he said.

There are other kinks in this legislated system besides its initial neglect of mental health representation. One most often mentioned was the plethora of plans now required under vari-

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ous federal legislation. Says Howard Gurevitz, chair of APA's Health Planning Committee, "One of the defects of the legislation is that it didn't recognize that a lot of things to be done in the future were already being done in the past by other agencies." Neither did it set up avenues for coordination, he added.

Kent Robinson agrees that there seems to be an "undue proliferation of plans mandated in the mental health field." Because state personnel are represented in central Maryland's Mental Health Coalition, however, the local plan is "very closely integrated" with the state plan in the area.

An update of the act, when hammered out in final form by House and Senate conferees, is expected to widen the entrance for mental health representation as well as to weld together some of the fragmented plans. Already through the Senate is the Health Planning Amendments of 1978 (S.2410), which explicitly intends to fold mental health planning into physical health planning, as spelled out in the addition of two more congressional findings and purposes. By linking the planning processes together, it believes it will also integrate the separate delivery of services. Specifically, the bill adds a staff expert in mental health planning and use of mental health resources to the HSAs, requires a mental health component in the health systems plans, and designates the state mental health authority to review the mental health part of the health systems plans in fashioning that portion of the state health plan. All these changes were supported and advocated by APA.

The House health subcommittee attached the planning amendments to the Community Mental Health Centers Act three-year extension passed by the full House in mid-September. Sponsored by chair Paul G. Rogers (D.-Fla.), it, too, proposes several changes to inject mental health planning into the national health planning process, as well as to pare down the number of required federal mental health plans. Specifically, it requires on HSA boards consumer and provider members knowledgeable about mental health and, although it makes no provision for a staff expert, instructs HSAs to consult knowledgeable persons in devising their mental health goals. It also requires the State Health Planning and Development Agency (SHPDA) to provide reasonable opportunity to state mental health authorities to comment in writing on the state health plan.

10B-8

Sanity Commission Members

A PRISONER convicted of aggravated rape contended that he was not given an appropriate sanity hearing because neither of two physicians appointed to examine him were psychiatrists, but the Louisiana Supreme Court ruled that where there was no evidence that such specialists were available for appointment to the sanity commission, there was no trial error, it was reported in the August 1 issue of *The Citation*. However, if psychiatrists had been available, the court said, refusal to appoint them to the commission would have been an abuse of discretion. The case is cited as *State of Louisiana v. Crochet,* 354 So. 2d 1288 (Louisiana Supreme Court, December 19, 1977; rehearing denied, March 3, 1978)

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this "wishes without action," Dr. Masserman, or "self-righteous fulminations"? I suggest not. I suggest that precise condemnation of cruelty and injustice is the responsibility of men of good will and the *least* that the victims look to from us and our representative organizations.

Evidence of this sensitivity is borne out not only by the specious threat of the All-Union Society of Neurologists and Psychiatrists to events in Honolulu as published in Dr. Masserman's letter, but also by the fact that the Argentine government has hired a U.S. public relations firm, Burson Marsteller, to handle its account and endeavour to improve its image in the eyes of the American public.

Furthermore, private efforts are very often used as publicity to legitimize unethical practice. I have before me a copy of the transcript of a broadcast made in English for consumption in Great Britain from Moscow. In this broadcast, Professor Georgy Morozov of the Serbsky Institute of Forensic Psychiatric quotes by name Dr. Howard Rome and Dr. Denis Leigh as agreeing with Dr. Morozov in the falseness of the charges of the political abuse of psychiatry in the Soviet Union. This was broadcast in August 1978.

And this is in the face of the damning confirmatory evidence of such abuse given by Dr. Yuri Novikov, who recently defected to the West. Until his defection, Dr. Novikov was one of the chiefs of the six divisions of the Serbsky Institute. He confirmed in damning detail the charges of Alexander Podrabinek and the charges that were made about the Soviet Union in Honolulu.

The message is that private efforts can be manipulated by the big lie. There is no substitute for *a*) a careful review of evidence; *b*) the acceptance or rejection of such evidence by reputable professional bodies; *c*) the presentation of such evidence in the world press, before national and international organs; *d*) the institutionalization of such an approach; and *e*) private and friendly support to our colleagues in other countries who live in closed or authoritarian societies.

As a final word, Dr. Masserman and others should make a careful qualitative and public distinction between unethical, dangerous, and cruel social policy by official government organs and the ambiguities of an open society. Surely, as psychiatrists, we are aware of the dangers of Utopianism by now. That does not prevent us from admitting and working to correct inequities in our own countries. But it also does not mean to say that we should mention political abuse in Russia and tardive dyskinesia in the USA in the same breath. I can assure you that the enemies of the open society will only be too willing to do that for us.

M. H. Nelson, M.D.
Concord, Mass.

10B-26

Tourette's Syndrome

I WILL NOT take up your valuable space in a point-by-point reply to Dr. S. Novick's comments [*Psychiatric News*, September 1] on your report of my presentation to the 20th Anniversary Meeting of the Group Without A Name (GWAN) in Ottawa in April 1978. I would only point out that my "quite limited experience in the treatment of Tourette's syndrome" is great-

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er than that reported by Gilles de la Tourette himself.

I would rather comment on the implications of Dr. Novick's letter. He has used your report as a vehicle to "plug" his own organization (of which, incidentally, I am a member) and the recent publication of Dr. Shapiro's book. This is fair, and I have no complaint. What does concern me is the authority that Dr. Novick assumes and his audacity in deciding that anybody who does not accept what he regards as evidence must be wrong.

He has fallen into the common trap of an "either-or" interpretation and has failed to see that unusual movements can have a variety of causes and that they need not always be organic with a functional overlay but entirely functional. That the last does occur is consistent with my experience, and when it is associated with copralalia, then the term Gilles de la Tourette's syndrome is justified. To label every tiqueur as Tourette's syndrome is not justified.

Dr. Novick's attitude illustrates a syndrome that is becoming more common. A disability is or has been identified, and a society for its study is formed; and then frequently because the pure state is rare, the definition is expanded or modified, and practicing doctors are expected to accept these modifications, which may have been made for personal, political, and other reasons. A classical example was that of Infantile Autism, where the original condition was expanded to embrace all the mentally retarded of the middle and upper classes. It took post-mortem studies to isolate from these patients those with tuberous sclerosis and gargoylism and other organic diseases.

In my opinion, the organic basis of Gilles de la Tourette's syndrome, as defined by its originator, is not yet proven, and the debate should and will continue. That the condition is responsive to Haldol and Stelazine does not make it more organic than schizophrenia, for psychotropic drugs can affect both organic and functional states, e.g., the response of Huntington's chorea to phenothiazines.

Myre Sim, M.D.
Ottawa, Ontario, Canada

10B-23

Society for Elderly

I AM RESPONDING to the item in the July 21 issue of *Psychiatric News* about the call "for a new society of psychiatrists concerned with the elderly." The new society now in process of formation is called the American Association for Geriatric Psychiatry. In the news item, reference is made to the "Boston Gerontology Society," a society which serves as a model for the national organization.

The correct name for the Boston organization is the Boston Society for Gerontologic Psychiatry. This society was founded in 1960 and is an interdisciplinary group with over 175 professionals, mainly from Greater Boston, but including corresponding members across the country. Almost one-half of the members are psychiatrists, the rest being medical physicians, psychologists, social workers, social scientists, nurses with graduate degrees, and others. In addition to our scientific meetings on gerontologic psychiatry, we have a program of workshops for nursing home personnel and have published the *Journal of Geriatric Psychiatry* since 1967.

We would appreciate your pub-

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lication of this information. We are pleased to support Dr. Sanford I. Finkel in pressing forward the establishment of a national organization.

Martin A. Berezin, M.D.
Brookline, Mass.

10B-22

Nazi Victims

REGARDING the article in the August 4 issue titled, "Children of Nazi Victims seen as 'Marked' by Stress," I should like to correct a basic error contained in this otherwise thoughtful report.

I did not "indict" or "accuse" all psychiatrists who treated concentration camp victims. I by no means referred to *all* psychiatrists. I talked only of those who, through their brief, at times superficial and unelaborated statements (such as "pt. spent 18 months in concentration camp"), unwittingly tend to deprive the patients of their legitimate indemnification claims with reference to severe damages suffered during the Nazi persecution.

The West German compensation courts usually pay attention to the hospital records and the psychiatrists' statements therein. Through not describing in detail and depth the overwhelmingly traumatic experiences sustained by these victims, their compensation claims for the permanent psychological damages resulting from the persecution in concentration camps or from living through years of constant fear in precarious hideouts, are not understood and are, not infrequently, more or less overlooked by the courts.

I stress, however, that I do not indict or accuse *all* those psychiatrists who have concerned themselves with the admittedly often complex and difficult issues involved in most of these tragic cases.

William G. Niederland, M.D.
Englewood, N.J.

10B-7

Course

NEW YORK City Affiliate, Inc., National Council on Alcoholism, and New York University Post-Graduate Medical School will hold the third annual school on alcoholism for physicians and related health professionals December 14–16 in New York. The course updates diagnostic and therapeutic skills in caring for patients with drinking problems and alcohol-related disorders. Medical complications, clear methods of rehabilitation, various populations and age groups affected by alcohol, controversies in the field, and medical management during early sobriety will be reviewed. Tuition is $150 for three days; $25.00 for interns and residents (which includes three continental breakfasts and two lunches). The course has been approved for 17 AMA Category 1 credit hours. Further information is available from Robert W. Fuller, M.A., NYC Affiliate, Inc., NCA, 133 East 62nd St., New York, N.Y. 10021 (212) 935-7075.

10B-27C

Workshops

BIOFEEDBACK training workshops will be held November 11, December 9, January 20, February 17, and March 17 in New York. Further information is available from BMA Audio Cassettes, 200 Park Ave. South, New York, N.Y. 10003 (212) 674-1900.

10B-27D

Cost Containment

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requirement for a facility before it can receive reimbursement under the federal Medicare and Medicaid programs, so JCAH definitely has an effect on federal purse strings.

The JCAH statement reaffirms the organization's primary objective of promoting "the optimal achievable quality of care for those in need of it" and, says JCAH, ". . . shall continue to promulgate standards that enhance cost effectiveness through the control of practices and settings that minimize risk to both patients and personnel."

The section of the JCAH statement that most hospitals will take to heart, however, deals with a problem that facilities have always considered costly and unfair, namely separate, multiple surveys for the different services a hospital may provide. In psychiatry, for example, if the facility has inpatient beds, an outpatient service, and an alcoholism and drug abuse program, each of these units would require its own survey and accreditation. JCAH, in its cost control statement, says it "shall continue its efforts to reduce the duplicative surveys and inspections that health care institutions are subjected to and that impose a financial burden without significantly improving the quality of care."

The American Psychiatric Association, although it does not have a point-by-point statement, has come out endorsing the broad policy of health care cost containment and may seek funding to do some economical research and analysis to determine what cost control measures are proving to be effective. A major APA cost control measure, although it does not usually come under that heading, is the development of peer review mechanisms to assess the necessity, quality, and appropriateness of treatment and the cost for services provided. "Peer review does not mean lower cost necessarily," explained APA Deputy Medical Director Donald Hammersley, "but responsible spending—getting the most and the best for the money. To that extent, APA is actively in the game of cost control."

Hammersley explained some of the events that could have led to the exhorbitant health care cost inflation in the last decade. Physicians were singled out for obligatory cost containment by the Nixon Administration, he said, and once those limitations were removed, physicians felt not only the need to play a bit of catch-up but also to insulate themselves against any subsequent cost control measure that might be imposed by following administrations. And, indeed, cost containment is a catch-word of Carter Administration health care proposals, although psychiatric hospitals have been largely exempted from this, with the main crunch being toward those services having costly and infrequently used equipment. Psychiatric units in general hospitals, explained Hammersley, are cost effective because they usually have a high utilization rate and, therefore, few empty beds and because they require little expensive equipment. Likewise, psychiatric hospitals can be run more cheaply than general hospitals.

However, the inherent cost ef-

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fectiveness of psychiatry when compared to other services does not exempt it from participation in cost control efforts, and the most specific recommendations coming from the medical community to date are contained in the report of AMA's National Commission on the Cost of Medical Care. The chief recommendations in this document center around the approaches of strengthening consumer price consciousness and increasing the use of public-utility type regulation. AMA does not recommend a public sector, government-controlled health care system but rather a consumer choice among a variety of competing health care delivery arrangements such as health maintenance organizations, health care alliances, and variable cost insurance. "It is a milestone," says health economist and APA consultant John Krizay, "that AMA is endorsing this approach," and he feels that APA should do the same.

After analyzing different approaches, AMA's commission decided that "the most promising approach to cost containment, in the presence of insurance, is strengthening price consciousness. However," the report says, "it is obvious that no market, especially one as complex as health care delivery, can operate completely free of regulation. Further, some mechanisms must be put in place to assure that no group of consumers is denied quality care due to inability to pay. A strategy combining elements of price consciousness and some regulation would remove many of the problems inherent in strict public-utility regulation. . . . The objective should not be to keep resources devoted to health care from growing but rather to give those whose decisions affect health resources reason to take cognizance of costs."

Central to consumer price consciousness, in AMA's opinion, is cost-sharing—having the patient pay, selectively, for at least some part of the services he seeks. "It is important," says the report, "that care be taken to provide a proper balance between price disincentives designed to discourage unneeded or unnecessarily expensive care and insurance incentives designed to encourage the use of needed and appropriate care. Further, cost sharing should be tailored to meet the needs of low income families." The question here is how to offer health care to those families too poor to share in health care costs without penalizing them with inferior services because of their inability to pay. AMA does not answer this question.

However, the AMA commission did review a number of service options, including health maintenance organizations (HMOs), health care alliances (HCAs), variable-cost insurance (VCI), and health maintenance plans (HMPs). In an HMO plan, providers contract to provide all health care services to subscribers for a fixed monthly charge. Since those who have contracted to give services are at risk, they have an incentive to provide only necessary services, explains AMA. "Moreover, HMOs must compete for patients partially on the basis of price, and so must be aware of costs."

The problem AMA sees with expanding an HMO system is that it "requires a large-scale restructuring of the health care delivery system and cannot occur rapidly." However, HCAs and VCI, it says, "are designed to achieve the beneficial effects of competition without requiring extensive reorganization of practice patterns. Both programs," the report continues, "require little change in the way physicians practice but would require changes in the way insurance is written. Providers would be experience-rated so that insurance premiums would reflect the costliness of the providers consumers choose.

"Under variable cost insurance (VCI), health insurers would offer policies that would be tied to specific groups of hospitals based on their specific cost experience. Those policies that provide coverage for the more expensive hospitals would have the more expensive premiums. Consumers, on consultation with their physicians, would be free to choose hospitals from those where their physician has staff privileges; however, the amount of their expenses that is reimbursed would depend upon their coverage. Because consumers would benefit from purchasing lower-priced plans, they would have an incentive to choose physicians associated with cost-effective hospitals. Accordingly, hospitals would have an incentive to contain their expenses in order to gain more attractive ratings. . . . Finally, even if consumers did not choose lower priced plans, the subsidy of those who use high-cost providers by those who use low-cost providers would end.

"Under health care alliances (HCAs), groups of physicians would be collectively experience-rated according to their adjusted annual expense per patient. All covered patient-related expenses, including hospitalization, would be considered in arriving at an HCA's rating; adjustments for the sickliness of patients would be included."

It seems that under a VCI plan, there would still be the risk of a stratified service system, with the poor being limited to services on only the lowest rungs of that ladder. And another question that AMA could address more directly is the role of insurance companies and other third-party payers in influencing cost-containment by offering extensive coverage of high-cost, low-volume types of catastrophic illness and inpatient care to the exclusion of less expensive high-volume outpatient services. The report recommends only that "private and government insurance benefit packages should be adjusted to provide balanced coverage of alternative services and settings in the provision of health care."

The role third-party payers can play in the national cost control effort will be discussed more thoroughly by economist Krizay in the second part of this article.

10B-19

Salmon Lectures

ISAAC M. MARKS, M.D., reader in experimental psychopathology at the Institute of Psychiatry, University of London, will deliver the Thomas William Salmon Lectures November 30 at the New York Academy of Medicine. Topics will be "Cure of Neurosis" and "Care of Neurosis." There is no admission charge or reservation required to attend the lectures. Further information is available from James E. McCormack, M.D., director, The New York Academy of Medicine, 2 E. 103 St., New York, N.Y. 10029, TR6-8200.

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Hospitals

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gone—it would seem preferable to retain them until they are no longer needed. . . . It might be better for the patients not to give up what they now have till we are sure that there is something better to take its place. And then, there will be no problem about closure—it will take place by default."

According to Barter, "There has been a great deal of change in the system of care for the mentally in the past two decades. It has evolved from a system based upon state-operated institutions to one of locally based multiphasic mental health services. In the process of change, the future of the state hospital has been fiercely debated. . . . As the resources for community programs have fallen short of meeting the needs and as the inadequacies of partially fulfilled promises have become more evident, there has been a reawakening of interest in improving the utilization of all available resources, including the state mental hospital.

"No one advocates a return to the traditional state hospital or to custodial levels of care for the mentally ill. The future direction of the state hospital must be toward finding new roles and responsibilities which are complementary to community mental health programs."

Barter advocates that transformation of existing state hospitals into tertiary care centers for those patients "who pose problems which are difficult to manage within community mental health programs."

State hospitals should become domiciliary care facilities, recommend Richard N. Filer, Ph.D., of the Veterans Administration Central Office in Washington, D.C., and former APA president Jack R. Ewalt. "The mission of the VA domiciliaries [consists of] both medical and professional care programs that are tri-level to meet the needs of all patient-members. Veterans requiring prolonged care in a protective environment benefit from preventive medicine and rehabilitative measures. For intermittent residents, special behavioral and medical rehabilitation is provided on a temporary basis. Short-term restorative services enable other residents to return to community living within one year."

Francis A. Tyce, M.D., of Rochester, Minnesota, described an ideal and functioning state hospital that provides comprehensive community mental health services, while Robert De Vito, M.D., director of the Illinois Department of Mental Health and Developmental Disabilities, delineated the everyday realities confronting a conversion plan under way in Chicago, with the prime consideration understood, namely that "economic and political factors become the dominant forces that determine whether or not a plan will 'take.' " Enlisting the help of an interested governor of a state assures that the plan will go through. However, enlisting community support, slowly and patiently, assures the ultimate implementation of a worthwhile plan.

The speakers and their diverse solutions did not so much suggest a confusion of purpose as a realistic individualization of needs. What seems appropriate to one section of the country may prove unworkable in another. Hopefully, there appears to be a vigorous attempt to tackle change of an institution that may all too often be called what Albert Deutsch dubbed in 1937 as the "Shame of the States."

9B-21

Books

***Depot Fluphenazines: Twelve Years of Experience*, by Frank J. Ayd, Jr. (editor). Baltimore: Ayd Medical Communications, 1978, 160 pages, $15.** Anyone working with depot neuroleptics or interested in learning about long-acting injectable fluphenazine therapy should find this a worthwhile book. The 23 contributors provide readers with practical coverage of all aspects of depot fluphenazine therapy: indications, including their use in treating conditions other than chronic schizophrenia; dosages; frequency of injections; clinical response and plasma levels; the prophylactic efficacy of long-acting parenteral versus short-acting oral phenothiazines; the results of long-term treatment; and the organization and operation of a depot neuroleptic clinic. Three chapters in particular—Donlon's "Long-Acting Injectable Neuroleptics and Community Psychiatry"; Leff's "Psychopharmacological Monitoring of Social and Drug Effects in Schizophrenia"; and Ayd's "Overview of Twelve Years' Experience with the Depot Fluphenazines"—contribute to the value of this compilation of data by experts on the depot fluphenazines.

***Managing Madness: The Case Against Civil Commitment*, by Kent S. Miller. New York: Free Press, 1976, 185 pages, $9.95.** Miller asserts that "civil commitment for mental illness is wrong. It is practiced in a highly selective fashion; it frequently involves the violation of individual rights; it is predicated on false premises; it usually does not achieve its avowed purposes; and it is wasteful of resources and damaging to the mental health professions. These are strong statements, but they follow from the available facts." The publishers comment that the book "illuminates several important questions: Should compulsory commitment be a medical or a legal decision? What are the grounds for involuntary confinement? Is the objective of commitment to punish, to deter, or to treat? Are mental health professionals serving the interests of the patient or the state? What does the conflict over civil commitment reveal about broader issues and ideologies within the mental health field?" Miller is professor of psychology and sociology and director of the Community Mental Health Research Center at the Institute for Social Research, Florida State University.

***Marriage Contracts and Couple Therapy: Hidden Forces in Intimate Relationships*, by Clifford J. Sager. New York: Brunner/Mazel, 1976, 335 pages, $15.** The publishers note: "This volume brings out the significant role of the individual unwritten contract encompassing the expectations and promises—both conscious and unconscious—that each partner brings to the marriage or committed relationship. . . . Marriage Contracts and Couple Therapy uses this concept of the marriage contract to illuminate how and why many marriages do not fulfill their purposes and to demonstrate a practical therapeutic approach to preventing and treating marital problems. . . . On the basis of the information individual contracts revealed in therapy, Sager shows how the therapist can conceptualize each partner as resembling one of seven behavioral profiles—such as equal, romantic, childlike—and predict an interactional pattern in various partnership combinations. He also describes the contractual clause combinations that can lead to congruence, to complementarity, or to conflict in the interactional contract and in the development of a single joint contract."

***Psychosexual Problems*, edited by Sidney Crown. New York: Grune & Stratton, 1976, 471 pages, $14.75.** Twenty contributors, most of them English, discuss different aspects of psychosexual difficulties, including the relationship between sexual problems and the life cycle, the types of problems seen in different kinds of practices, sex education, and sex therapies. The last paragraph of Crown's chapter, "Conclusions," gives an impression of the perspectives offered in the book. It deals with sex education: "Experimentation with different courses of sex education are certainly necessary during the next few years. Courses should vary both in content and teaching methods. Objective evidence should gradually accrue measuring, for example, immediate change in factual knowledge and in attitudes of those taught as well as assessing remote effects in terms of the prevention of psychosexual problems. The methodological problems are considerable, but, insofar as the results of any teaching in principle are measurable, it should be possible to make progress. To end with one of [Martin] Cole's most provocative suggestions, human sexuality, with understanding gained from the arts, sciences, biology, psychology, sociology, ethics, and religion might form an appropriate subject for school-leaving examinations in the future." An index is included.

Strength of Incest Taboo Challenged

CHALLENGING beliefs surrounding what has been one of the most tenaciously held and culturally widespread sexual prohibitions among humans—the incest taboo—a research psychologist recently reported that some incest experiences appear to be positive and even beneficial.

Joan A. Nelson, M.A., disclosed that in an exploratory survey of 100 voluntary subjects, 23 reported no damage or harm from their incestuous experiences. Of 137 acts described, 39 percent were seen as negative, while 55 percent were viewed as positive.

Disclaiming being a "California kook," Nelson compassionately and articulately delivered what was one of the most controversial presentations at the recent 30th Institute on Hospital & Community Psychiatry sponsored by APA in Kansas City, Missouri. Adding caveat upon caveat, she stressed that the information was not to be interpreted as a rationalization for abolishing the incest taboo, but that she was attempting to "drive an intellectual wedge between criminal and consensual incest" as well as to catalyze further investigation and examination of the issues. The problem, she said, may lie not in the incest itself but in the frequently concomitant exploitation and abuse of power and in guilt over breaking the taboo.

Nelson claims as well that there is a great deal of parallel and unpublished research on the subject—most notably data collected for the Kinsey reports, allegedly positive, that was withheld from the public in the 1950s due to its explosive nature. She says the data has been released by one of the major researchers for the female volume, anthropologist Paul Gebhard, who became director of the Institute for Sex Research in Bloomington, Indiana, after Kinsey's death. It is to be part of a forthcoming book by Warren Farrell, author of the *Liberated Man*.

A spokesperson at the Institute confirmed that unpublished data on incest indicating a "lack of negative results" was released to Farrell. Although she declined to give further details, the spokesperson did clarify that this data included sexual relations between siblings and cousins.

Trying to reach subjects beyond the usually studied prisoner and patient populations, Nelson advertised for volunteers in national as well as local newspapers and magazines and through personal contacts. The large numbers of respondents who either completed a questionnaire or a personal interview came from solicitations in *Psychology Today*, referral letter, the San Francisco *Chronicle*, the New York *Times*, and through personal contacts. Respondents were mostly white, middle-class, and educated, and half said it was the first time they had revealed the acts to anyone.

Although acknowledging the limitations of the population selection and of the subjective reporting, Nelson nevertheless believes it possible to see trends in her preliminary data. Based on a broad definition of incest that ranged from fondling to rape between family or step-foster or surrogate family member, she found a high percentage of father-daughter incest (58 cases), sister-brother (42 cases), and a fairly high amount of brother-brother (18 cases). There were some reports of mother-son incest, with the remainder spread among granddaugh-

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Taboo

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ter-grandfather, sister-sister, niece-uncle, nephew-aunt, and cousins. She also cited a "disproportionately high" incidence in step-, foster-, and other surrogate-family situations.

Judged at face value by three independent graduate students, reports indicated that most experiences in which there was exploitation, seduction, bribery, or threats were seen as negative, while those involving mutual consent were more likely to be viewed positively. Negative reports also correlated highly, with older males exploiting younger females. Little girls, for instance, often saw themselves as victim, while fathers attested to their seductive cooperation. In general, males reported more positive experience than females.

Twenty-three reported no damage or harm from the incest, Nelson said; but many seemed to be working out conflicts and related years of personal struggle to assimilate the experience. Subjects most often cited personal problems of confusion in role identity and fear of social condemnation, both of which were linked to secrecy involved. The study, however, "found several two-person families with open consent and several multi-individual families with real or implied consent openly allowing active, sophisticated life-styles which included sexual sharing," Nelson said.

What the survey indicates, according to her, is that despite some confusion and apparent rationalization in some of the respondents' minds, some feel that it is possible to have beneficial incest without coercion, family dysfunction, or guilt and that some families are living successfully without honoring the taboo.

"Such behavior, however," cautions the researcher, "is not likely to be a social norm, at least in the near future. Any discussion regarding the abolition of the incest taboo is necessarily idealistic in nature and implies the existence of a society based on complete responsibility and love. Such a utopian environment has not been and is not likely to be a reality for some time to come."

Although guarding her study against being misconstrued as too "permission-giving," Nelson believes the subject will be a significant social issue in the next 50 years. Through the project, she hoped to help illuminate such questions related to the taboo, such as whether it still serves a useful purpose, whether the repression of sexual attraction toward family members leads to psychological or developmental pathology, whether laws forbidding it—penalties, she says, ranging from a $500 fine or 12 months in jail in Virginia to a one-to-50-year prison term in California—should distinguish between abusive and consensual incest. —B.S.H.

10B-18

Workshop

BETH ISRAEL HOSPITAL is sponsoring a workshop in continuing medical education, "Managing Emotional Aspects of Medical Illness," November 18–19 in Boston. The workshop has been approved for 14 hours CME credit. Further information is available from Beth Israel Hospital of Harvard Medical School, Psychotherapy Institute, 330 Brookline Ave., Boston, Mass. 02215 (617) 735-4768.

10B-27E

'Every Good Boy'— A Review

By Clarissa K. Wittenberg

TOM STOPPARD'S new play, *Every Good Boy Deserves Favour*, is a witty and emotional drama based on an extremely serious subject. Built upon the testimony of Vladimir Bukovsky, Victor Fainberg, and other Russian dissidents, it details the Soviet use of psychiatry as a tool of political repression. Stoppard, a prolific British playwright (*Rosencranz and Guildenstern are Dead*, *Jumpers*, *Travesties*, *Dirty Linen*, and *New Found Land*), created this mature work in collaboration with Andre Previn.

Billed as a play for actors and orchestra, this treatment of the story of a political prisoner locked in a cell with a madman who believes he has an orchestra is both fresh and effective. Bertolt Brecht knew how to turn a theatrical circus to a serious cause, and now Stoppard must be counted in the same tradition.

Both Previn and Stoppard have felt political repression in their own lives. Previn, now the principal conductor for the Pittsburgh Symphony Orchestra and former principal conductor for the Houston and London Symphony Orchestras, was born in Germany. As his family fled the Nazis, he lived in many places, first in Paris and then, under the sponsorship of the violinist Jascha Heifetz, in Los Angeles.

Stoppard was born in Czechoslovakia in 1937 and recently wrote a television play for Amnesty International's Prisoner of Conscience Year (1977). The play, *Professional Foul*, was stimulated (according to Stoppard) by the plight of three men, a playwright, an actor, and a journalist who had been arrested in Prague on January 6, 1977, in the act of trying to deliver a document to their own government. The document was in effect a request that the government enforce its own laws and was signed by 241 people who called themselves "Charter 77." Stoppard was particularly disturbed by the harsh treatment given the playwright, Vaclav Havel, whose Czechoslovakian human rights stance has brought him imprisonment. *Professional Foul* is an examination of ethics and of individual responsibility; and, yet, like *Every Good Boy Deserves Favour*, it is unusually entertaining.

Every Good Boy Deserves Favour is a simple play, if you can call a play with an entire orchestra on stage a simple play. There are six characters and three main areas that share the action. Two men are the central characters: Alexander, the dissident, and Ivanov, the madman "orchestra-leader." Their cell, with its two iron beds, occupies center stage; the orchestra sits around them; and on two platforms on either side of the stage are a simple school room and a doctor's office. The play lasts little more than an hour with a considerable amount of the time occupied by the music. Eli Wallach and John Wood held the two main roles in the American production, with Wood directing the play.

The play is about politics and the perversion of education and psychiatry to the service of propaganda and repression. And despite its mental hospital setting, the play is not an exploration of madness. Madness in this context is welcome relief, escapism, serving much the same purpose as imagination. The character of Ivanov as written by Stoppard is brilliantly witty and would be far poorer without his fantasy of an orchestra. There is some wordplay about reality and fantasy and even the tired joke about telling the doctors from the patients. Typical of the craziness is when the doctor, who has been chiding Ivanov that his orchestra is imaginary, realizes that he will be late to rehearsal and rushes off clutching his violin.

Still nothing distracts from the central idea that a horrible abuse is occurring in our time and that its central evil is the holding of political prisoners in mental hospitals and that the very concepts of both illness and treatment are being twisted to accommodate this policy. Drawing on reports from Russia, files of Amnesty International, personal visits, and conversations with Victor Fainberg and Vladimir Bukovsky (Stoppard dedicated the play to these men), Stoppard has traced what happened to one "ordinary man" who spoke out when friends were put into mental hospitals for their political acts.

The speech that Alexander makes to his doctor in refusing to "recant and show gratitude" for the treatment he had received in order that he might be released from the hospital would be familiar to any who have heard Bukovsky or others speak of their experiences in some Soviet hospitals. Alexander speaks in the play of KGB officers breaking in his door and later of some wearing white coats as they served as hospital orderlies. He says that medical treatments are used as punishment. "I was given injections of aminazin, sulfazin, triftazin, haloperidol, and insulin, which caused swellings, cramps, headaches, trembling, fever and the loss of various abilities including the ability to read, write, sleep, sit, stand, and button my trousers. When all this failed to improve my condition, I was stripped and bound head to foot with lengths of wet canvas. As the canvas dried it became tighter and tighter until I lost consciousness." The play details the pressure put on the prisoner's young son to influence his father to stop protesting and in particular to stop his

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Workshop

A TWO-DAY continuing education workshop will be held November 11–12 in New York on "Video Techniques in Psychiatric Training and Treatment." The workshop will be led by Milton M. Berger, M.D., director of education and training at the South Beach Psychiatric Center in New York and clinical professor of psychiatry at Downstate Medical Center of the State University of New York. Areas covered will include basic equipment, legal and ethical issues, preparation of patients, self-image confrontation impact, values of feedback, multi-level communications, replay techniques, and anatomy of a video production. The program meets APA and AMA requirements for 12 hours of Category II continuing education credit. The fee is $200. Checks should be made payable to H.E.M. Inc., and mailed to Health and Education Multimedia, Inc., Suite 4B, 50 East 72nd St., New York, N.Y. 10021.

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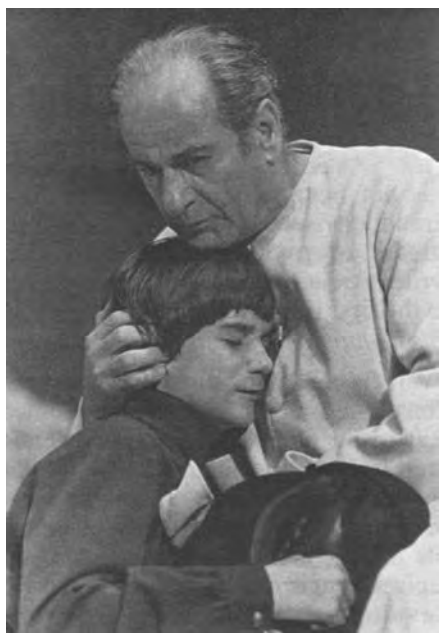
hunger strike—which was against the rules.

Stoppard uses the figure of the doctor to attack those doctors who know the truth and yet choose a politically safe path, even if it demands a blatant disregard for the welfare of "patients." Stoppard is also challenging the idea that by participating in such a system one can somehow make life safer or easier for a patient or a student rather than attacking the system or leaving it. The genius of Stoppard is to use an engaging, humorous, even black humor style to keep the audience on his side and sympathetic to his point of view. There are touching moments, particularly when the difficulties of the young son are reported and when his father begins to spout doggerel—a remnant of his imprisonment at "Arsenal'naya," when he was not allowed writing materials on "medical grounds," and when he found that it helped him to remember things if they rhymed.

The play carries a hard message, and it is more pointedly told through the story of one man than it might be painted as a broad picture. It is at the same time an optimistic play. Perhaps it is the lucidity of the madman who makes his own life tolerable despite all, and perhaps it is the music that seems orderly, joyous, and beautiful. The full size of the orchestra present is both humorous and impressive. It appears to indicate the strength and importance of Ivanov's fantasies, which in turn seem to symbolize the strength of the spirit. Similarly, the steadfastness of Alexander in defying all authorities for moral reasons is inspiring. The ending—when the colonel, who serves as a doctor despite his degree in "philology," asks the one patient "if he still has an orchestra" and the other patient if he still believes that "sane people are put in mental hospitals?" and then remaining adament that he is asking the right man the right question, cheerfully releases them—is both tidy and ominous. We see clearly that control still resides with the colonel. Alexander is united with his young son, but Stoppard has taken care to be certain that we know that this is merely a theatrical device and that in real life the endings are less comforting.



Credit: Richard Braaten

Bobby Scott and Eli Wallach

The value of a play dealing with such a subject can hardly be overestimated, particularly when the play is carefully wrought and entertaining. People will see this play who would otherwise never have become aware of the abuses in Soviet psychiatry. It is clear that Stoppard believes that discussion of such issues saves lives. There is at least a faint hope that the play will be produced on Broadway, and one might hope not only to see *Professional Foul* but *Every Good Boy Deserves Favour* as well on television. Certainly it is a play of particular interest to psychiatrists all over the world who have been so gravely concerned over the reports out of Russia.

(The play was first presented in London in July of 1977. A subsequent production played two performances a day at the Mermaid Theatre in London, closing in September 1978. This reviewer saw the London production. It has since briefly played at the John F. Kennedy Center for the Performing Arts in Washington, D.C., with Andre Previn, the composer and conductor, performing with the Pittsburgh Symphony Orchestra. Other stops on this Previn-led road tour include Pittsburgh and the Temple University Music Festival in Ambler, Pennsylvania.)

Hampstead Clinic Bulletin Begins Publication

THE ANALYTIC STUDY of childhood has not been accorded the role that Freud envisaged for it in the mainstream of psychoanalytic activities, writes Anna Freud in her introduction to the first issue of the new *Bulletin of the Hampstead Clinic*.

"It is only in subsidiary institutions, such as the Hampstead Clinic, that to all intents and purposes children have been substituted for adults as the main subjects of analytic research; that the direct study of infantile drives, urges, and tendencies has replaced their reconstruction; that the developmental pathways from immaturity to maturity are shown up in progression rather than in regression; that applied work in the children's field is not considered to be of secondary importance but as a fertile, all-important source of new insights and unsuspected findings; in short, that with the child as subject and target of our analytic effort within and outside the treatment situation, a way is opened towards the construction of a psychology of normal mental growth, including all the hazards, inconsistencies, and failures which bedevil human development."

The clinic was founded after World War II to give substance to Sigmund Freud's prophetic pronouncement that "children have become the main subject of psychoanalytic research and have thus replaced in importance the neurotic on whom its studies began." Since 1925, when these words were written in a foreword to Aichhorn's book, *Wayward Youth*, the effort has been made to make reality out of prophecy. As one of the few centers of such research, the clinic "has amassed a wealth of data, processed and classified under meaningful headings; has acquired diagnostic skills which facilitate a new categorization of infantile psychopathology; has collected a multitude of case studies from the benign to the most severe. . . ."

The ambitious undertaking of the new publication is "to create and maintain the atmosphere of a workshop in action, giving evidence of ongoing discussions, suggestions, supposition, theories in the making, and excursions into new clinical and theoretical territories." In short, some of the famed seminars, the "Wednesday Meetings," in which Miss Freud, the *Bulletin*'s consulting editor, continues to participate and which are faithfully attended by students and guests from all over the world are now slated to appear in print.

Joseph Sandler, the *Bulletin*'s editor, means to have the work and orientation of the clinic reflected in the new publication, believing "that the simple presentation of clinical reports in the way they are made at the clinic is of value—all too often the richness of clinical observations is lost in conventional journal presentations . . . [and] that regular reading of the successive issues will convey a valid impression of the particular set of psychoanalytic approaches adopted at the clinic."

In the first issue, Hansi Kennedy, who with Miss Freud and Clifford Yorke, is co-director of the Hampstead Child-Therapy Clinic, presents a succinct description of the place. Founded in February 1952, it emerged from the famed Hampstead War Nurseries directed by Miss Freud and Dorothy Burlingham. (In the U.S., the forerunner institution was first noted in a war-time film, *A Journey for Margaret*, starring the then child actress Margaret O'Brien, with the veteran actress Fay Bainter portraying a sympathetic Viennese-accented child psychoanalyst.)

One of the clinic's major functions is the Child Therapy Training Course, started in 1947, that in more than 30 years has trained 101 graduates, who, according to Kennedy, "hold senior positions in universities, hospitals, and clinics [and are] engaged in teaching, research, clinical or applied work. At present, 44 are working in England, about the same number in the United States; five are working in other parts of the world; and six, unfortunately, have died. At present, we have 11 students enrolled in the course. . . . Since 1975, the clinic has had a training arrangement with the Hahnemann Medical College in Philadelphia to accept some of their advanced residents in child psychiatry and doctoral students in psychology annually for a six-months' period of training in child mental health. In addition, we [started] a new one-year course in September 1978 primarily for experienced workers in allied professions who wish to apply psychoanalytic concepts in their own work. . . . This will not be a training in clinical work but will aim at giving an overview of the clinic's application of basic psychoanalytic concepts.

"The clinic receives approximately 250 inquiries each year," Kennedy reports. "At the last intake of the child-therapy course, 80 applicants competed for just four places. The number of students per year varies and is to a large extent determined by available training grants."

The *Bulletin* has already begun to discuss the other aspects of the clinic: the treatment services, with about 50 children and adolescents in therapy on a five-times weekly basis, with an in-depth diagnostic service; a well-baby clinic; a mother/toddler group; a nursery school (one part of which was formerly exclusively dedicated to blind children); as well as the research projects and study groups. Approximately 180 publications and several books and monographs have been brought out by the clinic over the past 26 years. Research into childhood development continues, particularly as it is affected by physical damage. The *Bulletin*'s first 61-page issue contains a paper by Miss Freud, "The Principal Task of Child Analysis," as well as two extensive case presentations by Marie Zaphirious and Marion Burgner, and a brief article by Rose Edgcumbe on encopresis.

The *Bulletin of the Hampstead Clinic* is published quarterly. Subscriptions, at $20 annually, are available by writing to 21 Maresfield Gardens, London, NW3 5SH, England.

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Meeting

THE SOCIETY of Behavioral Medicine will hold an organizational meeting November 19 during the Association for Advancement of Behavior Therapy convention in Chicago. Futher information is available from Marian Weiss, Administrative Assistant, Association for Advancement of Behavior Therapy, 420 Lexington Ave., New York, N.Y. 10017, (212) 682-0065.

10B-27J

Unraveling PKU Mystery Will Take 10 More Years

By Margaret Markham

AFTER A DECADE of intensive, prospective study of phenylketonuria, as many new questions seem to have emerged as answers. It will be at least another ten years before the physiologic puzzle of this disease will be fully unraveled, predicted a Yale University pediatrician at a recent genetics seminar at the Jackson Memorial Laboratory in Bar Harbor, Maine.

It is already apparent that the question of PKU treatment is a time bomb in disguise. Taking youngsters with *classic* PKU off their severely restricted diets may be followed by measurable changes in IQ, behavior, and EEG, according to some researchers. At the same time, putting those with a *transient* form of PKU on the same diet can do irreparable, even fatal harm to both physical and mental development. Preliminary data from an American study seems to confirm what Horst Bickel of Heidelberg, Germany, has maintained all along: that taking infants with classic PKU off dietary restriction could turn out to be an exercise in metabolic roulette.

This prediction seems to be borne out by data now emerging from studies at several centers in the U.S. and abroad, the Yale physician said. He cited as an example his own experience with an 11-year-old girl who had stopped following her special diet. Her school performance began to suffer, and testing showed that she had a drop in her IQ from 110 to 89.

"This change in approach to dietary restriction in children with PKU did not come about as a conscious policy," explained Leon E. Rosenberg at the seminar, which was sponsored by the Jackson Laboratory and the National Foundation—March of Dimes. "What really happened was that some parents had difficulty keeping their children on such a rigorous diet, or the youngsters began to cheat on their own. Nothing much seemed to be going wrong with them, at least not visibly. Pretty soon the notion spread that it might be safe to let the PKU youngsters eat what they wanted, once they had passed the earlier years of development. By the start of the present decade, reports were beginning to filter in that doctors were giving a nod to this approach, at least tacitly."

Last year, however, Barbara Cabalska and her group at the National Research Institute for Mother and Child in Warsaw reported in the *European Journal of Pediatrics* that they had noted unfavorable effects of such dietary indulgence. They found that in their uncontrolled study of 32 children with classic PKU, only 20 had remained on the required diet for close to five years. The rest had dropped out in about half that time. Once both groups were off the diet, levels of serum phenylalanine soared (up to as high as 49 mg/dl compared to normal value of 2 mg/dl). In both groups, there were drops in IQ. The most pronounced decline noted was in one child after four years of a non-restricted diet. In this instance the IQ dropped from 106 to 75. Many of the youngsters also exhibited psychomotor hyperactivity and learning difficulties. Cabalska also reported EEG changes in about one third of the group after they had abandoned dietary restriction, despite the fact that during their early years of controlled diet, their EEGs had been normal in almost all cases.

While this uncontrolled study has not been completely confirmed, Rosenberg said, it certainly exploded any sense of complacency about the notion that classic PKU may require only short-term or limited treatment.

Richard Koch, clinical professor of pediatrics at the University of Southern California in Los Angeles, heads the 15-center collaborative PKU study. This project was started a decade ago to resolve the hotly debated contention that dietary restriction in PKU is pointless. The survey now includes 155 children, of whom some 52 are past six years of age. Half of these older youngsters are now off the special diet to assess the effect in a controlled study. There are some early but as yet unevaluated data that youngsters off dietary restriction are beginning to show some drop in IQ and EEG deviations.

Because of the possible grave implications of the Polish study and other current observations, pediatricians are now beginning to counsel parents against giving in too readily to their children's demands to be free of the restricted diet. Already David L. Valle, head of the PKU program at Johns Hopkins University, is calling in all parents of PKU children to review the problem with them and for individual guidance, with an emphasis on sticking to the diet or returning to it if at all possible; although, according to Rosenberg, widespread EEG changes have not been noted among these dietary dropouts.

On his own part, Rosenberg said that pediatricians involved with PKU children at Yale are "no longer talking about termination of dietary restriction but suggest to parents that this will probably be a lifelong problem for the affected child."

He added that the multicenter collaborative study has yielded other crucial findings in addition to its aim to resolve controversy over prolonged dietary restriction.

"Beyond any shadow of a doubt, the collaborative study has shown that the institution of a low phenylalanine diet within the first month of life in children with classic PKU can allow normal or very near normal development despite the fact that there are some who still dispute this point. I no longer consider it a matter of debate," Rosenberg said emphatically.

"We also now know that PKU is no more homogeneous a disorder than many other genetic ones. In fact, there are at least five different metabolic bases for a rise in serum phenylalanine. Some of these require treatment; others do not.

"One form of this metabolic disorder, for instance, is a transient form that appears early after birth and is picked up by the usual neonatal screening procedures. We believe this is merely a slow maturation of the enzyme system involved in the metabolism of this amino acid. Instead of being absent entirely, as in classic PKU, it just gets to doing its job a little more slowly than normal. What is of paramount importance is that it is becoming very clear that if we treat this transient form as we do classic PKU by severe restriction of phenylalanine

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intake, we can do more harm than good. As we restrict the amount of the amino acid substrate in the transient form, we fail to stimulate the lazy enzyme system to finally get going. We may now be faced with a child in whom not only is somatic development retarded, but brain development as well."

Unlike classic PKU, which persists, the transient form usually clears up in a few months. What is ironic in this particular situation, Rosenberg commented, is that before PKU screening programs were started, these children would never have been singled out at all as "sick" since they are certainly not clinically ill. Thus in the past their transient chemical disturbance would have remained a biologic secret. The actual incidence of this type of PKU is not yet known. But the Yale physician believes it is a significant proportion of the PKU problem and that classic PKU variants (with complete absence of the essential enzyme) "account for probably considerably less than half of all children identified as having elevated serum phenylalanine by newborn screening."

Rosenberg deplored the frustration faced by physicians in their attempt to find an easy method for differentiating the various types of PKU. Unfortunately, he pointed out, the specific enzyme, phenylalanine hydroxylase, is limited to hepatic and renal tissues in terms of levels sufficient for quantitative determinations.

Response to Management

"Physicians don't go around doing biopsies of liver and kidney in newborns just to try to understand the metabolic basis for a disease. With PKU, therefore, we have to make a clinical judgment on the basis of a child's response to dietary management. Only by monitoring serum phenylalanine levels very carefully can we tell in about two or three months if we are dealing with an infant who has the transient form of PKU," the Yale pediatrician said.

Two other newly characterized types of hyperplenylalaninemia were mentioned by Rosenberg at the Bar Harbor symposium. One is due to deficiency of an enzyme, dihydropteridine reductase, and the other a deficiency of a co-factor, biopterin. In an interview, Seymour Kaufman, head of the neurochemistry laboratory at the National Institute of Mental Health, said that assay techniques for these two substances have been worked out. In the case of dihydropteridine reductase, the enzyme is present in fibroblasts, thus providing tissues for testing far more readily than in classic PKU. Techniques are also available for measuring biopterin levels in both liver and body fluids. To date, he said, about a dozen cases of these two genetic disorders have been detected, and they are believed to account for an appreciable though far less common an incidence of hyperphenylalaninemia than classic PKU. However, Kaufman underscored, these two forms carry a very high risk of fatality.

Promising as the various new leads are, they also raise new professional and social concerns. He deplored that even now retarded children are first discovered to be PKU victims at the age of two or more because they were initially discharged too soon from the neonatal nursery for the screening tests to have been definitive.

"I am anxious about how we disseminate information about metabolic diseases specifically and about medical genetics generally. The pace of work in this field has been intoxicatingly rapid so that we may not be able to catch up with it. It would be catastrophic to undo in the next couple of decades what we have so painstakingly done in the past two.

"Can it be surprising that a public which hears much more about cloning of cells than genetic counseling and about transduction rather than treatment has begun to distrust our motives and fear our powers? Nor is it surprising that the vast majority of our colleagues, who completed their formal education before the discipline of medical genetics existed, often fail to understand either the language or the goals of this new discipline," Rosenberg remarked.

"These potentially destructive tendencies are all correctable if we are aware of them and give them the attention they deserve."

Premenstrual Symptoms Said Tied to Menarche

By Dorothy Trainor

TO WHAT EXTENT do women who report a negative experience at menarche manifest a life premenstrual distress? A recent study has shown that premenstrual symptoms may be significantly caused by psychological attitudes and experiences at menarche.

Speaking at the annual convention of the American Psychological Association, psychologist Jon C. Meccarello of the State University of New York at Buffalo, said, "The preparation of the child for this experience is the responsibility of the parents (usually the mother) and of various educational institutions. Attitudes toward menarche and menstruation, as well as information providing adaptive responses are postulated to shape the viewpoint of the young woman in regard to her sexual and social self."

But he added, as Whisnant and Zegans pointed out in 1975, our culture tends to ignore the affective importance of menarche and instead conveys the view that it is a hygienic crisis. In support of these assertions, these investigators reported that postmenarcheal young women in their sample, in contrast to the openness of the premenarcheal females, reacted to menarche in a secretive and closed manner with little or no confiding to significant others except their mothers.

Delving further into the literature, Meccarello found that premenstrual symptoms include headache; an increase in nervous tension and anxiety; and increases in irritability, pain, fatigue, and lethargy. Increased rates of criminal and suicidal acts have been reported, and the women are more likely to seek medical help for their children and psychological services for themselves during their respective premenstrual phases.

To test his hypothesis that faulty adjustment to menarche is related to greater later premenstrual tension, Meccarello distributed a survey questionnaire to 35 graduate students who delineated their menarcheal and menstrual histories. Eighteen responded.

He reported that his investigations point toward the psychological factors of experience and attitude toward the menarche as a significant etiological component in the adult women's self-report and experience of premenstrual tension.

"In this group of competent, successfully functioning women, the orientation and experience of menarche differed significantly between those with intense premenstrual symptoms and those with mild symptoms or none at all. Women who reported high symptomatology reported more negative experiences regarding their menarche than women who reported low premenstrual tension.

"This is not to deny that other factors may also play roles in premenstrual tension (e.g., biological, medical, and general attitudes); yet, because of its high interrelationship with premenstrual tension reports, the experience of menarche may be a most important factor," he concluded.

10B-6

NIOSH Warns Of Disulfiram, Etheline Mix

THE NATIONAL INSTITUTE for Occupational Safety and Health (NIOSH) in its "Current Intelligence Bulletin 23" has recommended that no worker be exposed to both ethylene dibromide and disulfiram, based upon preliminary results of research suggesting a serious toxic interaction between inhaled ethylene dibromide and ingested disulfiram resulting in "exceedingly high mortality of laboratory rats."

Ethylene dibromide is used primarily as a lead scavenger in leaded fuels; as a soil, grain, and fruit fumigant; as an intermediate in the synthesis of dyes and pharmaceuticals; and as a solvent for resins, gums, and waxes. NIOSH estimates that approximately 9,000 employees are potentially exposed to ethylene dibromide during the course of these uses, and an additional 650,000 gasoline station attendants are potentially exposed to very low levels.

In addition to its use as a prescription drug for alcoholism control programs, disulfiram is also an accelerator used in the manufacture of rubber. NIOSH estimates that approximately 70,000 workers have occupational exposure to disulfiram and that as many as 100,000 people may be on disulfiram therapy for alcoholism.

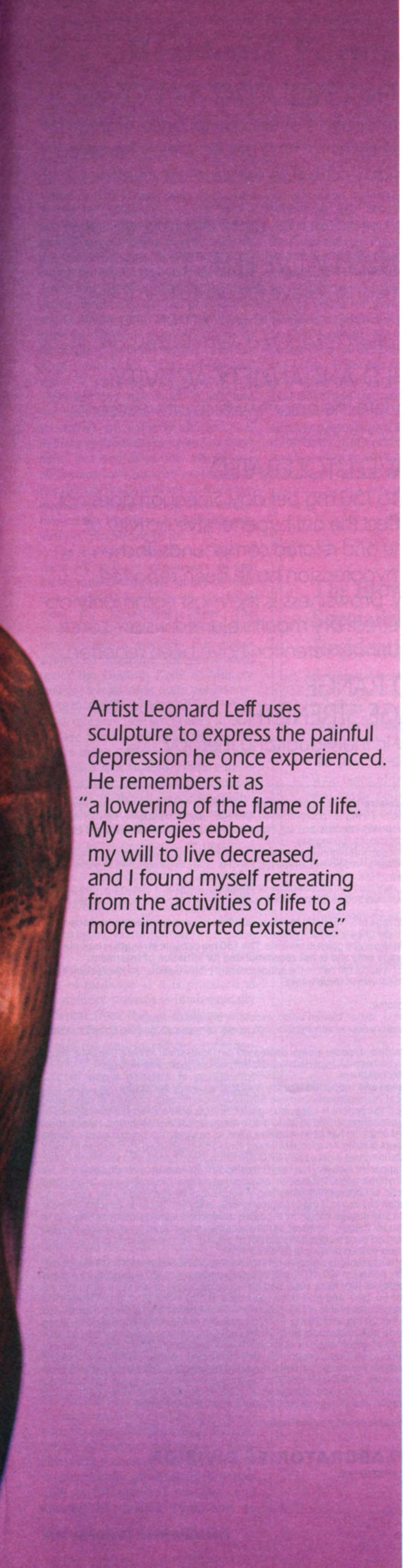
In the ongoing NIOSH-sponsored research, laboratory rats are exposed to 20 ppm ethylene dibromide by inhalation (the current eight-hour TWA OSHA exposure standard) and are also receiving a diet containing 0.05 percent disulfiram. They "are experiencing exceedingly high mortality levels as well as a high incidence of tumors (including hemangiosarcomas of the liver, spleen, and kidney). Even in those sites where tumors often occur spontaneously in rats, such as the mammary gland in females, the incidence of tumors appears to be increased and the tumors are occurring at an earlier than expected age. These results are preliminary and control animals have not yet been completely studied. Although the clinical significance of the data has not yet been evaluated, great caution is indicated."

The study, conducted by Midwest Research Institute in Kansas City, Missouri, involves four groups of animals each comprising 48 male and 48 female Sprague-Dawley rats. "After approximately 13 months of exposure, 45 of the 48 male and 47 of the 48 female rats exposed simultaneously to ethylene dibromide and disulfiram have died or have been terminated because they were dying (due to the formation of tumors)," it says.

While current research continues, NIOSH recommends that no worker be exposed to both ethylene dibromide and disulfiram.

"Workers should not be exposed to ethylene dibromide during the course of disulfiram therapy. Disulfiram . . . should not be administered to workers having potential occupational exposure to ethylene dibromide except in those cases where, in the best judgment of the responsible physician, the benefit of disulfiram therapy strongly outweighs the risk to the particular patient." Further, it cautioned, "whenever disulfiram [bis(diethylthiocarbamoyl) disulfide, tetraethylthiuram disulfide] is used in the workplace (e.g., as an accelerator in rubber production, as a fungicide or insecticide), precautions should be taken so that no worker is exposed to both ethylene dibromide and disulfiram."

10B-1



Artist Leonard Leff uses sculpture to express the painful depression he once experienced. He remembers it as "a lowering of the flame of life. My energies ebbed, my will to live decreased, and I found myself retreating from the activities of life to a more introverted existence."

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See Brief Summary on next page for information on contraindications, warnings, precautions and adverse reactions.

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At doses up to 150 mg per day, Sinequan does not generally affect the antihypertensive activity of guanethidine and related compounds. Tachycardia and hypotension have been reported occasionally. Drowsiness is the most commonly observed side effect. Dry mouth, blurred vision, constipation and urinary retention have been reported.

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BRIEF SUMMARY
SINEQUAN® (doxepin HCl) Capsules/Oral Concentrate

Contraindications. Contraindicated in individuals who have shown hypersensitivity to the drug, and in patients with glaucoma or a tendency to urinary retention. These disorders should be ruled out, particularly in older patients. Possibility of cross sensitivity with other dibenzoxepines should be kept in mind.

Warnings. The once-a-day dosage regimen of SINEQUAN (doxepin HCl) in patients with intercurrent illness or patients taking other medications should be carefully adjusted. This is especially important in patients receiving other medications with anticholinergic effects.

Usage in Geriatrics: The use of SINEQUAN on a once-a-day dosage regimen in geriatric patients should be adjusted carefully based on the patient's condition.

Usage in Pregnancy: Reproduction studies performed in animals have shown no evidence of harm to the animal fetus. Since there is no experience in pregnant women receiving this drug, safety in pregnancy has not been established. There are no data with respect to the secretion of the drug in human milk and its effect on the nursing infant.

Usage in Children: Usage in children under 12 years of age is not recommended because safe conditions for its use have not been established.

MAO Inhibitors: Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug. The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered and the dosage involved.

Usage with Alcohol: It should be borne in mind that alcohol ingestion may increase the danger inherent in any intentional or unintentional SINEQUAN overdosage. This is especially important in patients who may use alcohol excessively.

Precautions. Since drowsiness may occur with the use of this drug, patients should be warned of that possibility and cautioned against driving a car or operating dangerous machinery while taking this drug.

Patients should also be cautioned that their response to alcohol may be potentiated.

Since suicide is an inherent risk in any depressed patient, and may remain so until significant improvement has occurred, patients should be closely supervised during the early course of therapy. Prescriptions should be written for the smallest feasible amount.

Should increased symptoms of psychosis or shift to manic symptomatology occur, it may be necessary to reduce dosage or add a major tranquilizer to the dosage regimen.

Adverse Reactions. NOTE: Some of the adverse reactions noted below have not been specifically reported with SINEQUAN use. However, due to the close pharmacological similarities among the tricyclics, the reactions should be considered when prescribing SINEQUAN.

Anticholinergic Effects: Dry mouth, blurred vision, constipation, and urinary retention have been reported. If they do not subside with continued therapy, or become severe, it may be necessary to reduce the dosage.

Central Nervous System Effects: Drowsiness is the most commonly noticed side effect. This tends to disappear as therapy is continued. Other infrequently reported CNS side effects are confusion, disorientation, hallucinations, numbness, paresthesias, ataxia, and extrapyramidal symptoms and seizures.

Cardiovascular: Cardiovascular effects including hypotension and tachycardia have been reported occasionally.

Allergic: Skin rash, edema, photosensitization, and pruritus have occasionally occurred.

Hematologic: Eosinophilia has been reported in a few patients. There have been occasional reports of bone marrow depression manifesting as agranulocytosis, leukopenia, thrombocytopenia, and purpura.

Gastrointestinal: Nausea, vomiting, indigestion, taste disturbances, diarrhea, anorexia, and aphthous stomatitis have been reported. (See anticholinergic effects.)

Endocrine: Raised or lowered libido, testicular swelling, gynecomastia in males, enlargement of breasts and galactorrhea in the female, raising or lowering of blood sugar levels have been reported with tricyclic administration.

Other: Dizziness, tinnitus, weight gain, sweating, chills, fatigue, weakness, flushing, jaundice, alopecia, and headache have been occasionally observed as adverse effects.

Dosage and Administration. For most patients with illness of mild to moderate severity, a starting daily dose of 75 mg is recommended. Dosage may subsequently be increased or decreased at appropriate intervals and according to individual response. The usual optimum dose range is 75 mg/day to 150 mg/day.

In more severely ill patients higher doses may be required with subsequent gradual increase to 300 mg/day if necessary. Additional therapeutic effect is rarely to be obtained by exceeding a dose of 300 mg/day.

In patients with very mild symptomatology or emotional symptoms accompanying organic disease, lower doses may suffice. Some of these patients have been controlled on doses as low as 25-50 mg/day.

The total daily dosage of SINEQUAN (doxepin HCl) may be given on a divided or once-a-day dosage schedule. If the once-a-day schedule is employed the maximum recommended dose is 150 mg/day. This dose may be given at bedtime. **The 150 mg capsule strength is intended for maintenance therapy only and is not recommended for initiation of treatment.**

Antianxiety effect is apparent before the antidepressant effect. Optimal antidepressant effect may not be evident for two to three weeks.

Overdosage.

A. Signs and Symptoms

1. Mild: Drowsiness, stupor, blurred vision, excessive dryness of mouth.
2. Severe: Respiratory depression, hypotension, coma, convulsions, cardiac arrhythmias and tachycardias.

Also: urinary retention (bladder atony), decreased gastrointestinal motility (paralytic ileus), hyperthermia (or hypothermia), hypertension, dilated pupils, hyperactive reflexes.

B. Management and Treatment

1. Mild: Observation and supportive therapy is all that is usually necessary.
2. Severe: Medical management of severe SINEQUAN overdosage consists of aggressive supportive therapy. If the patient is conscious, gastric lavage, with appropriate precautions to prevent pulmonary aspiration, should be performed even though SINEQUAN is rapidly absorbed. The use of activated charcoal has been recommended, as has been continuous gastric lavage with saline for 24 hours or more. An adequate airway should be established in comatose patients and assisted ventilation used if necessary. EKG monitoring may be required for several days, since relapse after apparent recovery has been reported. Arrhythmias should be treated with the appropriate antiarrhythmic agent. It has been reported that many of the cardiovascular and CNS symptoms of tricyclic antidepressant poisoning in adults may be reversed by the slow intravenous administration of 1 mg to 3 mg of physostigmine salicylate. Because physostigmine is rapidly metabolized, the dosage should be repeated as required. Convulsions may respond to standard anticonvulsant therapy; however, barbiturates may potentiate any respiratory depression. Dialysis and forced diuresis generally are not of value in the management of overdosage due to high tissue and protein binding of SINEQUAN.

Supply. SINEQUAN is available as capsules containing doxepin HCl equivalent to: 10 mg, 75 mg, and 100 mg doxepin: bottles of 100, 1000, and unit-dose packages of 100 (10 x 10's). 25 mg and 50 mg doxepin: bottles of 100, 1000, 5000, and unit-dose packages of 100 (10 x 10's). 150 mg doxepin: bottles of 50, 500, and unit-dose packages of 100 (10 x 10's). SINEQUAN Oral Concentrate (10 mg/ml) is available in 120 ml bottles with an accompanying dropper calibrated at 5 mg, 10 mg, 15 mg, 20 mg, and 25 mg. Each ml contains doxepin HCl equivalent to 10 mg doxepin. Just prior to administration, SINEQUAN Oral Concentrate should be diluted with approximately 120 ml of water, whole or skimmed milk, or orange, grapefruit, tomato, prune or pineapple juice. SINEQUAN Oral Concentrate is not physically compatible with a number of carbonated beverages. For those patients requiring antidepressant therapy who are on methadone maintenance, SINEQUAN Oral Concentrate and methadone syrup can be mixed together with Gatorade®, lemonade, orange juice, sugar water, Tang®, or water; but not with grape juice. Preparation and storage of bulk dilutions is not recommended.

More detailed professional information available on request.

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Residents' Forum

A Feature of the APA Committee of Residents

The APA Committee of Residents solicits contributions to this column from all psychiatric residents. Inquiries and submissions should be addressed to Stevan Gressitt, M.D., c/o Psychiatric News, *1700 18 St., N.W., Washington, D.C. 20009*

By Michael L. Egger, M.D.

UNTIL the advent of the "voluntary armed forces" five years ago, exposure to military psychiatry was a part of the professional experience of most if not all young psychiatrists in the U.S. For some, it was to be endured; for others, enjoyed; but for all, it was a given. Now participation is a matter of choice, but the prospect of another doctor draft looms on the horizon as the number of physicians in the military dwindles yearly. For example, the U.S. Navy, which had about 275 psychiatrists on duty five years ago now has about 75 left, and the number is still shrinking. Other specialties are similarly afflicted, and military authorities, congressional experts, and medical society officials are all rushing forward with explanations for the perfectly obvious: Military medicine is not perceived as an attractive career by the overwhelming majority of physicians in the U.S.

The economic benefits or lack of them for military physicians is one major problem but the nature of military medicine is itself, in my judgment, the largest single issue. The physician on active duty in the military services is precisely that and is subject to discipline and punishment under the Uniform Code of Military Justice, a legal code quite unlike anything that exists in our civil law. While most offenses that are crimes in civil law are also crimes under the UCMJ, so are many "offenses" that are not: disrespect to a superior, failure to report for work, tardiness, or even malingering. In the civilian community, about the most that one's superior can do is to fire the offending physician so long as gross negligence or unethical conduct are not at issue. He has no power to fine, confine to "quarters," or otherwise curtail the liberties of his employees. Military commanders do have such power and occasionally exercise it.

But the differences go deeper than daily annoyances. The basic philosophy of medicine as it is practiced in the military services is fundamentally different from that of medicine elsewhere. Psychiatry is a case in point. One of the most sacred concepts cherished by psychiatrists is that the welfare of one's patients is paramount and that the needs of society supervene only when the patient's behavior is a clear and immediate danger to others. Such is not so in military psychiatry. As in the rest of the military establishment, the needs of the individual are secondary to the "needs of the service" or the "mission," which are pretty much whatever the patients' (and doctors') superiors say they shall be. The medical departments of all three armed services are very much under the control of the "regulars" or "line command," which set budgets as well as department policies.

For the psychiatrist, special problems exist. Persons in the military who dislike being there cannot simply quit before their period of obligated contractual service has expired as employees can in the civilian community with no consequence except a minor breach of contract suit or a questionable work record. About the only way to successfully get discharged honorably is for medical reasons, and among the easiest symptoms to "fake" are psychiatric ones: depression, appetite loss, sleep loss, and, for the more enterprising, suicidal thoughts and hallucinations. Careful evaluation and observation usually enable the clinician to separate the ill from the malingering, but not always, and there is the fear of becoming "hardened" to the dissatisfied malingerer and miss the genuinely ill.

Civil rights for psychiatric patients who are on active military duty are another problem: They are essentially nonexistent in the civilian context of the term. Whereas military dependents and retired personnel can refuse evaluation and treatment and must be "committed" by the civil process in whatever jurisdiction they are in, not so for active duty personnel. They are "ordered" to report to the hospital for evaluation, the hospital becomes their "duty station" and their ability to refuse treatment is left largely at the discretion of their psychiatrist. Although this frees the psychiatrist from much of the cumbersome civil commitment process, it places a heavy ethical burden on him, the moreso as the diagnosis and treatment rendered will largely determine the patient's ability to remain on active duty whether he wishes to or not. The needs of the patient do not always mesh nicely with the "needs" or "convenience" of the armed services.

While, in my experience, I am not aware of any gross abuses, the issue of patients being "ordered" for psychiatric evaluation for administrative, disciplinary, or dispositional reasons (i.e., his commanding officer doesn't like him, he is troublesome, etc.) is a real one. The psychiatrist may be "ordered" to evaluate the patient even if there is no obvious indication that he is mentally ill. The only effective protection for the patient is the psychiatrist's personal integrity and sense of loyalty to his patient and the ethical codes of the medical profession versus the institution he serves. Most younger "short-term" psychiatrists in the military conceive of themselves as physicians who happen to be in the military at the moment, but they feel little loyalty to the institution. Most "career" military physicians, including psychiatrists, feel themselves to be military officers first and physicians second. While this does not reflect on the ethical standards of either group, it does explain much of the petty bickering and perceived irritations complained of by both.

There are no obvious solutions for these difficulties in sight. "Civilianizing" the military medical departments to placate physicians is bitterly opposed by military leaders who fear loss of control of a vital component of national defense, and further "militarization" of the medical departments to make them better serve "the needs of the service" will worsen civilian animosities and physician discontent. In my view the philosophical bases of the medical profession and military organization are diametrically opposed, and any amalgamation of the two is at best an uneasy truce.

9A-2

Psychologist Says Sex Ethics Code 'Poorly Enforced'

By Dorothy Trainor

WHAT has gone wrong? Something is seriously amiss if it is true, as has been reported, that 20 percent of 500 male psychotherapists responding to a survey feel that there are "exceptions" to the rule against physician-patient sexual relations. Equally disturbing is another finding from the same survey that 70 percent of these 500 responders know patients or physicians who have engaged in a sexual relationship within the therapeutic setting.

This grievous matter was discussed by Herbert J. Freudenberger, Ph.D., a New York City private practice psychologist at the American Psychological Association convention in Toronto. He provided further evidence of such goings-on particularly from his knowledge of six male therapists who have been his patients and who admitted engaging in sexual relations with female patients. He titled his presentation, "The Male Therapist as a Returning Patient."

"Both APAs have a fine code of ethics that prohibits sexual contact between the professional therapist and patient. However, they are often, I believe, poorly enforced. The code of ethics itself is not internalized and is an imposed set of rules that is often not considered," he said.

In his hard-hitting presentation, Freudenberger suggested that a good idea for any male therapist thinking that this is a valid therapeutic approach would be to call in a woman consultant. (One could imagine what the woman consultant would say!)

"That is what I tell them when they come to me with that kind of crap," he observed.

The six therapists he had in treatment did not arrive in his treatment setting for the reason that they had experienced sexual relations with a patient or patients. Rather, this fact came out "many weeks or months" later.

"They rationalized their conduct. One justified this behavior by citing the work of Masters and Johnson in prescribing sex surrogate partners for therapeutic purposes. Another saw it as an extension of transference between the therapist and the female patient. Another talked about being a good lover and sex partner and helping the woman through her frigidity and dependency feelings. Three of them suggested that they were helping the patient to work through Oedipal conflicts in terms of father hang-ups in presenting themselves as a good father to the woman."

In any event, each saw the sexual contact as an outgrowth of the therapeutic process, he said. They also presented themselves as being courageous and in the forefront of things and, one asked, "What is wrong with him in terms of his uptightness?"

"When the decision is made to engage in this kind of conduct, to what degree is the woman able to make any kind of rational decision? Has she been informed that this relationship could jeopardize her well-being, her marriage, or other significant love relationship? The answer is obviously, 'No,' " he stated.

The few details given concerning these in-treatment therapists were that they were between ages 29 and 55 years, five being white and one black. One was an M.S.W., four were Ph.D.s, and one was an M.D. Two had completed analytic institute training, while the others had not had that formal training.

"On the surface, these men appeared to be authoritarian, active-aggressive, and arrogant. However, closer scrutiny revealed them to be inhibited and really quite socially uncomfortable. On further scratching, one found that at least three of them were depressed and one seriously so. One of them had a real or pseudo-coronary. They were complainers, not happy about their practices, and found less and less meaning in their work. I believe that they thought that the sex act would bring some degree of life to a depressing practice," Freudenberger said.

In addition, in some 18 years of practice, he has also had women patients in therapy who have engaged in sexual practices with another therapist, he noted. He saw the first of these about ten years ago.

"They approach this situation in a most placid, child-like way. They see themselves as worthless. They are inhibited as women. Many have poor marriages, poor relationships in marriage, and in many ways are suffering from a severe inability to understand themselves as women and people."

Number of Aspects

But what has gone wrong when such sexual shenanigans occur in the therapeutic setting? There are a number of aspects to be looked at, Freudenberger found.

"None of the training programs, as far as I know, deals with ethics or morality. Further, I think that we need to look at the kind of therapists we are graduating and their motivation to become therapists. I think we need to look for answers within the work frame and what the work value system means. We also need to look at society itself."

Motivation, he said, is based upon a value system, i.e., ego gratification, monetary compensation, and power; and power and control have become very important elements in our society.

See "Sex," facing page

"Frankly, having worked with and supervised many male therapists, I can tell you that many of them are working through in their practices their own deprivations and deficient parent-child relationships. These individuals are acting out in the therapeutic relationship that which has not been resolved. . . .

"Although our training is long and arduous, I believe that many times an 'obsessive' or 'compulsive' makes it through. I also believe that a number of psychopaths are graduated. I think that the non-conformist—many times the creative individualistic therapist—is not reinforced to graduate. Often that individualistic person will drop out in time and split either from training or the therapeutic setting. What we are bringing out are often very rigid characters with a very meager value system," he opined.

Therapists need to look at the value system and pay attention to ethics, for therapists cannot separate themselves from their society, he said.

"I believe that we as therapists reflect society, and sometimes unfortu-

The Lonely Student—Lonely by Choice

By Dorothy Trainor

LONELINESS appears to be a leitmotif of our time. Millions are affected regardless of age and social variables. The lonely college student is a case in point, and University of Tulsa research has questioned the reasons a student may feel interpersonally deprived "in an atmosphere of available others."

Speaking at the American Psychological Association's annual meeting, Warren H. Jones, associate professor in the department of psychology at the University of Tulsa, said that it is difficult to imagine social circumstances in which individuals have greater opportunity to make friends.

"No doubt the clinical importance of loneliness increases with time . . .; but there is something paradoxical and hence perplexing about loneliness when it persists over a long period, and the lonely college student is an example of this paradox."

What prevents the lonely student from alleviating his loneliness by becoming involved with other people? Using the UCLA Loneliness Scale, the researchers pursued two avenues of study. One approach concerned the personality and interpersonal correlates of loneliness, and the second focused on the status and frequency of subjects' relationships, particularly heterosexual relationships. As might be expected, the lonely college students reported fewer dates and less satisfaction with dating. Married subjects yielded significantly lower loneliness scores than single or divorced subjects.

However, the principal findings in the lonely ones were self-defeating attitudes, emotional patterns, and coping strategies. Four differences in the behavior of the lonely versus the nonlonely students were: *a*) they do not like themselves; *b*) they do not like other people individually or collectively; *c*) their interpersonal attitudes and behaviors tend to minimize the probability of continued interpersonal contact and subsequent friendship formation and *d*) they *are not* overtly rejected by others.

Inherent Mechanisms

"Thus the present data suggest that the mechanisms maintaining loneliness may be, in part at least, inherent in the attitudes, perceptions, and behavior of the lonely person. Perhaps lonely people project their negative self-perception onto others and fail to initiate—or possibly even avoid—potential relationships," Jones said.

Of course he added, the lonely may avoid such involvements because of inadequate interpersonal skills or previous negative experience. Also, it may be true that loneliness operates as a kind of defense mechanism.

Interestingly enough, while some gender differences were observed, Jones reported that they were most frequently a matter of magnitude and not the direction of the observed relationship. Their analyses also showed no relationship between physical attractiveness and loneliness.

"The experience of loneliness may be sufficiently distressing that lonely [people] are distracted from interpersonal opportunities by their own discomfort. Or perhaps [their] desire for satisfying relationships is so strong that they expect too much and consequently find others lacking. In any case, interpersonal opportunities are missed and loneliness continues," he commented.

Many questions remain to be answered, Jones maintained, but one implication seems clear: Loneliness may become a self-fulfilling process that operates internally without mediation by the responses of others.

"Thus perceived, loneliness could validate pessimistic expectations, resulting in fewer and less effective attempts at interpersonal interactions, leading to increased isolation and so on."

This suggests that, in some cases, loneliness may either become chronic or continue until the introduction of therapeutic or fortuitous situational intervention, he concluded.

This report was presented at a symposium on the psychology of loneliness. Research was also reported by Dan Russell, a graduate student at UCLA. Letitia Ann Peplau, who was also to report on another UCLA study, was unable to be present. Research on senior citizens' loneliness was reported by Daniel Perlman, of the University of Manitoba. Also reporting was Vello Sermat of Toronto's York University. Yet another report was to have been given by Ann Gerson of the University of Manitoba, but she, too, was unable to be there. (An Air Canada strike was on.) No doubt this quantity of reporting indicates the importance given to the subject. 10B-5

Sex

Continued from facing page

nately we reflect it on a woman patient in our practice. I think it is important to recognize that the milieu in which we function contains components that really promote sexual assault on women patients, i.e., the whole power trip."

What can be done? Start talking with each other and share with each other what the hell has gone wrong, he suggested.

"We also need to look at economics. A very significant aspect of economics is built into the private practice setting. Economics have to do with fee structure, with perceiving the woman as an object; and objects become dehumanized and that dehumanization is reflected in mechanical ways."

It is about time as well, Freudenberger concluded, that men, too, consider raising their consciousness to get in touch with their attitudes and role behavior in their therapeutic practices.

"The women are exploring their socialization and the role they play much, much more significantly and in a much more dynamic, creative way than men. Men are still hiding in the woodwork." 10A-22

Annual Meeting

THE ANNUAL MEETING of the Ontario Psychiatric Association will be held January 25–27 in Toronto. Further information is available from S. D. Littmann, M.D., Chair, Program Committee, Ontario Psychiatric Association, 250 College St., Toronto, Ontario M5T 1R8. 10B-27A

Reading Notes

By Karl Menninger, M.D.

Kathleen Jones delivered the fifty-first Maudsley Lecture before the Royal College of Psychiatrists at York last November. I wish I knew more precisely who Kathleen Jones is or was other than being a professor of social administration at the University of York at Heslington.

In her lecture, published in the April 1978 issue of the *British Journal of Psychiatry*, she says we need some psychiatric innovators. We need them in the community services, in the declining mental hospitals, and in psychiatric administration. "We need an energy and a vision and a breadth of concern which psychiatry possessed twenty years ago. . . ."

I agree with her.

* * *

I borrowed from the library a book titled, *Winners & Losers: Battles, Retreats, Gains, Losses and Ruins from a Long War* by Gloria Emerson, a New York *Times* reporter (Random House, 1972). I was moved to read it by several reports I received after I had reviewed the book, *A Rumor of War*, by Philip Caputo.

Well, *Winners & Losers* is another book which ought in some way to be enshrined and placed aloft in every public library. It should be recommended to all high school students and others who might be likely to catch the war fever again some day, because, as one of the reviewers said, "Reading *Winners & Losers* makes me realize how quickly we have lapsed into insensibility, political and moral, after Vietnam." Harrison Salisbury wrote, "My God! What a book Gloria Emerson has wrought! It is sheer agony to read, the kind of agony which grips your mind and heart and does not let you stop no matter how you try. You go on and on and on, and before you are through you know that Vietnam will never be over for this generation of Americans and should never be over. . . . This is not a book; it is a candle which has lighted and its shadow touches us all; its flame burns our minds and our souls."

Many other people feel that this book should be read almost as a ritual, as a memorial, and as a warning, and I agree. I suffered all through the Vietnam years with a feeling of horror and revulsion and anger and disapproval and guilt. My country! But I really didn't visualize a tenth of what was being done. In looking over the pages of this book, I wonder if all the things Gloria Emerson has described actually occurred on this same planet with me. And where was I? Listening to President Johnson's rhetoric? Or to Humphrey's? Or even to Nixon's? I watched aghast, scarcely believing the dutiful, edited reports of horrors on the TV screen. We knew our employees, our sons, and our nephews and neighbors were doing horrible things over there, somewhere, terrible things, forever damnable things. We invented words to make it possible to speak of them to others in public—"bombing,""desolating," "search—destroying." "Tiger cages," "body count"!

"In the beam of my flash light, his brains were a shiny gray mass. Somebody kicked the body . . . and said, 'Oh, excuse me, Mr. Charlie, I hope that didn't hurt,' and we all doubled over with laughter . . ." (p. 319). Scared, bitter, aching, dehumanized, weary fighters for freedom struggled on through the mud and the grass and bushes of the jungle.

* * *

Here comes a reading note about an Indian religion about which most of you don't know printed in a journal most of you don't read. The May 25, 1978, issue of the weekly *Navajo Times* has a special report running to many pages (interspersed with advertisements and news and other articles) dealing with the Native American Church. Members utilize peyote as a part of the ceremonial worship service in just as solemn and serious a way as Christians conduct their communion services. Eating the peyote buttons is not pleasant, sometimes very nauseating (which the Indians consider symbolic purging), but the mood that peyote produces or induces can be very conducive to reflection, meditation, prayer, and thanksgiving. The great classic book on the subject is *The Peyote Religion Among the Navajo* (Aldine, 1966) by David F. Aberle.

The Native American Church embraces many Indians of many tribes, especially the Southwestern ones. It is growing much larger and more influential, partly because it has been especially successful in combating alcohol addiction—more helpful than anything else the Indians have known or tried. I have attended a Native American Church service. I have listened to the drums and to the songs and to the prayers. I have seen the physical and psychological effects of the ingestion of peyote. I have talked with church members, including one psychiatrist and several "Anglos."

Twenty-five years ago I testified to a federal commission that I considered peyote not only *not* harmful, but actually greatly beneficial to the Indians as it is used. I pointed to the masterly monograph of Weston La-Barre on the subject, which amply established the nonharmful uses of peyote. Many others have borne witness that, instead of a bad thing, peyote has been a good thing through the Native American Church; and, as you know, special permissions have been issued to permit its collective use, without incrimination.

Invitational Conference

A SPECIAL invitation conference, "The Future of Mental Health Administration: The Role of Psychiatrist-Administrators," will be held November 3 at Gracie Square Hospital in New York City. The conference is cosponsored by the APA Commission on Certification in Administrative Psychiatry and the administrative psychiatry fellowship programs at William S. Hall Psychiatric Institute in Columbia, South Carolina, and the Albert Einstein College of Medicine in New York. There are no fees for the conference. Further information is available from Seymour R. Kaplan, Albert Einstein College of Medicine, 1300 Morris Park Avenue, Bronx, New York 10461, (212) 430-3046 or 430-4046.

10B-30C

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Eisenberg

Continued from page 8

in the primary care context, he pointed to evidence that this is best carried out when mental health workers are "directly integrated into a comprehensive medical care setting, such as a neighborhood health center."

Coming to his third direct recommendation, Eisenberg pointed out that in relation to the burden of emotional disturbance, mental retardation, school failure, and delinquent behavior of the more than 60 million Americans under 18 years old, their share of the mental health budget is "disproportionately low." There is good scientific evidence, he maintained, of primary prevention of neuropsychiatric disorders by public health measures. Based on this, he called for universal access to family planning, prenatal and perinatal care, and therapeutic abortion; a primary health care system for all children from birth onward; a full range of psychiatric services for children and adolescents; and a family support system as well as acceptable long-term alternatives.

Eisenberg also stressed services for minority groups and urged, especially in times of financial restraints, allocating no less than five percent of health costs to health research "lest we doom ourselves to repeating error and our patients to care that will be no better tomorrow than it is today."

Summing up, he said, "If the professions have any justification for the privileges accorded them by society, that justification lies in discovering the truth and making it known in order to advance human welfare. . . . We can 'get by' by keeping quiet; our patients cannot."

Eisenberg is professor of psychiatry at the Harvard Medical School and senior associate in psychiatry at Children's Hospital Medical Center in Boston. 10B-14

Marmor

Continued from page 7

one is doing, why it succeeds, or why it fails—all based on an understanding of the specific psychological needs of the patient. It is based on understanding the inner and outer forces contributing to patient distress and should enable the patient to cope more effectively with life's problems."

A major concern of Marmor's audience, which included representatives from nationwide daily newspapers and several weekly news magazines, was class bias in the provision of psychotherapy. In response, Marmor placed the historical development of one-to-one psychotherapy in a period in which a major focus was placed on individualism and developing one's own interests.

He also feels that it is valuable for the therapist to have an experience as a patient. "The process of being a therapist is a stressful one. There must be a high degree of responsibility and knowledge of one's own weaknesses."

Marmor suggests that people seeking a therapist do so through well established organizations, although he feels that ultimately the patient must trust his feelings with regard to the choice. "Either there is a fit or there isn't."

The conference for science writers on "Research Perspectives on Treating Mental Illness" was sponsored by the National Science Foundation and APA.

10B-25 —M.C.M.

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Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw. Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. Fine vermicular movements of the tongue may be an early sign of the syndrome. The full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include grand mal convulsions, cerebral edema, polyphagia, pigmentary retinopathy, photophobia, skin pigmentation, and failure of ejaculation.

The phenothiazine compounds have produced blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); and liver damage (jaundice, biliary stasis).

Pigmentation of the cornea and lens has been reported to occur after long-term administration of some phenothiazines. Although it has not been reported in patients receiving TRIAVIL, the possibility that it might occur should be considered.

Hypnotic effects, lassitude, muscle weakness, and mild insomnia have also been reported.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs and must be considered when amitriptyline is administered. *Cardiovascular:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; increased intraocular pressure; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitization; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. *Gastrointestinal:* Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. Rarely hepatitis (including altered liver function and jaundice). *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness, weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1–3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

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Continued from page 9

others; and whether some patients may regress in such a program.

Fresh from a year of work on the President's Commission on Mental Health, Allan Beigel stressed the importance of developing a national research policy. And he pointed out clearly the responsibility that direct caregivers have in helping to define priorities and in generally being involved.

It seemed to him, he said, that if service providers think only of delivering services and ignore research, they are "really doing a disservice to the entire field. We are at the front lines," he emphasized, "and if we do not make a commitment to research, it is very clear that . . . the policy developed will take place in isolation from the pragmatics of working in the service delivery marketplace and from the knowledge [that] those [who] work in that marketplace have."

He indicated that the link between evaluation and research is inescapable. "It's still not clear to us in many target populations which we work with what types of skills, what type of services, what link of delivery strategies work best for what kinds of patient problems." Until this can be pinpointed, he asserted, "it will be very difficult for us to give a responsible answer to questions related to the cost of the services that we deliver."

He sees a need to strive for flexibility of funding resources, assessing current restrictions that impede certain monies from being applied appropriately to mental health problems. Otherwise, he said, "we will continue to be caught in a Catch-22 of everybody wanting to define everything as mental illness, when, in fact, the needs of many persons with mental illness are not mental illness or mental health needs." This applies particularly to the chronic patient in the community.

Beigel said he was encouraged by the ebbing of competitiveness between institutional and community facilities but disappointed to see ongoing turf disputes among mental health, alcohol, and drug abuse professionals. He also applauded the role of community supports that are not a part of the official mental health structure, such as self-help groups and volunteers, opining that the professionals' role is to link to these groups and advise when called upon but not to absorb them into the formal system.

Related to this as well is the inflexibility of laws, rules, and regulations and their "unrelatedness" to service delivery realities. Beigel held out as a possible remedy the Community Mental Health Services Act, being drafted as a by-product of the President's Commission report, which he said he hopes will replace the Community Mental Health Centers legislation within the next 18 months.

Looking into the future, he predicted the forging of a partnership between the public and private sectors. Developments in the past 15 years, he pointed out, have been almost exclusively in the public sector, while the private sector maintains its separate system. A public-private interface will be necessary, he maintained, to most effectively use available funds. 10B-24

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permitted. Malpractice ins. provided. Bnft. package costing $12,000 also provided. Contact George Sakurai, M.D., Ass. Dir., San Bernardino County Dept. of Mental Health, 750 E. Gilbert St., San Bernardino, CA. 92415 (714) 383-3286

PSYCHIATRY RESIDENT POSITIONS. First, Second and Third yr. rsdncy. posns. Dept. of Psychiatry at Univ. of Calif., San Diego is currently accepting applications for all levels of rsdncy. trng. An exciting, stimulating, eclectic trng. prgm. in psych. emphasizing an integration of biological psych. and psychodynamics. Unique trng. exper. in liaison/consult. psych. and alcohol trtmt. as well as solid clin. exper. in Inpt. and Outpt. psych. Contact: Rita Ballard, Coordinator; Residency Training Program; Dept. of Psychiatry M-003; Univ. of Calif., San Diego; La Jolla, CA. 92093 for application and full information.

Central Calif.—Bd. elig./cert. PSYCHIATRIST—Growth oppty. in est, Kern County Mental Health Pgm. New facilities serving metro. area of 200,000 pop. Exc. bnfts. incl. retirement, vac., sick lv., ins. Sal. commensurate with exp. Contact Kern County Personnel Dept., 1120 Golden State Ave., Bakersfield, CA 93301 or call Daniel Grabski, M.D., Dir. (805) 861-2261.

El Dorado County, South Lake Tahoe—PSYCHIATRIST, ½ time ($17,370–$20,945 + $17.50 monthly differential for South Lake Tahoe). Filing date open until posn. is filled. Must be a Dr. of Med. with 3 yrs. of psych. rsdncy. trng. Selection based on quals. and interview. Obtain apprvd. application and min. quals. from PERSONNEL, 330 Fair Lane, Placerville, CA. 95667. Ph: (916) 626-2229. El Dorado County is an EOE.

Fresno—SEVERAL PSYCHIATRISTS CURRENTLY NEEDED to fill existing vacancies in an expanding MHC serving a pop. of 465,000 in the Central San Joaquin Valley of Calif. Interest in working with long-term patients in Outpt. and Inpt. settings req'd. Must have Calif. Lic. Poss. entry into prgm. at managerial level. Sal. range: $46,000 to $52,000 on contract. For further info., contact: Robert P. Withrow, M.D., M.P.H.; Emergency Health Services; Fresno County Dept. of Health; 4441 E. Kings Canyon; Fresno, CA. 93775 Ph: (209) 488-3274

Los Angeles/Newport Beach—Behaviorally-orient., multi-discpl. group seeking Bd. Cert. PSYCHIATRIST with trng. in behavioral approaches and interest in acad.-orient., prvt. clin. prac. Please send CV to: Gene Richard Moss, M.D.; 400 Newport Center Dr.; Newport Beach, CA. 92660

Los Angeles—UCLA Schl. of Med. seeks appropriate candidates for the DELLA MARTIN CHAIR IN PSYCHIATRY, newly endowed Professorship for distinguished acad. psychiatrist (English speaking, elig. Calif. Lic.) committed to research especially on major mental illnesses of adols. and young adults. EOE/AAE. Send CV, ltr. discussing career goals, 5 refs. to: Arnold B. Scheibel, M.D., Chairman; Della Martin Search Committee; 760 Westwood Plaza; L.A., CA. 90024

Los Angeles-Fontana—HMO Cert. will result in a large expansion of the Kaiser-Permanente Dept. of Psychiatry. We have opngs. for Calif. Lic. PSYCHIATRISTS (ABP&N apprvd. rsdncy.) who wish to make a full-time career assoc. Patients have prepaid coverage and represent a wide range of econ. levels and psychopathology. Interdiscpl. approach is emphasized, as is work with families. Therapists use a variety of therapeutic approaches. Beg. sal. is $42,000–44,000. Annual increases and profit-sharing potential. M.D. owned partnership provides $17,000 in frng. bnfts. Write or call: Edward L. Green, M.D., Director of Professional Services, 765 W. College St., Los Angeles, CA. 90012. Ph: (213) 972-8511 or Harlan H. Omlid, M.D., 9985 Sierra Ave., Fontana, CA. 92335. Ph: (714) 829-5091.

Modesto—PSYCHIATRIST for a variety of prgms. in the Stanislaus County Dept. of Human Svcs., MH Division. The work requires part-time for 15-bed acute Inpt. unit with opptys. to spend time in other CMH Prgms. such as Outpt. Svcs., crisis intervention and aged svcs. Consult. and educ. opptys. are also avail. We are int. in a flex. and humanistic individual interested in participating in group, family and individual psychotherapy, clin. consult., clin. supervision, and trng. Family Prac. Residents. Sal. nego. Contact: Larry B. Poaster, Ph.D.; Division of Mental Health; 800 Scenic Dr.; Modesto, CA. 95354 Ph: (209) 526-6543

Patton—PATTON STATE HOSPITAL needs PSYCHIATRISTS AND FAMILY PRACTITIONERS. 1200 bed, modern hosp. for Mentally Disordered, Mentally Disabled, and Penal Code patients; 66 miles east of Los Angeles. Many recreat. facils., health insur. plan, other frng. bnfts., malprac. coverage. Regular hrs., occasional O.D. duty. Starting sal. $41,660 to $44,964 dep. on quals. Contact Bob Martinez, Acting Exec. Dir.; Patton State Hospital; 3102 E. Highland Ave.; Patton, CA. 92369. Ph: (714) 862-8121 ext. 321.

Sacramento—Univ. of Cal., Davis, Dept. Psychiatry has openings for GENERAL PSYCH. Fac. Dept. operates 3 CMHC's as setting for educ. & scientific prgms. for all MH disciplines. An A.A.E./E.O.E. Write Joe P. Tupin, M.D., Division of Mental Health, Sacramento Medical Center, 2315 Stockton Blvd., Sacramento, California 95817. Posns. avail. immed. Applications accepted until 12/31/78. Sal. level nego.

San Francisco—(CMHC) serving middle class area, part-time, outpt. posns. for GEN. PSYCHIATS. and one part-time, outpt. post. for a CHILD PSYCHIAT. with family therapy orientation. Bd. Elig./Cert. preferred. Call or write Ruth Mansfield, Ph.D., Sunset Out-Patient Services, 1351-24th Ave., San Francisco, CA. 94122, 415-564-1290.

San Francisco—PSYCHIATRIST to join estab. suburban prvt. prac. group on San Fran. Peninsula. Send CV or inquiries to: Suite #7; 215 North San Mateo Dr.; San Mateo, CA. 94401

San Luis Obispo—Rural setting between Los Angeles & San Francisco. Opng. July 1, 1978—FULL-TIME PSYCHIATRIST to work in Compre. MHC and provide consult. to multi-discpl. staff in Outpt., Day Trtmt., Drug Abuse, Jail and satellite clinic in Arroyo Grande. Civil Svc. posn., good frng. bnfts. Sal. range: $35,316 to $42,936. Contact: Enn Mannard, M.D.; 2180 Johnson Ave.; San Luis Obispo, CA. 93401. Ph: (805) 544-4722.

Sepulveda—UCLA-VA Hosp., Cal. Psychiatry Dept. currently has openings for 2 half-time Bd. Elig./Bd. Cert. STAFF PSYCHIATRISTS to join active tchng. and clin. svcs. on inpt., outpt. mental health units organized on a commty. psychiatry model. Oppty. for tchng. in an active rsdncy. pgm. plus oppty. to pursue research ints. Applics. must qual. for fac. appt. with UCLA. Sepulveda VA is loc. in the San Fernando Valley, 20 mls. from UCLA. Sal. range dep. on quals., exc. frng. bnfts. Non-disc. in employment. Contact George Saslow, M.D., Chief, Psychiatry Service, VA Hosp., Sepulveda, CA 91343, tel. (213) 894-8271, ext. 2246.

COLORADO

Alamosa—MEDICAL DIRECTOR: Bd. Cert./Bd. Elig. Psych. to supervise and direct all phases of clin. prgms. in an estab. rural CMHC with a mutli-discpl. staff of 64. Loc. in a small college town in the world's largest alpine valley in Southern Colorado with an intriguing Hispanic, Indian and Anglo cultural heritage, the Ctr. offers the oppty. for a prof. challenging career combined with an unlimited potential for outdoor recreat. activities. With one of the nations largest percentages of possible sunshine, the area offers exc. skiing, hunting, fishing, climbing, back-packing, etc., etc., for year 'round outdoor enjoyment. Sal: $40,000 to $56,000 dep. on quals. and exper. Submit resume to: Dr. Luis B. Medina; 1015 4th St.; Alamosa, CO. 81101 Ph: (303) 589-3673

Aspen—CHILD PSYCHIATRIST to join small prvt. clinic in mtn. town. Should be interested in commty. work. Office-sharing, individual income basis. Samuel B. Schiff, M.D.; Box 3238; Aspen, CO. 81611 Ph: (303) 925-3837

Denver—ADULT & CHILD PSYCHIATRIST. Colo. Kaiser-Permanente Dept. of Psychiatry (2 phys., 4 paraprof.) is expanding to meet demand of HMO Cert. We are seeking a full-time psychiatrist w/wide-ranging abilities who is comfortable with a variety of therapeutic approaches in treating adults & chldn. Must be Bd. Elig. for Child Psychiatry. Sal. nego. Contact: R. C. Howard, M.D.; 2005 Franklin St.; Denver, CO. 80205 EOE.

CONNECTICUT

CHILD PSYCHIATRIST, half-time or full-time in a commty. Chldn.'s Hosp., JCAH accred., to participate in the organ. and functioning of a Day Trtmt. Svc. and Outpt. Svc. complementary to already existing Inpt. Svcs. Loc. 15 mins. from Hartford, 45 mins. from New Haven, and near N.Y.C. Full frng. bnfts. incl. paid vacation, sicktime, retirement, grp. life and health insur., etc. Exciting poss. for prof. growth incl. poss. acad. appt. to the UCONN. Med. Schl. Cert. in Psychiatry and Bd. Cert. or Elig. in Child Psych. as well as CT. Lic. will be req'd. Sal. nego. Contact: Hector Jaso, M.D.; Associate Clinical Director of Psychiatry; Newington Children's Hospital; 181 East Cedar St.; Newington, CT. 06111 Ph: (203) 666-2461, ext. 264. EOE.

PSYCHIATRIST—part time posn. Assoc. Psychiatrist to provide coverage for 15-bed short-term adult Inpt. multi-discpl. unit and assist in tchng. pgm. Opptys. for prvt. prac. avail. Mount Sinai is a univ. affil. tchng. hosp. loc. midway between N.Y. and Boston. Compet. sal. and exc. bnft. pckg. on prorata basis. Contact: J. Haksteen, M.D.; Chief of Psychiatry; Mount Sinai Hospital; 500 Blue Hills Ave.; Hartford, CT. 06112.

SERVICE CHIEF (PSYCHIATRIST) Substance Abuse Unit with a 78-bed psychiat. facil. in a short-stay inst. Must be interested in working with a multi-disciplinary approach. Cand. must be bd. elig., with at least 2 yrs. of admin. exp. SAL: $45,000–$50,000. Send resume c/o Medical Director, Hall-Brooke Hosp., Westport, Conn. 06880

SERVICE CHIEF FOR ADULTS (PSYCHIATRIST) within a 78-bed psychiat. facil. in a short-stay inst. Must be interested in working with a multi-disciplinary approach. Candidate must be bd. cert., with at least 2 yrs. of admin. exp. SAL: $45,000–$50,000. Send resume c/o Jose Rodriguez Friere, M.D., Hall-Brooke Hosp., Westport, Conn. 06880

THREE YEAR full accred. PSYCHIATRIC RESIDENCY PROGRAM avail. at Norwich Hospital, a commty.-orient. MH facil. Computerized and problem orient. record-keeping. Close association with Institute of Living, St. Francis Hospital, and Univ. of Conn. Health Center. Beautiful surroundings close to ocean and near metro. ctrs. Sals: First yr. $14,219; Second yr. $14,886; Third yr. $16,667. Free housing when avail. Exc. frng. bnfts. Write: Director of Training, Norwich Hospital; P.O. Box 508; Norwich, CT. 06360

Newington—POSNS. FOR PSYCHIATRISTS in Inpt. svc. of new hosp. in a new MH region. Multi-discpl. approach. Exc. opptys. for advancement. Convenient beautiful loc. close to exc. schools and cult. ctrs. in central Conn. Exc. frng. bnfts. Write: Vincenzo Cocilovo, M.D., Superintendent, Cedarcrest Hospital, Newington, Conn. 06111.

Newtown—CONNECTICUT PSYCHIATRIC RESIDENCIES. AMA approved psych. rsdncy. vacancies. Active varied trtmnt. prgm. dynam. oriented and affil. with Yale, Univ. Trng. in New Haven avail. to qualif. residents. Prgm. includes affil. at CMHCs for ambulatory psych. in a commty. setting. Three and four pgms. avail. dep. on level of trng. Extensive didactic tchng. schedule includ. basic and clin. neurology. Superv. provided for inpt. and outpt. exper. with adult and adols. Apts. avail for married residents with no children at no cost. Limited housing for married physicians with families. Sal. 1st yr. $14,219, 2nd yr. $14,886, and 3rd yr. $16,667. Write to: Robert B. Miller, M.D.; Superintendent; Fairfield Hills Hosp.; Newtown, CT 06470.

Norwich—PSYCHIATRISTS—clin. and tchng. posns. avail. in 800-bed commty.-orient. MH facil. with many specialized, forward-looking prgms. Computerized record keeping. Fully apprvd. 3-yr. rsdncy. trng. prgm. Sals. starting at $26,199–$36,959, with addit. paid call, exc. frng. bnfts., retirement and insur. prgms. Housing avail. Write: Superintendent; Norwich Hospital; P.O. Box 508; Norwich, CT. 06360

Portland—STAFF PSYCHIATRIST, Elmcrest Psychiatric Institute is a 105-bed prvt. psych. hosp. for adols. and adults, sit. in Central Conn. We are seeking a full-time Bd. Cert. or Bd. Elig. psych. to work in a prgsv. trtmt. setting that is primarily psychosocial with emphasis on grp. and family psychotherapy. Sal. dep. on exper. and quals. Call or write: Louis B. Fierman, M.D., F.A.P.A., Medical Director; Elmcrest Psychiatric Institute; Portland, CT. 06480 Ph: (203) 342-0480

Waterbury—CHILD PSYCHIATRIST, half-time Bd. Qual. to work in new prgm. providing liaison svcs. to a Pediatric Ambulatory Care Clinic from a Commty. Child Guidance Clinic. Opptys. for tchng., consult., and svc. Poss. of another part-time posn. in the commty. Knowledge of Spanish helpful. Exc. frng. bnfts. Sal.—HT—$17,000. Write: Robert S. Adams, M.D.; Child Guidance Clinic of Waterbury; 70 Pine St.; Waterbury, CT. 06710

DISTRICT OF COLUMBIA

PSYCHIATRIST—Unusual oppty., Adols., Young Adults, Family, Individual & Group, prvt. grp. prac., Inpt-Outpt., commty. consult., trng., tchng. Reply Box P-838, *Psychiatric News*.

Metro. Washington Area—ADULT & ADOLESCENT PSYCHIATRISTS—large single specialty partnership assoc. with prvt. psych. hosp. with active, individual, group, therapeutic commty. prgm. desires adols. psychiatrists. Ideal posn. for energetic, ambitious, and creative person interested in combination of Inpt. and Outpt. prac. Med. Schl. affil. poss. Exc. oppty. for prof. and economic growth. Send complete resume with initial inquiry for Adols. posn. to: John Meeks, M.D.; Psychiatric Institute of Washington; 4460 MacArthur Blvd., N.W.; Washington, D.C. 20007 For Adult posn. to: Robert T. Lewit, M.D.; 2220 K St., N.W.; Washington, D.C. 20006

FLORIDA

PSYCHIATRIST, Bd. Cert. and experienced, to associate with busy practitioner in most desirable Florida East Coast area—A Golden Opportunity. Must have Fl. Lic. Send CV to Box P-843, *Psychiatric News*.

PSYCHIATRIST—to associate in busy prvt. prac. Ex. Oppty. Florida license req'd. Send CV and details to Box P-864, *Psychiatric News*

Clearwater—DIRECTOR OF NURSING SERVICE—200 beds JCAH accred. prvt. psychiat. hosp. seeks PSYCHIATRIC NURSE with BSN or MSN degree to assume respon. for the supervision and administration of nursing svc. Min. of 5 yrs. exp. with progressively increased respons. to incl. past exp. as Dir. of Nursing Svcs. Hosp. staff incl. 12 psychiats., 2 psychols. and 6 social workers. Send CV, including sal. hist., in confidence, to La Rue Hayes, Personnel Dir. Horizon Hosp., Inc., 11300 Highway 19 South, Clearwater, FL 33516 EOE

Clearwater—O.T.R. DIRECTOR—Rapidly growing JCAH accred. prvt. psychiat. hosp. seeks enthusiastic ind., strong in both clin. and admin. areas. Min. 5 yrs. exp. with progressive O.T. respons. Please send CV, inc. sal. history, in confidence, to La Rue Hayes, Personnel Dir., Horizon Hosp., Inc, 11300 Highway 19 South, Clearwater, Fla., 33516. EOE

Macclenny—CLINICAL DIRECTOR—Bd. Cert. Psychiatrist. Directs all MH Prgms. in a prgsv. JCAH accred. state mental hosp. Loc. in a rural commty. 25 mins. from Jacksonville. Frng. bnfts. incl. on-ground housing; paid vacation, sick time and retirement; state supplemented grp. life and health insur.; pleasant working conditions. Contact: T. F. Burke, M.D.; Mental Health Program Supervisor; District IV; 5920 Arlington Expressway; Jacksonville, FL. 32231 An EOE.

Macclenny—PSYCHIATRISTS—Bd. Cert. or Bd. Elig. Psych. Staff members involved in MH prgms. in a prgsv. JCAH accred. state mental hospital. Loc. in a rural commty. twenty-five mins. from Jacksonville, FL. Frng. bnfts. include on-ground housing; paid vacation, sick time and retirement; state supplemented group life and health insurance; pleasant working conditions. Contact: T. F. Burke, M.D.; Mental Health Prgm. Supervisor; District IV; 5920 Arlington Expressway; Jacksonville, FL 32231.

Pensacola—PSYCHIATRIST—G.P. PHYSICIAN—Opngs. are anticipated from time to time in well estab. CMHC. FL lic. req. This is a CMHC with four large prgms.; Drug Abuse, Alcohol Counseling Center, Child Development Center and General Mental Health Program. Pensacola offers beautiful beaches and exc. recreat. opptys. No state income tax. Letters of inquiry, with resume, should be forwarded to Morris L. Eaddy, Ph.D., Executive Director, CMHC of Escambia County, Inc., 1201 West Hernandez St., Pensacola, FL 32501. An EOE.

Tampa—CHILD PSYCHIATRIST, ASSOCIATE OR ASSISTANT PROFESSOR, to direct child psych. prgm. in affil. MH facil. and teach students, residents and child fellows. Appt. incl. opptys. for collaborative research, consult. and prvt. prac. FL. Lic. pref. Sal. dep. on quals. The Univ. is an EOE. Applicants should contact: Anthony Reading, M.D.; Professor and Chairperson; Dept. of Psychiatry; Univ. of South Florida College of Medicine; 12901 North 30th St.; Tampa, FL. 33612 or call (813) 974-2118

GEORGIA

Milledgeville—Central State Hospital, a prgsv. psych. hosp. has opngs. for STAFF PSYCHIATRISTS. Milledgeville is a beautiful and prosperous city of approx. 15,000, 2 hrs. from Atlanta, 45 mins. from Macon and immed. accessible to Lake Sinclair, a large hydro-electric lake. It is within easy reach of Georgia and Florida beaches. Beg. sal. up to $42,942.00 annually dep. on quals. with subsequent sal. advances of approx. 5% annually. The hosp. pays approx. 17% of salary for an exc. frng. bnft. pckg. Limited housing on Hosp. grounds avail. Contact: W. T. Smith, M.D., Chief Medical Officer; Central State Hospital; Milledgeville, GA. 31062 Ph: (912) 453-5381

HAWAII

THE HAWAII MENTAL HEALTH DIVISION has immed. opngs. for CHILD PSYCHIATRISTS in admin. and clin. posns. Our chldn.'s MH Svcs. Branch operates a variety of direct-svc. and consult. prgms. which are based primarily on Oahu, but which also have respon. for prgms. on the Neighbor Islands. Base sal. is $32,792 with exc. working and living conditions, prvt. prac. opptys., and the option of participation in our on- call roster system. Immed. opngs. for ADULT PSYCHIATRISTS. Current opngs. are: Staff Psych. (half time) Big Island (Hilo), CMHC; Staff Psych., Maui, CMHC; Staff Psych., Honolulu, Kalihi-Palama CMHC; Staff Psych., Oahy (Kaneohe) Hawaii State Hospital. Send CV and names of 3 psychiatrist references to: M. W. Neal, M.D., Chief Psychiatrist; Mental Health Division; 550 Makapuu Ave.; Honolulu, HI. 96816

Tired of smog and the Rat Race? Come to Hawaii for fine living, and the chance to meet your family. The Hawaii State Mental Health Div. operates a statewide system that offers prof. rewarding work in metro., rural, and Neighbor Island clinics; on special prgm. (chldn., forensic, substance abuse) teams; and at our state hosp. We are recruiting for eclectic self-sufficient psychiatrists with the capacity to adapt to Hawaii's multi-faceted commty. Base sals. are not compet. but the living conditions are, and we offer exc. frng. bnfts, plus oppty. for prvt. prac., and the option of up to $6,000 per yr. from participation in on-call rosters. Our prgms. are a primary trng. resource for the Univ. of Hawaii Dept. of Psych. and tchng. appts. may be avail. to the qual. If interested, send CV and names of 3 psychiatrist references to: M. W. Neal, M.D., Chief Psychiatrist; Mental Health Division; 550 Makapuu Ave.; Honolulu, HI. 96816

ILLINOIS

FELLOWSHIP IN GERIATRIC PSYCHIATRY sponsored jointly by the Ill. State Psychiat. Inst. and Rush Med. Col. beg. July, 1979. Fellowship provides trng. in inpt., outpt., and consultative geropsychiatry, commty. geropsychiatry, and ind. and collaborative psychol. and bio. research under the supervision of Drs. Jack Weinberg, Lawrence Lazarus, Herbert Meltzer and John Davis. Applicants should have completed psychiat. rsdncy. and be elig. for Ill. lic. Sal. $23,000. Reply with C.V. to Lawrence W. Lazarus, M.D. Dir. of Geriatric Svcs., Ill. Psychiatric Inst., 1601 West Taylor St., Chicago, Ill. 60612.

Chicago—UNIVERSITY PSYCHIATRIC RESIDENCY: Apprvd. 4-yr. prgm.—opngs. all levels. Prgm. develops broadly based clin. within a med. model. Focus upon the seriously ill patient, psychosomatic illness, psychopharm., behavior and brief psychotherapies. Exper. in Inpt. psych., behavioral and trad. neurology, consult./liaison, child & adols. psych., and ambulatory svcs. Specialized trng. in neuropsychology & joint trng. toward a Ph.D. in clin. psychology plus rsdncy. Cert. avail. Many electives. Research encouraged. Stipends: $14,497 to $16.779; many frng. bnfts. Contact: Michael Alan Taylor, M.D.; Professor and Chairman; Dept. of Psychiatry & Behavioral Sciences; Univ. of Health Sciences/The Chicago Medical School, Bldg. 50; North Chicago, IL. 60064 EOE.

Decatur—PSYCHIATRIST-Affiliate with an expanding modern facil. in Central Illinois. Innov. commty. and Inpt. care prgms. involving adults and adols. Except. environ., recreat. and family setting. Major univs. nearby. Part-time poss. as well as prvt. prac. potential. Send vita or contact: Dale L. Kelton, Ph.D., Regional Administrator, Adolf Meyer MHC, Decatur, IL. 62526. Ph: (217) 877-3410.

INDIANA

AN ESTAB. CMH PRGM. LOC. IN LAWRENCEBURG, HAS A CURRENT OPNG. FOR A STAFF PSYCHIATRIST TO JOIN THE MEDICAL DIRECTOR-PSYCHIATRIST AND MULTI-DISCPL. STAFF. DUTIES INCL. OUTPT., SOME INPT. AND MODERATE LOCAL TRAVEL TO SERVE SATELLITE CLINICS. ENTRY SAL. IS NEGO. FROM $45,000 UPWARDS, DETERMINED BY INDIVIDUAL QUALS. AND EXPER. AND CAN REACH $55,000+ FOR THE BD. CERT. CANDIDATE WITH EARLIER CMHC EXPER. FRNG. BNFTS. ARE EXCEPTIONAL AND ACAD. AFFILS. POSS. THE STAFF ENJOYS COMMTY. PRAC. AND LIVING IN AN ATTRACTIVE NON-URBAN SETTING, WHILE HAVING EASY ACCESS TO CINCINNATI (20 MILES AWAY) OFFERING ALL METRO. ADVANTAGES. PLEASE REPLY TO: FARABEE & ASSOCIATES, INC.; P.O. BOX 472; MURRAY, KY. 42071 FARABEE IS RETAINED BY THE PROGRAM IN ITS SUPPORT.

THE INDIANA STATE HOSPITALS, AT LOCATIONS THROUGHOUT THE STATE, HAVE SEVERAL CURRENT AND EXCEPTIONAL OPNGS. FOR PSYCHIATRISTS OF MOST EXPER. LEVELS. THE SAL. SCHEDULE RANGES FROM $36,436 to $48,826 P.A., WITH INCREMENTAL INCREASES. FRNG. BNFTS. ARE BROAD AND GENEROUS. AN ADJUNCT PRVT. PRAC. IS POSS. AND ACAD. AFFIL. CAN BE DISCUSSED. WHILE THE HOSPITALS PRIMARILY SEEK FT PHYSICIANS, PT ASSOCIATIONS ARE POSS. PLEASE REPLY, WITH A COPY OF THE CV TO: FARABEE & ASSOCIATES, INC., P.O. BOX 472, MURRAY, KY. 42071 OR CALL COLLECT (502) 753-9772. FARABEE IS RETAINED IN SUPPORT OF THE HOSPITALS.

Bloomington—DIRECTOR OF PSYCHIATRIC DIVISION-respons. for the psychiat. div. of a large midwestern univ. Student Health Svc. Person should have abilities and interests in the prac. of clinical psychiat. emphasizing late adolescent and early adult, as well as have admin. abilities. Must have abilities and interests in the multi-disciplinary approach to college health, inc. close consultation with 15 primary care physicians. Present division consists of 3 psychiats., one counseling psychol. and 3 psychiat. social workers. The division also supervises trng. prgms. for med. students, psychiatric residents, psychols., and psychiat. social workers. Interested person please send resume by Nov. 3, 1978 to: Chairman, Search and Screen Committee, Student Health Svc., Indiana Univ., 600 North Jordan, Bloomington, IN 47401. EOE/AAE

Elkhart—THERE IS A CURRENT OPNG. FOR A SENIOR PSYCHIATRIST WITH A LARGE AND WELL-ESTAB. COMMTY. PRGM.—THE OAKLAWN PSYCHIATRIC CENTER, INC. ENTRY SALARY IS NEGOTIABLE, DEP. ON INDIVIDUAL QUALS. AND EXPER., TO $52,000; PLUS EXCELLENT FRNG. BNFTS. AN ACAD. AFFIL. IS POSS. CANDIDATES MUST BE BD. CERT. AND EXPER. IN COMMTY. PRAC.; AND, SINCE OPPTY. FOR PROFESSIONAL GROWTH IS VERY POSITIVE, SHOULD BE MOTIVATED FOR ASSUMPTION OF INCREASED RESPONS. WITHIN A REASONABLE TIME. RESPOND WITH A COPY OF THE CV TO: DIRECTOR, PROFESSIONAL RECRUITING; FARABEE & ASSOCIATES, INC.; P.O. Box 472; MURRAY, KY. 42071 OR CALL (COLLECT) (502) 753-9772. FARABEE IS RETAINED BY THE CENTER.

Evansville—THE SOUTHWESTERN INDIANA MENTAL HEALTH CENTER, INC., A COMPRE. AND ESTAB. COMMTY. PRGM. IN THIS CITY HAS A CURRENT OPNG. FOR A SENIOR-LEVEL PSYCHIATRIST. DUTIES INCL. OUTPT., CONSULT. AND RELATED RESPONS., WITH A MINIMUM OF INPT. WORK. THE WELL-BALANCED STAFF OF 150, DIRECTED BY THE EXECUTIVE DIRECTOR-PSYCHIATRIST INCLUDES 4 OTHER PHYSICIANS, ONE OF WHOM SUPERVISES INPT. CARE. CTR. FACILS. ARE MODERN, FUNCTIONAL AND ATTRACTIVE. ENTRY SAL. IS NEGO. TO $50,000 PLUS GEN. FRNG. BNFTS. AN ACAD. AFFIL. IS POSS. EVANSVILLE—IN A SOUTHERN LOCATION—IS A CITY OF SUBSTANTIAL SIZE, OFFERING MANY ADVANTAGES AT A MODERATE COST OF LIVING. PLEASE RESPOND WITH A COPY OF THE CV TO: FARABEE & ASSOCIATES, INC.; P.O. BOX 472; MURRAY, KY. 42071 or CALL COLLECT (502) 753-9772. FARABEE IS RETAINED BY THE CENTER.

Jasper—THE SOUTHERN HILLS MENTAL HEALTH CENTER, A MATURE AND ESTAB. COMMTY. PRGM. IN THIS CITY HAS CURRENT OPNGS. FOR 2 PSYCHIATRISTS, AS FOLLOWS: A CLINICAL DIRECTOR, TO DIRECT THE CLIN. SVCS. OF THE PRGM. SAL. IS NEGO. TO $55,000. A RESIDENTIAL SVCS. COORDINATOR, TO SUPERVISE INPT. AND RELATED ACTIVITIES, WITH SOME OTHER RESPONS. SAL. NEGO. TO $45,000. CANDIDATES SHOULD HAVE EARLIER COMMTY. EXPER. AND ENJOY PRAC. IN A NON-URBAN SETTING WHICH PROVIDES PROF. SATISFACTION AND AN ABUNDANT LIFE-STYLE, AT A MODERATE COST OF LIVING. ELIG. FOR IND. MED. LIC. REQ'D. PLEASE RESPOND WITH A COPY OF THE CV TO: FARABEE & ASSOCIATES, INC.; P.O. BOX 472; MURRAY, KY. 42071 OR CALL COLLECT (502) 753-9772. FARABEE IS RETAINED BY THE CENTER.

Marion—ONE PSYCHIATRIST, Bd. Cert., with some admin. exper. Permanent Lic. any U.S. State req'd. Sal. open to $47,025 dep. on quals. and exper. Special bonus pay of about $6,000 avail. 40 hr. work week; 30 days vacation; 15 days sick lv; 9 paid holidays; low cost life and health insur.; exc. retirement plan. Moving expenses paid. EOE Contact: Personnel Service, VA Hospital, Marion, IN. 46952. Ph: (317) 674-3321, ext. 419 Collect.

IOWA

Grp. consisting of psychiatrist, 2 SWs; & M.A. Psychol. needs 2nd PSYCHIATRIST. Assoc. posn. with guaranteed sal. initially, commensurate to trng. and exper.; partnership later if so desired. Univ. twn., prgsv. and growing, recreat. & cult. oppty. 2 psych. units at local prvt. hosps. with approx. 70 beds. Contact: Otto C. Della Maddelena, M.D.; 3346 Kimball Ave.; Waterloo, IA. 50702

PSYCHIATRISTS-MHI, CHEROKEE—A SERVICE TEACHING HOSP. Accred. 3 yr. rsdncy. trng. plus wide tchng., trng., and commty. prgms. Stable eclec-tic full svc. acute care Inpt. Univ. affil. OPENINGS FOR CLINICAL DIRECTOR AND STAFF PSYCHIATRIST. Sal. to $48,880. Lib. frngs. (20% gross) Deferred income avail, prvt. prac. opptys. Call Collect or write: T. B. McManus, M.D.; 1200 West Cedar; Cherokee, IA. 51012 Ph: (712) 225-2594

Clarinda—immed. opening for CHILD PSYCHIATRIST to be Medical Director of a 40-bed adoles. unit presently operating on behavior management. Unit personnel also respon. for resident. pgm. for teen-age girls off hosp. campus. Three level pgm. is unique in 25-county catchment area served by the hosp. Sal. range $34,658–$46,540. Contact: T. E. Shonka, M.D., Superintendent, Box 338, Clarinda Mental Health Institute, Clarinda, Iowa 51632, or call collect (712) 542-2161.

Clarinda—WANTED: PSYCHIATRISTS with or without subspecialty int. Sal. nego. from $34,658 to $46,540. Frng. bnfts. and deferred compensation avail. Info. concerning institution and commty. avail. on request. T. E. Shonka, M.D., Supt. Mental Health Institute, Box 338, Clarinda, Iowa 51632.

Des Moines—CHILD PSYCHIATRIST, FT, Bd. Elig. and must have Iowa Lic. to work in D.M. Ch. Guid. Ctr., a prgsv. well estab. prvt. agency with multi-dimen. progms., incl. partial hosp. outreach prgm. prof. trng., commty. consult. and eval. prgm. Member of AAPSC. Poss. part-time consult. and tchng. posn. at Raymond Blank Bhildren's Hosp., Pediatric Residence Prgm. Exper. desirable pref. with both dynam. & eclectic approach. Sal. nego. Frng. bnfts. incl. ret.; malprac.; insur.; vacat. & sick lv. Posn. open Jan. 1, 1978. Send vita to: Mary E. Kohl, M.D., Coord. Div. Cl. Serv.; DMCGC; 1206 Pleasant St.; Des Moines, IA. 50309 EOE/AAE

KANSAS

Wichita—PRIVATE GROUP PRACTICE. We are a prof. association of 4 psychiatrists assoc. with 4 Ph.D.'s and one MSW engaged in the gen. prac. of psych. utilizing indiv. and grp. psychotherapy, family therapy, behavior modif., biofeedback, pharmacotherapy, ECT, and commty. consult. both Inpt. and Outpt. Loc. in a midwestern metro. area of 350,000 with 180 psych. beds., 2 CMHCs, 2 univs., 1 college, med. schl., theater, symphony, recreat., and all other amenities. We need a well-trained, eclectic, high energy level, autonomous but team orient., competent psych. who wants the freedom to grow into his full capacity while enjoying early partnership, exc. remuneration and outstanding frng. bnfts. If you are interested, write or call us collect: Wichita Psychiatric Center, P.A.; P.O. Box 8037; Wichita, KS. 67208 Ph: (316) 684-0201

KENTUCKY

MEDICAL DIRECTOR NEEDED FOR CMHC SERVING 8 COUNTY AREA (POP. 106,000) IN APPALACHIAN COAL REGION OF SOUTHEASTERN KENTUCKY. MUST BE BD. ELIG.; CURRENT LIC. TO PRAC. MED. IN THE STATE OF KY.; PREF. WITH CMH EXPER. RESPON. FOR ADMIN., DIRECTING AND COORDINATING ALL CLIN. SVCS. OF THE CTR. APPLY ONLY IF INT. IN WORKING IN AN HONEST-TO-GOODNESS CMHC, AND LIVING IN A MTN. COMMTY. OF 10,000 PEOPLE. LARGE METRO. CTR. 2 HRS. AWAY. IMMED. PLACEMENT, SAL. NEGO. CONTACT: SLAYREAN GOFF, EXEC. DIR., MENTAL HEALTH CENTER, P.O. BOX 800, HAZARD, KY. 41701. PH: (606) 436-5761. ALL APPLICANTS WILL RECEIVE CONSIDERATION FOR EMPLOYMENT WITHOUT REGARD TO RACE, COLOR, RELIGION, SEX, NATIONAL ORIGIN OR AGE. AN EOE.

Hopkinsville—STAFF PSYCHIATRIST opngs. in 450-bed JCAH accred. psych. hosp. Exc. relationship with CMHC, outstdg. frng. bnfts. with univ. affil. poss. KY. Lic. req'd., completion of 3 yrs. apprvd. rsndcy. Sal. $37,641 to $41,599, higher sal. poss. according to exper. and Cert. with poss. of addtl. income by PT empl. for other agencies. Please write or call: Calvin N. Turns, Chief of Staff; Western State Hospital; Hopkinsville, KY. 42240 Ph: (502) 886-4431

Louisville—EXECUTIVE DIRECTOR for MH/MR Ctr. Gross revenue $7 to $8 million. Requirements: Min. of 10 yrs. management exper. preferably in medium to large health care facil. Bachelor Degree pref. Masters in Business and/or health admin. Ability to deal effectively with chief operating officer of variety of gov't. agencies and commty. groups. Please send resume incl. sal. history to: Executive Director Search; P.O. Box 1112; Louisville, KY. 40201 An EOE. M/F

Morehead—a full-time PSYCHIATRIST to join prvt., multi-spec. grp. prac. and CMHC, adjoining hosp., developing 20-bed MH Unit. Exc. Sal. and bnfts. Univ. commty. loc. in scenic Appalachian Mtn. foothills. Outstanding family living. Contact. Richard A. Callis, Administrator; Morehead Clinic; 234-R Flemingsburg Rd.; Morehead, KY. 40351 Ph: (606) 784-6641

Owensboro—STAFF PSYCHIATRIST: One FT staff psych. to join well-estab. compre. CMHC in congenial Owensboro, KY, third largest city in state. To have medical leadership of teams working in outpt., inpt., partial hospitalization and other prgms. involving total MH needs of an active commty. Facilities, frng. bnfts. and CME opptys. excel. Start. sal. $38,000-48,000 depend. on quals. Contact: Bryan Warren, M.D., Clin. Dir., Green River Compre. Care Ctr., P.O. Box 950, Owensboro, KY 42301. Ph. Collect: (502) 684-0696.

Western Kentucky—PSYCHIATRIST for CMHC serving 9 counties in Pgm. incl. outpt. svc., partial hospitalization and inpt. care in adjoining modern hosp. Outstanding oppty. for innovative ind. committed to CMH concepts. Catchment area loc. in recreational ctr. of Western Kentucky along the beautiful Ohio River. Outstanding opptys. for all outdoor recreation; exc. schls. Sal. nego. Exc. frng. bnfts. Pos. vacant as of Oct. 1. Send resume to Charles McArthur, Ph.D.; Executive Director; Community Mental Health Centers of Western Kentucky; P.O. Box 1502; Paducah, KY 42001. AA/EOE.

LOUISIANA

Lafayette—CLINICAL PSYCHIATRIST—Prvt. MHC wishes to add a psych. who wants to develop his own prac. or to change the geographical loc. of his prac. Oil rich area, booming commty., lots of hunting and fishing, moderate weather, near Gold Coast, 2 ½ hrs. drive from New Orleans. Commty. is attractive and very active culturally. Your patient load will be drawn from half million population living within 50 sq. mile radius of clinic. Clinic itself offers automated multiple unit hypnotherapy clinic for your use. If you are personable and possess high level therapeutic skills, your income with this clinic within 5 yrs. of practicing should exceed $100,000. For details call Dr. Hunter Shirley (318) 984-5424 or write the Lafayette Institute of Behavior Therapy & Crisis Management, 4416 Johnston St., Lafayette, LA. 70503.

New Orleans—VA Hosp. is recruiting for STAFF & RESIDENTS IN PSYCHIATRY. Staff posn. is on Inpt. psych. unit. Rsdncy. prgm. is affil. with Tulane Univ. and provides for rotation through the other affil. hosps. Interested persons should contact: Daniel K. Winstead, M.D., Chief; Psychiatry Service; VA Hospital; New Orleans, LA. 70146 The Veterans Admin. is an EOE.

MAINE

Bath-Brunswick—PSYCHIATRIST—CLINICAL DIRECTOR. Respons. for clinical coordination/consultation of adult svcs., adult OPD consultation, eval. and trtmt., inpt. on-call coverage shared with 2 others psychiats. Sale. $41,500. Respond to: Richard A. King, RSW Bath-Brunswick Area MHC, 18 Pleasant St., Brunswick, ME 04011. EOE M/F

Fort Fairfield—PSYCHIATRIST AMHC is a truly compre. CMHC with a staff of 100, which offers a full range of svcs. to people of all ages. Psychiat. staff presently consists of one Gen. Psychiat. We need you to share in medication review, supervision of a ten bed Inpt. Unit, and med./psychiat. consul., and we encourage you to tailor the remainder of your time to satisfy your own needs for partic. in staff dvlpmt., commty. educ., trtmt. of indvdls., fams., and/or grps., dvlpmt. of child psychiat. svcs., and consult. to other prof. staff. We would be int. in applics. from indvdls. who have completed apprvd. psychiat. rsdncys. and who have ints. in working with adults, chldn., or a combination of the two. Applics. from Career Child Psychiatrists would be most welcomed. Arrostook County has a peaceful, pollution-free, rural environ. in which both summer and winter recreat. opptys. abound. There are rolling hills, trout streams and lakes, small towns, two branches of the Univ. of Maine, and a Jet Airport. Frng. bnfts. incl. reloc. costs; 4 weeks vac.; a retirement pgm.; med., life, and disability insur.; and a compet. sal. Submit resume or call: Robert R. Vickers, Exec. Dir., Aroostook Mental Health Center, Fort Fairfield, Maine 04742. Ph: (207) 472-3511.

MARYLAND

Cumberland—Immed. opngs. for FT PSYCHIATRIST in 250-bed commty. orient. State Psych. Institution serving W. Md. Sal. $31,133–$40,850. MD. Lic. req'd. Can earn addit. compensation for night, weekend and holiday coverage. Write: Albert M. Powell, Jr., M.D.; Finan Center; P.O. Box 1722; Cumberland, MD. 21502 or call (301) 777-2270

Olney—Montgomery General Hospital is seeking a Psychiatrist to fill a newly created posn. of CENTER DIRECTOR of our CMHC. We are a 234-bed prvt. nonprofit gen. hosp., with acad. affils., loc. in the countryside immed. north of Washington, D.C. This individual should be a Bd. Cert. Psych. with 5 to 10 yrs. of clin. exper. and demonstrated significant admin. involvement and respon. The ideal candidate for this posn. would be committed to the CMHC's concept of compre. prof. svcs. and would be willing to devote their full-time efforts to the leadership of our estab. but growing ctr. Being a viable Ctr. within an estab. commty. hosp., we are looking for an individual who has strong clin. skills as well as the ability to administer a dynamic organ. A substantial sal. level is commensurate with previous exper. and educ. background. To pursue this oppty. please send your resume and sal. history to: Robert Kurtz, M.D.; Chairman, Search Committee; Montgomery General Hospital; 18101 Prince Dr.; Olney, MD. 20832 An EOE.

MASSACHUSETTS

ADVANCED TRAINING PROGRAM (2YRS.) in Liaison Consult. Psychiatry to develop future educators and faculty in this specialty. Great flexibility poss. individualizing trng. exper. Opptys. to participate in prgm. design, dvlpmt. and assessment as well as extensive clin. and tchng. exper. Candidates should be grads. of apprvd. 3-yr. psych. rsdncy. prgms., pref. with previous exper. in liaison consult. work. Immed. opngs. avail. and openings for July 1st, 1979. Joint appt. to Harvard Med. Schl. For more info.; contact: Dr. Theodore Nadelson, Director; Liaison Consultation Service; Dept. of Psychiatry; Beth Israel Hospital; Boston, MA. 02215

Berkshire County—Exciting oppty. to serve as MEDICAL DIRECTOR of dynamic commty. MH Center 30–35 hrs. per wk.: 5–10 hrs. are req. for medication clinics and 20–30 hrs. can be used for psychotherapy, supervision, consultation, program dev., or other areas of special interest. Clinic office can be used for up to 10 additional hrs. of pvt. prac. Sal. up to $37,213 for 35 hrs. plus exc. bnft. package. Our goals are to maintain a truly outstanding commty. MH center while providing a work environment which is rewarding, stimulating, and fun. We are seeking candidates who can help us towards these goals and who want to live in an area of sophistication but low pop. density. Berkshire County is an area of beautiful New England scenery with exc. schls. and the easiest access to all type of outdoor sports and cult. offerings. Send resume to Franklin S. Dorsky, Ph.D., Director, Northern Berkshire Mental Health Ass., Suite 628, 85 Main St., North Adams, Mass. 01247

MICHIGAN

CHILD PSYCHIATRIST: Part-time to help deliver child psychiat. svcs. within a compre. comm. MHC for mentally ill and developmentally disabled children, inc. consul., supervision, and educ. to an active staff. In accordance with aptitude, needed to assume the respons. for decisions and, if interested, may participate in pgm. planning, dev., and trng. of residents. Exceptional opp. for pvt. prac. in a growing area. Comp. sal. and frng. bnfts. Genesee County Community Mental Health Services. Send CV to Irwin S. Finkelstein, M.D., Med. Dir., 420 W. Fifth Ave., Flint, M.I. 48503.

Energetic PSYCHIATRIST with eclectic orient. wanted to join staff of Outpt. psych. clinic. Inpt. and Outpt. respons. for prvt. psych. patients. Sal. nego. Send CV to: Erol Ucer, M.D., Director, Ucer's Psychiatric Clinic and Day Treatment Center, Inc., 8401 Holly Road, Grand Blanc, MI. 48439.

POSITION IMMEDIATELY AVAILABLE FOR PGY-I OR PGY-II LEVEL PSYCHIATRIC RESIDENT. Starting July 1, 1979, apprvd. 3-yr. and Categorical* 4-yr. psych. rsdncy. prgms. which are a part of Wayne State Univ. Dept. of Psychiatry. These are dynamically orient., commty. psych. prgms. loc. in the heart of the Detroit area. Tchng. staff includes psychoanalysts, psychiatrists, and behavioral scientists in related areas. Visiting prof. prgm. Tchng. prgm. is directed toward individual needs of each resident. Close supervision in psychoanalytic psychotherapy, emerg. psych., grp. therapy, psych. consult., suicide prevention, aftercare, and emerg. walk-in svc. Frng. bnfts. Sal. range as of Oct. 10, 1978: PGY-I $15,221.52; PGY-II $22,049.28; PGY-III $23,155.92; PGY-IV $24,554.88; 5th Year $34,827.84. Contact: Bernard Chodorkoff, M.D., Ph.D.; Detroit Psychiatric Institute; 1151 Taylor Ave.; Detroit, MI. 48202 Ph: (313) 876-4430

VACANCIES EXIST FOR THREE PSYCHIATRISTS as Section Chiefs of MHC, Drug Dependence Trtmt. Prgms., or Alcohol Dependence Trtmt. Prgms. and one STAFF PSYCHIATRIST in Gen. Acute Inpt. Psych. at this large. active, GM&S hosp. Prgsv. prgm. of Cont. Educ.; affil. with Wayne State Univ. plus tchng. prgms. in many fields involving several colleges. Well staffed multi-displ. prgms. in med. and psych. Exc. retirement plan, lib. lv. policy, and low cost health and life insur. prgms. Sal. commensurate with educ. and exper. ranging from $35,875 to $47,025 plus an addit. bonus up to $6,000. Send CV to: Dr. R. A. Huggins, Chief; Psychiatry Service; or Dr. James M. Schless, Chief of Staff, VA Hospital; Allen Park, MI. 48101 An EOE.

Ann Arbor—FELLOWSHIP IN FORENSIC PSYCHIATRY The Ctr. for Forsenic Psychiat., a multidisciplinary inpt. and outpt., diagnostic and trtmt. facil., now offers post grad. fellowship trng. in Forensic Psychiatry. Lrng. by ind. study, specialized Forensic seminars, law schl. courses and supervised clin. exp. at a variety of commty. agencies. Sal., $35,015.76 with lib. frng. bnfts. Contact: Elissa Benedek, M.D., Dir. of Research and Training, Forensic Ctr., Box 2060, Ann Arbor, MI or call (313) 429-2531 Ext. 226. EOE

Ann Arbor—STAFF PSYCHIATRISTS AND UNIT DIRECTOR needed for prgsv. forensic diagn., trtmt. and trng. ctr. Oppty. to live and work in very desirable area with high calibre Forensic multi-discpl. staff, incl. 4 Bd. Cert. Psychiatrists. New higher annual salaries effective 10/1/78: Staff Psychiatrist—up to $52,930, with step increases to at least $58,338 after 2 to 3 yrs.; Unit Director—up to $55,561, with step increases to at least $61,241 after 2 to 3 yrs. Addit. compensation for on-call duties plus lib. frng. bnfts. Contact: Lynn W. Blunt, M.D., Clinical Director, Center for Forensic Psychiatry, P.O. Box 2060, Ann Arbor, MI. 48106 or call (313) 429-2531, ext. 203 or 204. An EOE.

Flint—PSYCHIATRIST posn. avail. for team orient. psych. to be respon. for patient care in one or more of the prgms. of a Compre. CMHC for mentally ill and developmentally disabled chldn. and adults, incl. Outpt., day trtmt., emerg., rehab., consult. and educ. In accordance with interest and aptitude may assume respon. for prgm. planning, dvlpmt., and eval. and may participate in trng. of residents. Should be Bd. Elig. or Bd. Cert. Sal. starts at $44,675 dep. on quals. and exper. Send vita to: Irwin S. Finkelstein, M.D.; Genesee County CMH Services; 420 W. Fifth Ave.; Flint, MI. 48503 Ph: (313) 767-7630

Newberry—PSYCHIATRIST to join us on staff of small (census approx. 200) State Hospital Loc. in Michigan's beautiful Upper Peninsula. Sal. $44,725–$52,284 dep. on exper., quals. and posn. filled, with 6% increase Oct. 1. Exc. State Civil Service frng. bnft. pckg. Some housing avail. at very moderate cost. Must be able to obtain permanent Michigan Lic. Contact: Steven A. Myers, M.D., Chief; Clinical Affairs; Newberry Regional Mental Health Center; Newberry, MI. 49868

Troy—PSYCHIATRIST WANTED for a prvt. Outpt. clinic. Bd. Elig. or Bd. Cert. Multi-discpl., dynamic and very active prac. Sal. dep. on exper. and nego. Exc. working conditions and location, suburb of Detroit. Please contact: Y. M. Alkar, M.D.; Medical Director; 2151 Livernois; Troy, MI. 48084 or call (313) 362-4144

MINNESOTA

CHILD PSYCHIATRIST FT to organize and help deliver child psych. svcs. for dvlpng. MH pgm. of 20-yr. old multi-spec. grp. (HMO) serving 115,000. Exc. med. staff sal. frng. bnfts., and quality of life. Oppty and time provided for tchng. Send CV to: R. J. Rauch, M.D.; Chairman; MH Dept.; Group Health Med. Ctr.; 606 24th Ave., South; Minneapolis, MN. 55454 Call Collect (612) 371-1661.

Austin—STAFF PSYCHIATRIST: Immed. opng. for Bd. Elig. commty.-orient. person to join prof. staff of eleven in a 2-cnty. semi-rural MHC loc. 90 miles south of Minneapolis. Duties: usual Outpt. diagn. and trtmt. tasks with wide variety of patients; some forensic work; oppty. for prvt. Inpt. work at local hosp.; agency consult. Must have good therapeutic skills. Sal. $45,000 to $50,000 range with exc. frng. pckg. incl. educ. lv., increasing vacation, 6½% gross sal. retirement, and disability, life, malprac. and health insur. Call or send vita to: L. R. Maier, Ph.D., Program Director; Freeborn-Mower MHC; 908 First Dr., N.W.; Austin, MN. 55912 Ph: (507) 433-7389

Minneapolis—PSYCHIATRIST (FT) to join expanding MH staff of 8 in well-estab. HMO serving 115,000+ in the Twin Cities. Posn. can be structured to suit applicant's interest in either of two forms. One poss. involves directing Inpt. svcs. although some Outpt. work is included. Alternatively, the posn. can involve nearly exclusively Outpt. work. Option exists of including development and direction of our consult./liaison svc. Bd. Elig. req'd. Outpt. posn. also requires proficiency in dynamic psych. Sal. is competitive and frng. bnfts. are exc. Oppty. and time provided for tchng. Send CV to: R. J. Rauch, M.D., Chairman, MH Dept.; Group Health Med. Ctr.; 606 24th Ave., South; Minneapolis, MN. 55454 Call collect (612) 371-1661

Minneapolis—FELLOWSHIPS IN CONSULTATION PSYCHIATRY. Full-time 1–2 yr. fellowship posns. avail. beg. July 1979 or earlier at Univ. of MN. Hosp. thru. NIMH funded trng. prgm. Combines clin. exper., tchng., seminars, and oppty. to join ongoing

consult. outcome research, incl. publication of findings. Must have min. of 2 yrs. apprvd. rsdncy. trng. Send inquiries to: M. K. Popkin, M.D.; Box 345, Mayo Bldg.; Univ. of Minn. Hospitals; Mnpls., MN. 55455

Minneapolis—Univ. of Minn. Med. Schl. invites nominations and applications for the posn. of PROFESSOR AND HEAD OF THE DEPT. OF PSYCHIATRY. This posn. encompasses major respons. for leadership in an extensive clin. science dept. in a lge. univ. health sciences ctr., together with several major and limited affiliated hosps. in the metro. area. The Dept. of Psychiat. carries substantial respons. for conducting educ. prgms. in Psychiat. and Clin. Psychol. The Med. Schl. and the Dept. of Psychiat. are respons. for tchng. lge. numbers of undergraduate, grad. and postdoctoral students. The Dept. has numerous ongoing significant prgms. in biomedical and behavioral research, both basic and clinical. The Dept. Head had respons. for and establishes acad. relationships in the Med. Schl., the Health Sciences, the Univ., nat. prof. orgs., and with the MH svcs. of the commty. Inquiries, incl. a CV, should be sent promptly to Dr. Frederic J. Kottke, Chairman, Search Comm. for Psychiatry Headship, Hosp. Box 297, 420 Deleware St., S.E., Univ. of Minn., Minneapolis, Minn. 55455. Applications must be received no later than December 31, 1978. An EO/AAE.

New Richmond, St. Croix County, Wisconsin—PSYCHIATRIST/CLINICAL DIRECTOR for compre. MHC operating Inpt./Outpt. MH and Alcoholism Trtmt. Prgms., Prgms. for Developmentally Disabled incl. Adult Day Care and sheltered work. Exc. staff utilizing a compre. trtmt. and growth model. Sal. $35,000 to $50,000 with frng. bnfts., incl. such items as med. insur., malprac., prof. travel, etc. This new facil. is loca. 35 miles from Minneapolis/St. Paul, MN. and the Univ. of Minn. AA/EOE Send resume to: Gary D. Johnson, Administrator; St. Croix Health Center; Route #2, Box 16-A; New Richmond, WI. 54017 Ph: (715) 246-6991

Rochester—PSYCHIATRIST for active adult admitting unit in highly regarded State Hosp. Must have completed 3 yrs. rsdncy. and be Elig. for Minn. Lic. No night or weekend duty. No malprac. premiums. World famous array of med. facils. in local area. Exc. educ. climate for professionals and families. Contact: Glen M. Duncan, M.D.; Director of Clinical Services; Rochester State Hospital; Rochester, MN. 55901 Ph: (507) 285-7002 Rochester State Hospital is an EOE.

St. Peter—PSYCHIATRIST, ASSISTANT MEDICAL DIRECTOR for new Minn. Security Hosp., currently under construction. Background in forensic psych. desirable, ample oppty. for further trng. and exper. Must also be interested in admin. hosp. work. Present Med. Director nearing retirement. Sal. is nego.—$40,000 to $50,000 plus bnfts. Patient pop. mixed, all involuntary. Interesting and unusual cases predominate. St. Peter is loc. in the beautiful Minn. River Valley, many scenic lakes, exc. schl. system, prvt. college, State Univ. nearby. Minn. Metro. Area within 1½ hrs. drive. Contact: Ronald C. Young, M.D., Medical Director; Minnesota Dept. of Public Welfare; Centennial Office Bldg.; St. Paul, MN. 55155 Ph: (612) 296-3058

MISSOURI

Springfield—Bd. Cert. or Elig. PSYCHIATRIST, hosp. setting in Med. Ctr. for Fed. Prisoners. 400-bed psych. svc. has one vacancy. Oppty. for Forensic trng. if interested in conjunction with The Menninger Foundation. Sal. to $47,500. dep. on quals. Civil Svc. System bnfts. and retire. prgm. Outside work poss. Exc. schools, colleges and recreat. Pop. over 100,000. Mod. climate. U.S. citizenship. May be lic. in any state. Contact: Jack Eardley, M.D.; U.S. Medical Center for Federal Prisoners; Springfield, MI. 65802 Ph: (417) 862-7041. May call collect.

Springfield—PSYCHIATRISTS: CHILD & GENERAL psych. posns. avail. July 1st in compre. CMHC. Diversified clin. staff of 30. Broad range of consult. and trtmt. activities in a variety of settings and prgms. City of 191,000 in Ozarks lake country. Compet. sals. and frng. Send resume to: P.O. Box 1611, SSS; Springfield, MO. 65805.

St. Joseph—PSYCHIATRISTS, Bd. Elig. or Cert., to work as Staff Psychiat. Respons. incl. clin. svs., diag., consul., sprvsn., therapy & prgm. development. Sal. comp. with excel. frng. pkg. St. Joseph is a prgsv. commty. of 90,000 near Kansas City, and approx. 40 mi. from KCI airport. Ctr. is well estab. commty. agncy. with recently accepted CMHC responsibility. Current staff incl. 46 prof. in various disciplines. Contact: Norman Tolo, Exec. Dir., Family Guidance Ctr./CMHC, 200 Corby Bldg., St. Joseph, MO. 64501, or call coll. 816-364-1501. EO/AAE.

St. Louis—CLINICAL DIRECTOR for Psych. Inpt. Service; concurrent appt. with Wash. Univ. Schl. of Med. Sal. from $43,261 dep. on quals. Addit. $2,200 for American Boards or equivalent. Lib. frng. bnfts. EOE. Missouri Lic. req'd. Apply: Kathleen Smith, M.D., Superintendent; Malcolm Bliss MHC; 1420 Grattan; St. Louis, MO. 63104 Ph: (314) 241-7600 ext 212.

MONTANA

WARM SPRINGS STATE HOSPITAL—Prgsv. psych. hosp. sit. in the heart of the Rocky Mtns. has opngs. for Bd. Cert./Bd. Elig. PSYCHIATRISTS who are int. in earning a sal. ranging between $40,000 to $48,000 approx. dep. on quals. Uncongested living in Big Sky Country—Western Montana. Nearby wilderness areas provide ample opptys. for skiing, fishing, hunting, and other outdoor recreat. Highly compet. frng. bnfts. incl. Malprac. Insur. paid by Montana State: Univ. Affil.; EOE. Apply: Superintendent's Office, Warm Springs State Hospital, Warm Springs, MT. 59756.

Butte—STAFF PSYCHIATRIST, Bd. Elig. to join a staff of 3 psychiatrists in prgsv. rural CMHC with a high quality multi-discpl. staff in beautiful scenic mountainous area with excessive hunting, fishing, skiing, and recreat. Posn. involves providing psych. svcs. to all phases of estab. prgms. with limited travel involved. Sal. range mid $40,000's dep. on exper. Exc. frng. bnfts. incl. paid health insur., paid educ. lv., plus help with relocation expense. Send resume or call collect: Francine Larson, M.D., Clinical Director; Southwest Montana MHC; 512 Logan; Helena, MT. 59601 Ph: (406) 442-0640

NEBRASKA

Lincoln—FULL-TIME PSYCHIATRIST for CMHC. Attractive Univ. City (pop. 180,000). Sal. nego. between $36,000–$45,000. Contact: Charles E. Richardson, M.D., Director; Community Mental Health Center for Lancaster County; 2200 St. Mary's Ave.; Lincoln, NB. 68502 Ph: (402) 475-9561

Norfolk—STAFF PSYCHIATRIST for Inpt. adult prac. at accred. modern, prgsv. 208-bed state hosp. loc. in commty. of 20,000. Sal. range of $37,700 to $41,550 for those just completing rsdncy. $41,250 to $57,643 for Bd. Elig. and $45,253 to $62,107 for Bd. Cert. dep. on exper. We also have an opng. for a STAFF PHYSICIAN to provide gen. med. care with a sal. range of $35,000 to $46,000 dep. on exper. All applicants must be Elig. for NB. Lic. Contact: H. D. Herrick, M.D., Superintendent; Norfolk Regional Center; P.O. Box 1209; Norfolk, NB. 68701 Ph: (402) 371-4343

Omaha—FACULTY APPOINTMENTS AVAILABLE: Associate Professor, Child Psychiatry; Associate Professor interested in adult Inpt. trtmt.; Assistant Professor interested in Outpt. trtmt. Duties incl. tchng., clin. supervision, and research. Admin. respons. optional. Sals. competitive. Med. svc. plan permits sal. supplementation through prvt. prac. Starting date July 1, 1979 or before. EOE. Send CV and bibliography (publications not essential at Asst. Prof. level) to: Merrill T. Eaton, M.D.; Professor and Chairman; Dept. of Psychiatry; Univ. of Nebraska College of Medicine; 602 South 45th St.; Omaha, NB. 68105

NEW HAMPSHIRE

Laconia—PSYCHIATRIST to join modest-sized MHC with emphasis on quality care, commty. and med. orient. Easy access to lakes, mtns., oceans, and Boston. Sal. and frngs. compet. and nego. Contact: Lawrence G. Jasper, Ph.D., Exec. Director; Lakes Region MHC; Elliot St.; Laconia, N.H. 03246 Ph: (603) 524-1853

NEW JERSEY

CHILD PSYCHIATRY FELLOWSHIP: Expanded 2-yr. apprvd. trng. prgm. at Rutgers Med. Schl.; 2 first yr. and 1 second yr. opngs. effective July 1979. This is an eclectic compre. trng. prgm. integrated into the full facils. of Rutgers MHC and Rutgers Med. Ctr. Contact: Julian Kassen, M.D.; Dept. of Psychiatry; Rutgers Medical School; P.O. Box 101; Piscataway, N.J. 08854

Belle Mead—New Jersey's largest prov. psychiatric hosp. seeks STAFF PSYCHIATRIST, bd. elig. or cert. to join eclec. staff of 20 psychiatrists in modern & innov. short term hosp. Rsdnts. finishing trng. invited to apply. Loc. in attractive rural setting 9 miles from Princeton & easily accessible to N.Y. & Phila. Income is derived from sal., fee for svc. & unlimited pvt. prac. & exceeds $50,000 per yr. Bnfts. incl. full ins. pgm. Opptys. for research & tchng. avail. for those interested. Contact George Wilson, M.D., Medical Director, Carrier Clinic Foundation, Belle Mead, N.J. Call collect (201) 874-4000, x304.

Marlboro—STAFF PSYCHIATRISTS are needed by Marlboro Psych. Hosp. in semi-rural N.J. (one hr. from Manhattan and 20 mins. to shore) Sal. to $44,900 and exc. frng. bnfts. Send resume to: Mr. Roy Ettlinger, Exec. Dir.; Marlboro Psych. Hosp.; Station A; Marlboro, N.J. 07746

Moorestown—Rewarding pvt. prac. oppty. for dynamic psychiat. in N.J., 30 mins. from ctr. city Philadelphia. Prefer full time, but could be part time. Prac. is interestingly varied and includes inpt., outpt. and consultation. Reply: Box P-862, *Psychiatric News*.

North Central N.J.—PSYCHIATRIST: Exper. to be member of team of 4 co-equal therapy partners. Exc. potential-small initial invest. in three office location. Suburb. area, near beaches, mtns. and Manhattan within one hr. easy travel. Prac. to provide full range of psychotherapy svcs. Require a mature physician with Bd. Elig. and/or exper. in psych. who can make a prof. change in early 1979. Send full CV, in strict confidence (hand written OK) to: Box P-855, *Psychiatric News*

Piscataway—CHILD PSYCHIATRY FELLOWSHIP: Unexpected vacancy in second yr. of fully apprvd. 2 yr. trng. prgm. in Child Psychiatry at Rutgers Medical School. Contact: Julian Kassen, M.D.; Dept. of Psychiatry; Rutgers Medical School; P.O. Box 101; Piscataway, N.J. 08854

NEW MEXICO

PSYCHIATRIST NEEDED IN EASTERN NEW MEXICO. Move to warm climate. Assist in planning and implementation of a pgm. which received Compre. MH funding Oct. 1, 1977. MH Resources, Inc. is headquartered in a commty. of 14,000 persons, Portales, N.M., home of Eastern New Mexico Univ. MH Resources, Inc. serves 7 counties of eastern N.M. with a catchment area of 80,000 persons. Please send resume or inquiries to: Personnel Manager, Mental Health Resources, Inc., 300 East First; Portales, N.M. 88130. Ph: (505) 359-1221. Posn. open IMMEDIATELY.

NEW YORK CITY & AREA

CHILD PSYCHIATRY FELLOWSHIPS-PG V, VI, in outstanding psychoanalytically-orient. MH agency. Exper. in OPD and resid. trtmt., preschool prgm., commty. svcs. Intensive supervision in individual, family and group methods. Trng. in pediatric neurology and pediatric consult. avail. Trng. yr. begins Sept. Stipend $19,500. Apply to: Aaron H. Esman, M.D.; Chief Psychiatrist; Jewish Board of Family & Children's Services; 120 W. 57th St.; New York, N.Y. 10019 Ph: (212) 582-9100 ext. 339.

FELLOWSHIPS: Immed. post-rsdncy. PT or FT. Interesting, innova. psychoanalytic trng.-clin. pgm. Trng. also in spectrum of CMH practices incl.: exper. in grp., fam., child, commty. MH consul., rehab. and research pgms. FT stipend $25,000. PT stipend $15,000. Contact: Samuel V. Dunkell, M.D., Dir. of Psychiatry, Post-graduate Center for Mental Health, 124 E. 28th St., New York, NY 10016.

RESIDENCY APPLICATIONS being acceptd. for trng. in appvd. 4 yr. pgm. in psychiat. at Harlem Hosp. Ctr. under auspices of dept. of psychiat., College of Physicians & Surgeons, Columbia Univ. Trng. offered in diagnosis & intensive trtmt. of acute & chronic psychiat.-illness on inpt. & OP svcs. under supvn. of com.-oriented psychoanalytically trnd. psychiats.; in psychiat. consul. to gen. hosp. & com. soc. agencies; & child psychiat. Courses in relevant basic sciences & clin. subjects are given in addition to tchng. thru indvd. supvn. & preceptorship; emphasis placed on tchng. of compre. psychiat. care. Stipends: $16,780–$19,500 per yr. Write Director of Education & Training, Dept. of Psychiatry, Harlem Hosp. Ctr., Lenox Ave., & 136th St., New York, N.Y. 10037.

Manhasset, L.I.—PSYCHIATRIST for biochemically orient. trtmt. prgms. for adults and chldn. Previous trng. or exper. in internal med., gen. prac. or pediatrics valuable, but not req'd. Full or part time. Diagnosis, trtmt. and supervision. N.Y.S. Lic. req'd. Write: North Nassau Mental Health Center; 1691 Northern Blvd.; Manhasset, N.Y. 11030 Ph: (516) 627-7535

Manhattan—Chief, Psychiatric Outpt. Clinic in Manhattan, Med. Schl. Affil. General Hosp. with expanding Dept. of Psychiat. PSYCHIATRIST, Bd. Elig. or Cert. N.Y.S. Med. Lic. and 2 yrs. exp. in administrative or supervisory cap. Good sal., frng. bnfts. and Med. Schl. appointment. Contact–Dr. Zimberg, Hospital for Joint Diseases, 1919 Madison Ave., New York, N.Y. (212) 650-4473.

Manhattan—PSYCHIATRISTS—a prominent psychiatric ctr. serving the adult pop. of Manhattan is looking for psychiatrists. Requirements: Completion of apprvd. rsdncy.; N.Y.S. Lic.; Bd. Cert. or Bd. Elig. pref. Sal. range $29,000 to $37,000 dep. on quals. Gen. frng. bnfts. Pleasant working conditions in an atmosphere conducive to prof. dvlpmt. Send CV to: Roger Biron, M.D., Deputy Director Clinical (Acting), Manhattan Psychiatric Center, Ward's Island, N.Y.C., N.Y. 10035.

Queens—PSYCHIATRIST-gen. psychiatry in HMO setting. 35 hrs. Sal. dep. on exper. NYS Lic. Call: S. Goldensohn, M.D.; 89-14 168th St.; Jamaica, N.Y. 10022 Ph: (212) 291-2336.

NEW YORK STATE

DEPUTY DIRECTOR, CLINICAL—$42,796. Central N.Y. Psych. Ctr. is a new facil. loc. near Utica, N.Y. and was estab. last year to provide psych. trtmt. to mentally ill patients of the State's correctional network. The facil. is fully accred. by the Joint Commission on Accred. of Hospitals. The facil. offers a unique multi-discpl. team approach to the trtmt. of the mentally ill inmate patients. The Deputy Director, Clinical, is respon. for the direction of all clin. prgms. as well as the eval. and maintenance of clin. standards and quality of care. Candidate must have a valid NYS Lic. and be Cert. by the ABP&N. In addit. to these quals, it is desired that the candidate have admin. and supervisory exper. on institutional level. Housing and exc. frng. bnfts. avail. Qual. candidates please submit CV to: Mr. Martin H. Von Holden, Director; Central N.Y. Psychiatric Center; Box 300; Marcy, N.Y. 13403 or Ph: (315) 768-7110.

NEW YORK STATE BD, CERT. CHILD PSYCHIATRIST—(analytic training pref.) Staff position. 7 hrs. per week, Wed. only. $30 per hr. plus frng. bnfts. Contact Frank Roma, Director, Northern Westchester Guidance Clinic, P.O. Box 333, Rt. 202, Lincolndale, N.Y. 10540 (914) 248-5800.

Buffalo—PSYCHIATRISTS serving the adult pop. of the Niagara Frontier in a working relationship with the State Univ. of N.Y. We are a prgsv. commty.-based JCAH accred. psych. facil. Sal. range $34K to $44K plus frngs. dep. on quals. Require: NYS Lic. of NYS permit with Lic. from other state, completion of an apprvd. psych. rsdncy.; Bd. Cert. or Bd. Elig. pref. Write: Dr. Nicholas Bona, Deputy Director, Clinical; Buffalo Psychiatric Center; 400 Forest Ave.; Buffalo, N.Y. 14213

Elmira—DEPUTY DIRECTOR CLINICAL-accred. commty. based psych. ctr. has vacancy for Deputy Dir. Clin. Deputy Dir. Clin. has immed. charge of trtmt. prgms. and policies for Inpt. and Outpt. svcs. He/she works closely with Director and Deputy Dir. for Admin. to establish facil.-wide policies and procedures, solve top level management problems, and form long range projections for the facil. Also respon. for eval. and maintenance of clin. standards and quality of care. Loc. in the beautiful Finger Lakes region of N.Y.S. Elmira offers attractive housing, exc. educ. systems, yr.-round recreat. activites; there are ample opptys. for Cont. Prof. Educ. and trng., since Elmira is within 30 miles of Cornell Univ. and two hrs. from Syracuse and Rochester. Sal: $42,796 to $45,459 Exc. frng. bnfts. Quals: Candidates must have a valid lic. in N.Y.S. and be Cert. by the ABP&N. In addition, candidates should have admin. or supervisory exper. at the institutional level. Interested physicians should submit a resume to: Girish V. Shah, M.D., Director; Elmira Psychiatric Center; P.O. Box 1011; Elmira, N.Y. 14902 or call collect (607) 737-4739 EOE (M/F)

Elmira—PSYCHIATRISTS—Challenging opptys. for psych. to help develop a new, accred. commty. psych. ctr. serving 3 counties (pop. of 250,000). The Elmira Psych. Ctr. is the hub of a prgsv., compre. network of cooperative state and local psych. svcs. Emphasis on commty.-based Outpt. trtmt., integrated with small, intensive Inpt. prgms. Elmira is loc. in the beautiful Finger Lakes region of N.Y.S. There are ample opptys. for educ. and prof. growth since Elmira is approx. 2 hrs. from Rochester and Syracuse, and within 30 miles of Cornell Univ. Attractive housing, exc. educ. system; yr.-round recreat. opptys. avail. Quals: N.Y.S. Lic. or elig. Sal. commensurate with trng. ($29,340–$37,144). Bnfts. incl. health insur., dental insur., membership in the N.Y.S. Employees' Retirement System, paid sick lv., and over 6 weeks of annual paid vacation, personal and prof. lv. For more info., write to: Girish V. Shah, M.D., Director; Elmira Psychiatric Center; P.O. Box 1011; Elmira, N.Y. 14902 Call collect (607) 737-4739 EOE (M/F)

New Hampton—PSYCHIATRIST II, Sal. $33,705–$35,375. Opng. in forensic psych. ctr.—Dept. of Mental Hygiene of N.Y.S. Gen. N.Y.S. Civil Svc. bnfts. Lic. in N.Y.S. or Permit. Loc. is 55 mi. north of N.Y. City. Contact: Dr. E. Tekben, Director, Mid-Hudson Psychiatric Center, P.O. Box 158, New Hampton, N.Y. 10958

Ogdensburg—PSYCHIATRIST needed at open door, commty. orient. psych. ctr. loc. on the St. Lawrence River in northern N.Y. 60 miles from Ottawa, Ontario and 2 hrs. from Montreal, Quebec. Serves essentially rural and acad. commty. (6 colleges within 30 mile radius) vacationland area, hunting, fishing, skiing, etc. within easy reach. Resident pop. approx. 650 incl. chldn. and alcoholism unit. Exc. sal. and frng. bnfts. 35 hr. work week. No malprac. insur. necessary. Bd. Elig. or Cert. acceptable. Need N.Y. Lic. or N.Y. limited permit. Write: Lee D. Hanes, M.D., Director, St. Lawrence Psychiatric Center, Ogdensburg, N.Y. 13669 or call (315) 393-3000.

Rochester—Growing, innov. CMHC needs exper. PSYCHIATRIST as DIRECTOR OF PATIENT MANAGEMENT to coordinate, direct and assure quality of all clin. care. The Genesee Mental Health Center (GMHC) has two multi-discpl. teams of primary therapists. These 25 primary therapists provide direct clin. svcs. at all levels of care (ambulatory, partial hospitalization and Inpt.) Director of Patient Management is directly respon. to Director of Center for 1) supervision of two team leaders; 2) coordination with directors of ambulatory, partial hospitalization and Inpt. programs; and 3) review of quality of care. Full time preferred but nego. Additional activities for remaining 50% of time incl. patient care, consult. and educ., supervision of non-medical primary therapists and staff trng. GMHC is a 4½ yr. old MHC based in a commty. gen. hosp. NOT dependent on fed. funding. Exper. req'd. in direct patient care, commty. psychiatry and supervision. Sal. commensurate with exper. and credentials. Attractive frng. bnfts. NYS Lic. req'd. Bd. Cert. pref.; Bd. Elig. acceptable. Send resume to: Dr. S. Hanson, Director, GMHC; 224 Alexander St.; Rochester, N.Y. 14607 An EOE.

Rochester—PSYCHIATRIST II-posns. avail. to provide Inpt., daycare and Outpt. psych. svcs. to urban and suburban adult and geriatric pop. A challenging oppty. working as a team leader with inter-discpl. trtmt. teams and psych. consults. Close working relationships with CMHC's; univ. dept. of psychiatry and community agencies. Apprvd. 3-yr rsdncy. prgm. Many educ. opptys. Min. quals. are a N.Y.S. Med. Lic. and 2 yrs. post-rsdncy. exper. in psych. Starting sal. is $35,391 (Bd. Elig.) and $37,144 (Bd. Cert.) dep. on quals. Lib. frng. bnfts. Apply to: Richard T. Kraus, M.D.; Acting Director; Rochester Psychiatric Center; Rochester, N.Y. 14620 Ph: (716) 473-3230

Utica—PSYCHIATRISTS—Compre. Mental Health Pgm. incl. alcoholic, child, adols., active commty. svcs., excel. oppty. for prof. growth. Sal. $29,340 to $40,374 dep. on quals. Lib. frng. bnfts., housing and excel. recreat. facils. avail. Write: Director, Utica/Marcy Psychiatric Center, 1213 Court St., Utica, N.Y. 13502.

Willard—Pgms. completely unitized, open-door-hosp. offers posns. to PSYCHIATRISTS int. in hosp. & commty. work. Loc. in beaut. Finger Lakes Region of NY on East shore of Seneca Lake, 10 colleges, incl. Cornell Univ., within 30-mi. radius. JCAH accred. Staff sals. dep. on quals: $27,942–$38,449. Fringe bnfts. incl.: non-contrib. pension plan, med. ins., vac., 11 pd. hols. plus 5 personal lv. days. Write: Director, Willard State Hosp., Willard, N.Y. 14588.

NORTH CAROLINA

DIRECTOR OF CLINICAL SERVICES—Psychiatrist Bd. Cert. with exper. in clin. management. 1200-bed state psych. facil. with innov. gen. and specialty svcs. JCAH 2-yr. accred. Cooperative prgms. with CMHCs. Multi-discpl. team approach to trtmt. prgms. Well qual. med. and clin. staff. Affil. with Bowman Gray Schl. of Med. and several other colleges and univs. Exc. frng. bnfts. incl. vacation, holidays, sick lv., life insur., and paid malprac. Loc. in beautiful foothills of Blue Ridge Mtns. Many recreat. opptys. Metro. ctr. only 1½ hrs. away. Housing avail. Sal. range $46,000–$58,000. Apply to: James W. Osberg, M.D.; Director's Office; Broughton Hospital; Morganton, N.C. 28655 or call (704) 433-2324 for addit. info.

Ahoskie—CMHC needs a full-time PSYCHIATRIST to help serve a 4-county rural/small town area with gentle climate and gentle people. Unspoiled rivers flow thru rich farmland and forest. One hr. to Metro. Norfolk; 1¼ hrs. to new Med. Schl. in Greenville; 2 hrs. to Outer Banks and ocean. Center is 10 yrs. old, bldg. 1½. Most Outpt. work wtih poss. dvlpmt. of Inpt. facil. Harmonious young staff of 57, voracious to learn. Sal. $42,000 with exc. bnfts. Contact: Ruth Straka, Area Director; Roanoke-Chowan MH Service; Ahoskie, N.C. 27910 Ph: (919) 332-4137 An EOE.

Asheville—In our cont. expansion pgm. one addit. posn. is avail. for a PSYCHIATRIST in innov., prgsv. 85-bed prvt. psychiat. hosp. The hosp. is fully accred. by the Joint Commission on Accred. of Hosps. and is cert. by Medicare. Must be Bd. Cert. Philosophy of the hosp.—eclectic. Sal. open. Asheville is a resort town loc. at 2200 ft. in Blue Ridge Mtns. of Western N.C. and is the med. ctr. for Western N.C. Write or call: Mark A. Griffin, Jr., M.D., Appalachian Hall, P.O. Box 5534, Asheville, N.C. 28803. Ph: (704) 253-3681.

Asheville—STAFF PSYCHIATRIST-4-cnty. area CMHC (pop. 193,000) in scenic Western N.C. seeks commty.-orient. psych. to join multi-discpl. staff in providing svcs. to adults on Outpt. and Inpt. basis. Outpt. svcs. incl. work with crisis intervention and emerg. svcs., day trtmt., and after care. Oppty. to provide in-svc. trng. and commty. educ. as well. Applicants should be Bd. Elig. or Cert., have some trng. or exper. in gen. med.; and have one year's exper. following their psych. rsdncy., pref. in a CMH setting. Sal. range $35,000 to $47,000, based on quals. Contact: Eleanor S. Shuping, ACSW, Program Coordinator; Blue Ridge CMHC; 356 Biltmore Ave.; Asheville, N.C. 28801 Ph: (704) 254-2331

Smithfield—Immed. opng. for Bd. Cert. or Bd. Elig. full-time PSYCHIATRIST for prgsv., compre. CMHC loc. near 3 univ. and Research Triangle. Ctr. serves one county catchment area with pop. of 65,000. Duties incl. Inpt. and Outpt. trtmt. svcs. for chldn., adols., and adults. Will share clin. duties with full-time Clin. Dir. Sal. range $39,936–$55,032 nego. Part-time work avail. to supplement base sal. N.C. Lic. req'd. Contact: Dr. D. Devon Pollard, Clin. Dir.; or Mrs. Clarice Barbour, Personnel Officer; P.O. Box 411; Smithfield, N.C. 27577 Ph: (919) 934-5121. An EOE.

Spindale—PSYCHIATRIST: full-time posn. in psych. Outpt. setting to provide and supervise clin. svcs. to adults and chldn. MH Area covers two counties with a pop. of 72,000. Emphasis is on commty.-based Outpt. trtmt. This oppty. is in Rutherford and Polk Counties loc. halfway between Charlotte and Asheville at the foothills of the beautiful mtns. of Western N.C. The area features yr. round recreat. opptys. Sal. commensurate with trng. and exper., ($35,700–$45,588). Bnfts. incl. health insur., membership in the N.C. Local Governmental Employees' Retirement System; twelve (12) paid sick lv. days a yr.; fifteen (15) paid vacation days a yr.; and fourteen (14) days a yr. of petty lv. For more info. contact: Mr. Virgil A. Cook, Area Director; Rutherford-Polk Mental Health Programs; City Route #3, Fairground Road; Spindale, N.C. 28160

Spindale—STAFF PSYCHIATRIST: Immed. opng. for Bd. Elig. commty.-orient. psychiatrist to join a 2-cnty. CMH Prgm. with a staff of 56. This is a rural area loc. at the foothills of the beautiful mtns. of Western N.C. Exc. commty. for family life. Sal. range is $35,000 to $45,000 with exc. frng. bnfts. Send resume to: Area Director; Rutherford-Polk Area MH Prgms.; City Route #3; Fairground Road; Spindale, N.C. 28160

NORTH DAKOTA

PSYCHIATRIST WANTED—Compre. CMHC looking for Bd. Cert. or Bd. Elig. psych. to join multi-discpl. staff. The oppty. exists for prvt. prac. and univ. affil. Sal. range from $45,000 to $50,000 with 4 weeks paid vacation, 2 weeks educ. lv., sick lv., retirement plan, and hospitalization plan. Write: David A. Snyder, Exec. Dir. or Dr. Rufino R. Ramos, Med. Cir; North Central MH & MR Center; 140 Souris Dr.; Minot, N.D. 58701 or call (701) 852-3665

Bismarck-Mandan—PSYCHIATRIST for CMHC and Retardation Ctr. serving a rural 10-county region (pop. 112,000) loc. in growing Bismarck-Mandan (cities pop.—50,000) area seeks a full time psychiatrist, who dep. on exper. may assume MEDICAL DIRECTOR respon. Psychiatrist will participate in all pgms., adults & chldn. Sal. and conditions compet. Contact: Erv Bitz, Exec. Director, Memorial MH & Retardation Ctr.; P.O. Box 369; Mandan, N.D. 58554 or call (701) 663-6570.

OHIO

Chillicothe—LIAISON AND INPT. PSYCHIATRISTS WANTED. Bd. Cert. or Elig. req'd. Chillicothe VA Hosp. is a 1000-bed hosp. with large after-care prgm. JCAH apprvd. OSMA apprvd. cont. med. educ. prgm. for AMA Phys. Recognition Award. Hosp. loc. in southern Ohio natural recreat. and scenic area, 45-min. from Columbus. Financial assistance in moving. EOE. Write: Chief of Staff; VA Hospital; Chillicothe, OH. 45601 or call (614) 773-1141 ext 202.

Southern Ohio—PSYCHIATRISTS—Expanding acute care J.C.A.H. accre. hosp. in beautiful southern Ohio needs 2 bd. cert. of elig. PSYCHIATRISTS to lead treatment teams. High sal., generous frng. bnfts., full or part-time with prvt. prac. Write: Henry W. Hogan, M.D., Med. Dir., Portsmouth Receiving Hosp., Portsmouth, Ohio 45662

Tiffin—PSYCHIATRIST with completed rsdncy. trng. for well-estab. three county commty.-state Outpt. psych. clinic and Day Hosp. loc. in one of six bldgs. in modern commty. health svcs. campus with three satellite clinics in the outlying counties. Prvt. prac. permitted; exc. frng. bnfts. Cult. and other prof. advantages avail. in pleasant commty. of 23,000. Heidelberg College, Tiffin Univ., Tiffin State Hospital, active med. society, quick access to Toledo, Cleveland, Columbus, and cities near the Ohio Turnpike. Apply: Sandusky Valley MHC; 67 St. Francis Ave.; Tiffin, OH. 44883

OREGON

PSYCHIATRIST—Acute inpt. prgm. seeks leader of interdisciplinary trtmt. team receiving 150 admissions per yr. 4 other psychiats. are associates in the same prgm. which is an affil. of a compre. CMHC serving the sparsely pop. eastern portion of OR. Loc. in a town of 15,000 with clean air, friendly people, major airline and freeway access to metro. areas, and exc. outdoor recreational opptys. Sal. up to $41,256. Contact J. Albert Baxter, M.D., Clin. Dir., Eastern Oregon Hosp. and Training Ctr., Box A, Pendleton, OR 97801 (503) 276-1711. EOE.

Roseburg—Active GM&S health Care Facility with 159 Psychiat. beds is seeking a Bd. Cert. or Bd. Elig. PSYCHIATRIST interested in direct patient care. Liberal sal. plus generous U.S. Govt. frng. bnfts. Eng. lang. proficiency req'd. Applicants should contact Richard Schneider, M.D., Chief, Psychiatry Svc., Veterans Administration Hosp., Roseburg, OR 97470. Call 503-672-4411. An EOE.

PENNSYLVANIA

PSYCHIATRIST—The Hazelton-Nanticoke Mental Health/Mental Retardation Ctr., a compre. CMHC loc. in the beautiful Pocono Mountains of N.E. Pa., is seeking applications from qual. individuals to join their multi-disciplinary svc. delivery team. Psychiats. are needed to work in all svcs., inc. providing direct patient care, staff supervision, insvc. trng. and agency consultation. There is also ample oppty. for prvt. prac. Requirements: Lic. to pract. med. in Penn. plus 3 yrs. of approved rsdncy. trng. Sal. Range: $45,000+; exc. bnfts. EOE. Contact: Steven R. Kafrissen, M.D., Deputy Ctr. Dir., Clin. Svcs., Hazleton-Nanticoke MH/MR Ctr., West Washington St., Nanticoke, Pa. 18634 (717) 735-7590

Bridgeville—PSYCHIATRISTS: Bd. Cert. or Bd. Elig. Immed. opngs. Exc. oppty. to work in a state hosp. affil. with Western Psych. Institute and Clinic. Will need to be involved in developing new prgms. or to assist in on-going prgms., such as Resocialization, Forensic, Intermediate and Acute Psychiatric Services in a fully integrated Base Svc. Unit/State Hosp. Facil. near Pittsburgh. Sal. compet. Exc. frng. bnfts. Penn. Lic. req'd. If avail, call (412) 221-7500 or write: Robert H. Trivus, M.D., Ph.D.; Superintendent; Mayview State Hospital; Bridgeville, PA. 15017

Clarks Summit—PSYCHIATRIST, Bd. Cert. or Bd. Elig. Mental hosp. in metro. area. Easy access to New York, Phil., and close to Pocono resort area. Good sal. with exc. frng. and retirement bnfts. Residence avail. Penn. Lic. req'd. Contact: Henry Buxbaum, M.D.; Superintendent; Clarks Summit State Hospital; Clarks Summit, PA. 18411 Ph: (717) 586-2011.

Coatesville—VA HOSPITAL—JEFFERSON MEDICAL COLLEGE—PSYCHIATRISTS needed for Clin./Acad. Posns. at Coatesville VA Hosp. Dean's Committee Hosp. Faculty posn. at Jefferson Med. College, Philadelphia, PA. Opptys. for clin. care and respon., tchng., research. Exc. sals., frng. bnfts and working conditions. Inquiries to: Chief of Staff; VA Hospital; Coatesville, PA. 19320 Ph: (215) 384-7711 ext. 325. An EOE.

Lebanon—Philhaven Hosp. has an opng. for Bd. Cert. or Elig. PSYCHIATRIST in a free standing psych. facil. providing a broad spectrum of svcs. to the commty. Philhaven is a member of Mennonite MH Svcs., Nat'l. Assoc. of Prvt. Psych. Hosp., and the Hosp. Assoc. of Penn. Fully accred. by the Joint Commission with a recent physical expansion providing full Inpt./Outpt., and partial hosp. facils. Loc. in the beautiful Penn. Dutch country near Hershey, PA., and a short drive from both Harrisburg and Lancaster. Phila. and Baltimore are 2 hrs. away by direct interstate transportation. This is an oppty. to work in a unique facil. staffed by people from a wide variety of denominations but with a common Christian commitment, and with a common language that eventuates in warm interpersonal relationships and a deeply caring interpersonal milieu. Sal. is dep. on educ./exper. factors and is in the forties and low fifties plus frngs. Please pay us a visit when you are in this area or contact directly: Charles A. Neff, Medical Director; Philhaven Hospital; 283 S. Butler Rd.; Lebanon, PA. 17042 Ph: (717) 273-8871

Northeastern Pennsylvania—PSYCHIATRIST to join CMH/MR Ctr. staff; role of psych. is clin. team leader, teacher, assessor, consult; modalities emphasized are family network therapy, group methods, crisis intervention, short-term goal directed efforts. Sal. and frngs. top for committed person. Loc. in N.E. Penn. in a yr. round outdoors area, 2 turnpike hrs. to N.Y. and Phila. This MHC is committed to equality of oppty. and the goals of AA. Reply to: Personnel Director; Luzerne-Wyoming County MHC; 103 S. Main St.; Wilkes-Barre, PA. 18701 Ph: (717) 823-2155

Philadelphia—CHILD PSYCHIATRY FELLOWSHIP—2 yr. accred. prgm. in Child Psych. with Ecological and Family Focus. For application and further info. write to: Lee Combrinck Graham, M.D., Director; Child Psychiatry Training; Philadelphia Child Guidance Clinic; 2 Children's Center; 34th and Civic Center Blvd.; Phila., PA. 19104

Philadelphia—CHILD PSYCHIATRY FELLOWSHIP AVAILABLE IMMEDIATELY. 2 yr. apprvd. fellowship. Child Psych. Ctr. at St. Christopher's Hosp. for Chldn. Child Psych. section of Temple Med. Schl., loc. with the Dept. of Pediatrics of the Med. Schl. Complete trng. in compre. child psych. Broad multi-faceted theoretical and practical orient: individual psychotherapy; grp. therapy; behavior therapy; consult.; child management. Extensive clin. supervision. Didactic courses and seminars provided for each of these clin. expers. Patient pop. ranges from preschool thru adols. Pediatric consult. liaison to 156-bed chldn's hosp. as well as Outpt. and emerg. svc. Oppty. for exper. with developmentally delayed; neurologically and sensorially impaired chldn. Special classes for emotionally dist. chldn. affil. with clinic. Commty. psych. exper. incl. oppty. for consult. to schools; nursery prgms.; and resid. trtmt. prgms. Oppty. to teach gen. residents in psychiatry; pediatric residents and med. students. Five full-time child psychiatrists. Multi-discpl. staff of psychologists, social workers, educ. specialists and paraprofessionals. Write to: William Hetznecker, M.D.; Director of Training; Child Psychiatry Center; St. Christopher's Hospital for Children; 2603 North Fifth St.; Phila., PA. 19133

Philadelphia—PSYCHIATRIST—Bd. Cert. of Elig. Psychiatrist to provide direct clinical svc. and staff supervision for an outpt. CMHC loc. in an attractive res. section of Northeast Phila., Pa. Starting sal. $32,000+. Write or call C. Giannasio, M.D., c/o Benjamin Rush Ctr., 10125 Verree Rd., Phila., Pa. 19116. Tel: 215-698-4218.

Philadelphia—PSYCHIATRISTS: Bd. Elig. Full or part time. Lic. to prac. in PA. req'd. Sal. nego. Call (215) 248-3648, The Northwest Center for CMH & MR Programs; 27 E. Mt. Airy Ave.; Phila., PA. 19119

Philadelphia—PSYCHIATRIST—Hall Mercer Commty. MH/MR Ctr., of Penn. Hosp. has a part time posn. avail. for 30 hrs. per wk. in the Adult Psychiatric Outpatient Program. Respons. incl. providing psychiat. consul. to non-physician clin. staff of the adult emerg. team in the intake eval. and short term trmt. of clients on a scheduled or emerg. svc. basis. Will also participate in in-svc. trng. prgms. Full time starting sals. from $27,500 to $35,500 with exc. work environment. Clin. appts. at Penn. Hosp. and Univ. of Penn. Med. Schl. Contact Dana Charry, M.D., Supervising Psychiatrist, Hall Mercer MH/MR Center of Pa. Hosp., 8th & Locust. Sts., Phila., Pa. 19107. (215) 829-5201. EOE.

Torrance—PSYCHIATRISTS: Bd. Cert. or Bd. Elig. Immed. opngs. Posns. avail. as Staff Psychiatrist in Intermediate and Acute Psychiatric Svc. and Resocialization Commty. Placement Svcs. Opngs. for Staff Psychiatrist, Clin. Director, and Asst. Superintendent. Penn. Lic. req'd. Sal. compet. Exc. frng. bnfts. If avail., call (412) 459-8000 or write: Ray E. Bullard, Jr., M.D., Superintendent; Torrance State Hospital; Torrance, PA. 15779

RHODE ISLAND

The E. P. Bradley Hospital, a prvt. Psych. Hosp. for Chldn. in Providence, is seeking academically-oriented psychiatrists, with skills in direct patient care, tchng. and clin. admin. These posns. carry faculty appts. at the appropriate rank with Brown Univ., since Bradley is an affil. and provides the trng. prgms. and facils. for Fellows in its Child Psych. Prgm, Psych. Residents, etc. The following posns. are open: DIRECTOR OF TRAINING-PSYCHIATRY. Is respon. for all aspects of Psych. Trng. incl. design, admin., supervision, and eval. Included are supervision and direction of trainees assigned and coordination of hosp. trng. prgms. Other respons. incl. preparation and presentation of didactic seminars and lectures, chairing appropriate committees, etc. Quals: Have appropriate trng. and have achieved Cert. in both Gen. and Child Psychiatry. Exper. of at least 7 yrs. is desired—particularly that in an organized setting for care of emotionally dist. chldn. and adols. DIRECTOR-INPATIENT PROGRAM. Is respon. for the planning, supervision, admin. and eval. of the Inpt. prgms., incl. direction and coordination of med. and prof. svcs. Also, supervision of Dept. Heads and planning the Inpt. Med. Prgm., etc. Develops and participates in trng. prgms. Quals: Have appropriate trng. plus Cert. in Gen. Psychiatry and Cert. (or preparing for) in Child Psychiatry. Exper. of at least 5 yrs. with a tchng.-trng. residential or other Inpt. unit is desirable. STAFF PSYCHIATRIST. Is respon. for med. aspects of patient care, incl. trtmt. planning, direct svcs., consult. and diagnostic interviews, etc. Will be involved in tchng. and research explorations. Quals: Have completed Fellowship in Child Psychiatry. Salaries for these posns. are negotiable, commensurate with individual quals. and exper. Fringe bnfts. are substantial and adjunct prvt. prac. under Hospital and University policies is possible. Bradley and Brown University are vigorous Equal Opportunity Employers. Please respond with a current copy of the CV to: FARABEE AND ASSOCIATES, INC.; P.O. Box 472; Murray, KY. 42071 or call (collect) (502) 753-9772. Farabee is retained by the Hospital.

SOUTH CAROLINA

FELLOWSHIP IN COMMTY. PSYCHIATRY & MH PGM. ADMINISTRATION—a 2 yr. Fellowship in Commty. Psych. and MH Pgm. Admin. is being offered by the William S. Hall Psychiatric Institute, beg. July 1, 1978. The Fellowship will consist of supervised clin. and admin. prac. in Compre. CMHCs and the S.C. Dept. of MH. Fellows accepted for the pgm. will be provided an oppty. to do grad. study at the Schl. of Public Health, Univ. of S.C., leading to an MPH Degree in Health Care Admin. For further info. write: Thomas W. Messervy, M.D., MPH, Div. of Commty. Psychiatry; William S. Hall Psychiatric Institute; P.O. Box 119, Columbia, S.C. 29202.

WANTED: PSYCHIATRIST II to perform direct patient trtmt. duties for a 3-cnty. MH operation. Annual sal. range between $27,472 and $39,638 dep. on educ. and exper. Please send inquiries to: H. Lloyd Howard; Tri-County MHC; 114 S. Marlboro St.; Bennettsville, S.C. 29512.

Charleston—The Charleston VA Hosp. and the Dept. of Psych. at the Med. Univ. of S.C. are seeking a Sr. faculty member to be DIRECTOR OF INPATIENT SERVICES at the VA Hosp. to begin in 1979. The Charleston VA Hosp., loc. immed. adjacent to the univ., is a primary tchng. hosp. for the College of Med. The Univ. is a rapidly dvlpng. health sciences ctr. loc. in historic Charleston on S.C.'s beautiful seacoast. Applicants should have acad. exper. and be Elig. for Assoc. or Full Professorship. A commitment to a high standard of Inpt. psych. care and demonstrated expertise in clin. tchng. are requirements. The Director of Inpt. Svcs. will also be expected to provide leadership in the dvlpmt. of clin. research projects. The Med. Univ. of S.C. and the Charleston VA Hosp. are EOE. Qual. minority and women candidates are encouraged to apply. Interested persons should send a CV to: Layton McCurdy, M.D.; Professor and Chairman; Dept. of Psychiatry & Behavioral Sciences; Med. Univ. of S.C.; Charleston, S.C. 29403

Columbia—MEDICAL DIRECTOR—Imm. opening for bd. elig. psychiat. in compre. MHC. Ctr. is accred. by JCAH, operates psychiat. inpt. svc. in local gen. hosp. Multi-discp. staff of 100. Ctr. loc. in prgsv. area, close to recreational facilities, mountains, beach. Ctr. has affils. with major univ., a tchng. psychiat. inst. and is loc. in capital city of Columbia, S.C. Exc. res. areas, schls., cult. opptys. Basic sal. range $41–$45,000. Contact Director, Columbia Area Mental Health Center, 1618 Sunset Dr., Columbia, S.C. 29203, or call (803) 758-3594.

Columbia—STAFF PSYCHIATRIST—Immed. openings for two (2) bd. elig. psychiats. in compre. MHC. Ctr. is accred. by JCAH, operates psychiat. inpt. svc. in local gen. hosp. Multi-disc. staff of 100. Ctr. loc. in prgsv. area, close to recreational facilities, mountains, beach. Ctr. has affils. with major univ., a tchng. psychiat. inst. and is loc. in capital city of Columbia, S.C. Exc. res. areas, schls., cult. opptys. Basic sal. range $41–$45,000. Contact Director, Columbia Area Mental Health Center, 1618 Sunset Dr., Columbia, SC 29203, or call (803) 758-3594.

Florence—PSYCHIATRIC SECTION CHIEF in a rapidly growing CMHC serving a 3 county area. Imm. opening for commty. oriented psych. to join multi-discpl. staff in planning and providing psychiat. svcs. to the health sector in the commty., psychiat. cons., educ. & trng. activities, supervision of direct and indirect psychiat. svcs. from within the Ctr., direct svc. within selected units of Ctr., and some administrative respons. Ties with tchng. facility in psychiat. being developed. Florence has 4 yr. college, vigorous Little Theater, & a new 300 bed Reg. Hosp. Local pvt. affil. avail. State employee frng. bnfts., sal. range $33,259–$45,921. EOE. Contact and send CV to Brantley M. Adams, Ph.D.; Chm. Search Committee; 2100 W. Lucas St., Florence, S.C. 29501; Tel. (803) 662-1401

Florence—PSYCHIATRIST II in rapidly growing CMHC serving a 3 county area. Imm. opening for commty. oriented psychiat. to join multi-disciplinary staff in providing direct clin. svcs. to adults on outpt. and inpt. basis. Outpt. svcs. inc. work with crisis intervention and emerg. svcs. Oppty. to provide in svc. trng. and commty. educ. as well. Ties with tching. institutions being est. in psychiat. Florence has a 4 yr. college, a vigorous Little Theater and a new 300 bed Reg. Hosp. Pvt. affil. avail. State employee frng. bnfts. Sal. range $30,236–$42,662. EOE Contact and send CV to: Brantley M. Adams, Ph.D.; Chm. of Search Comm.; 2100 W. Lucas St.; Florence, S.C. 29501; Tel. (803) 662-1401.

Greenville—Full time STAFF PSYCHIATRIST for well estab. Compre. MHC providing multi svcs. in accordance with Fed. and State regulations and standards. Part of modern med. complex incl. 68-bed psych. hosp. Loc. at the foot of the Blue Ridge Mtns. in S.C.'s largest and still growing industrial commty. 4 hrs. from sea shore and surrounded by lakes and other recreat. areas. Frng. bnfts. are provided as state employee—state retirement prgm., sick and annual lv. prgms., employee health coverage insur., and group rates for family. Sal. nego. within state merit system guidelines. Contact: Louis Cancellaro, Ph.D., M.D., F.A.P.A.; Director; Greenville Mental Health Center; 715 Grove Road; Greenville, S.C. 29605 Ph: (803) 242-8085.

SOUTH DAKOTA

Fort Meade—PSYCHIATRIST-Bd. Elig. or Bd. Cert. To take charge of a 30-bed ward in a 409-bed hosp. with 180 psych. beds. Affil. with Univ. of S.D. Med. Schl. New Bldg. loc. in the Black Hills of S.D. Exc. area to raise chldn.; exc. hunting, fishing, and camping. Modern housekeeping quarters avail. at very reasonable rental rate. No state income tax. EOE. Write or phone: Dr. Charles E. Townsend; Chief of Staff; VA Hospital; Fort Meade, S.D. 57741 Ph: (605) 347-2511

Rapid City-Black Hills Area—full-time MEDICAL DIRECTOR. Bd. Cert. or Elig. to join multi-discpl. staff of 55. Estab. Ctr. of 20 yrs. operation starting second yr. of federal funding. Oppty. for input into developing compre. prgm. Five full-time offices throughout the beautiful Black Hills. Sal. is more than compet. and frng. bnfts. exceptional. Recreational opptys. in Black Hills unsurpassed. Contact: Gary W. Selvy, Exec. Director; West River Mental Health Center; 710 St. Anne St.; Rapid City, S.D. 57701. Ph: (605) 343-8466.

Yankton—SOUTH DAKOTA NEEDS PSYCHIATRISTS. Specifically, we are looking for competent psychiatrists who are able and willing to provide high quality svc. and act as positive role model teachers for med. students. The Dept. of Psychiatry, Univ. of S.D. Schl. of Med., in alliance with the S.D. Human Svcs. Ctr., is assisting in the upgrading of the Human Svcs. Ctr. by providing faculty appts. to the physician staff, med. student rotations in the hosp., and assisting in recruitment of competent physicians who specialize in psychiatry. Sals. range from $45,000 to $52,500 per annum, with additional paid malprac. insur. and other frng. bnfts. If you feel the need to be of svc. both to patients and future physicians, please contact: David W. Bean, M.D.; Chairman, Dept. of Psychiatry; Univ. of S.D. Schl. of Med., and Administrator, S.D. Human Services Center; P.O. Box 76; Yankton, S.D. 57078 Ph: (605) 665-3671 The Univ. of S.D. and S.D. Human Services Ctr. are EOE Agencies.

TENNESSEE

EXCELLENT OPPTY. FOR GENERAL OR CHILD PSYCHIATRIST IN A PRIVATE INPATIENT SETTING. CLIMATE MODERATE. LOCATION IDEAL. REPLY BOX P-853, *Psychiatric News*

SENIOR PSYCHIATRIC RESIDENT, PG 04, WITH STRONG RESEARCH INTEREST NEEDED for Psych. Svc., Memphis VA Hospital: Resident will be enrolled in Univ. of Tenn. Dept. of Psych. Trng. Prgm. In addition to duties as PG 04 resident, the posn. calls for participation in a major SCHIZOPHRENIA RESEARCH PROGRAM focusing on phenomenological, nosological, cognitive-developmental, socio-ethological, pharmacotherapeutic and nutritional aspects. Exc. oppty. for advanced clin. research trng. and fulfilling rsdncy. requirements. Six month assignment is poss. Contact: Man Mohan Singh, M.D.; Professor of Psychiatry; Chief, Schizophrenia Program; VA Hospital; 1030 Jefferson Ave.; Memphis, TN. 38104 Ph: (901) 523-8990 ext. 5713

Bolivar, near Memphis—STAFF PSYCHIATRIST to serve as CLINICAL DIRECTOR. Oppty. to serve young, fast growing, financially sound, rural ctr. 60 miles northeast of Memphis. Svc. area pop. of 78,000, 5 counties. Work with staff of 26 others. Multi-discpl. approach to trtmt., frng. bnfts., sal. is nego. in $40,000 to $50,000 range. Beautiful Chickasaw Park, Shiloh National Park, TN. River and social and cult. bnfts. of Memphis are less than 1 hr. away. Good schools, favorable cost of living. Send resume or call: Glen Burse, Exec. Director; QUINCO MENTAL HEALTH CENTER; Highway 64 West; Bolivar, TN. 38074. Ph: (901) 658-6113.

Infrequent akathisia and other disabling extrapyramidal effects...

Extrapyramidal Effects of Selected Antipsychotic Agents*[2]

DRUG	EXTRAPYRAMIDAL EFFECTS
Chlorpromazine	Moderate
Perphenazine	High
Prochlorperazine	High
Fluphenazine	High
Acetophenazine	Moderate
Trifluoperazine	High
Chlorprothixene	Moderate
Thiothixene	Moderate
Haloperidol	High
MELLARIL® (thioridazine)	Low

*Based on antipsychotic dosage ranges

References

1. Van Putten T: The rising rehospitalization rate of psychiatric patients. Scientific Exhibit, American Psychiatric Association, 130th Annual Meeting, Toronto, Canada, May 2–6, 1977.

2. Byck R: Drugs and the treatment of psychiatric disorders, in Goodman LS, Gilman A (eds): *The Pharmacological Basis of Therapeutics*, ed. 5. New York, Macmillan Publishing Co, Inc, 1975, pp 170–171.

The rapidly rising readmission rate among discharged psychotic patients is mainly due to noncompliance with antipsychotic drug therapy. And this, in turn, may be largely attributed to disabling extrapyramidal side effects, notably akathisia.[1]

Although extrapyramidal effects are characteristic of antipsychotic agents in general, with Mellaril (thioridazine) such effects are infrequent. Adding an antiparkinsonian agent—which can cause its own side effects—can usually be avoided. Mellaril (thioridazine) is contraindicated in patients with severe hypotensive or hypertensive heart disease.

Mellaril® (thioridazine)

TABLETS: 50 mg, 100 mg, 150 mg, and 200 mg thioridazine HCl, USP
CONCENTRATE: 100 mg per ml

control of psychotic behavior with a low incidence of extrapyramidal symptoms

Before prescribing or administering, see Sandoz literature for full product information. The following is a brief summary.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides; carefully consider benefit versus risk in less severe disorders. During pregnancy, administer only when the potential benefits exceed the possible risks to mother and fetus.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy, observed primarily in patients receiving larger than recommended doses, is characterized by diminution of visual acuity, brownish coloring of vision, and impairment of night vision; the possibility of its occurrence may be reduced by remaining within recommended dosage limits. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving), and increase dosage gradually. Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension since phenothiazines may induce a reversed epinephrine effect on occasion. Daily doses in excess of 300 mg should be used only in severe neuropsychiatric conditions.

Store and dispense Concentrate below 86°F; use tight, amber glass bottle. Just prior to administration, Concentrate may be diluted with distilled water, acidified tap water, or suitable juices; preparation and storage of bulk dilutions is not recommended.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; rarely, nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—ECG changes (see *Cardiovascular Effects* below). *Other*—Rare cases described as parotid swelling.

It should be noted that efficacy, indications and untoward effects have varied with the different phenothiazines. It has been reported that old age lowers the tolerance for phenothiazines; the most common neurologic side effects are parkinsonism and akathisia, and the risk of agranulocytosis and leukopenia increases. The following reactions have occurred with phenothiazines and should be considered whenever one of these drugs is used. *Autonomic Reactions*—Miosis, obstipation, anorexia, paralytic ileus. *Cutaneous Reactions*—Erythema, exfoliative dermatitis, contact dermatitis. *Blood Dyscrasias*—Agranulocytosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplastic anemia, pancytopenia. *Allergic Reactions*—Fever, laryngeal edema, angioneurotic edema, asthma. *Hepatotoxicity*—Jaundice, biliary stasis. *Cardiovascular Effects*—Changes in terminal portion of electrocardiogram, including prolongation of Q-T interval, lowering and inversion of T-wave, and appearance of a wave tentatively identified as a bifid T or a U wave have been observed with phenothiazines, including Mellaril (thioridazine); these appear to be reversible and due to altered repolarization, not myocardial damage. While there is no evidence of a causal relationship between these changes and significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients showing characteristic electrocardiographic changes while taking the drug. While proposed, periodic electrocardiograms are not regarded as predictive. Hypotension, rarely resulting in cardiac arrest. *Extrapyramidal Symptoms*—Akathisia, agitation, motor restlessness, dystonic reactions, trismus, torticollis, opisthotonus, oculogyric crises, tremor, muscular rigidity, and akinesia. *Persistent Tardive Dyskinesia*—Persistent and sometimes irreversible tardive dyskinesia, characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements) and sometimes of extremities may occur on long-term therapy or after discontinuation of therapy, the risk being greater in elderly patients on high-dose therapy, especially females; if symptoms appear, discontinue all antipsychotic agents. Syndrome may be masked if treatment is reinstituted, dosage is increased, or antipsychotic agent is switched. Fine vermicular movements of tongue may be an early sign, and syndrome may not develop if medication is stopped at that time. *Endocrine Disturbances*—Menstrual irregularities, altered libido, gynecomastia, lactation, weight gain, edema, false positive pregnancy tests. *Urinary Disturbances*—Retention, incontinence. *Others*—Hyperpyrexia; behavioral effects suggestive of a paradoxical reaction, including excitement, bizarre dreams, aggravation of psychoses, and toxic confusional states; following long-term treatment, a peculiar skin-eye syndrome marked by progressive pigmentation of skin or conjunctiva and/or accompanied by discoloration of exposed sclera and cornea; stellate or irregular opacities of anterior lens and cornea; systemic lupus erythematosus-like syndrome.

SDZ 8-218

SANDOZ

SANDOZ PHARMACEUTICALS, EAST HANOVER, NEW JERSEY 07936

Clarksville—STAFF PSYCHIATRIST-Oppty. for psych. to become assoc. with growing multi-county MHC loc. 40 miles northwest of Nashville. Pop. respon. of 170,000, 7 cnty. svc. area. FT staff of 50, exc. frng. bnfts. Sal. dep. on quals. Resume to or call: John E. Walton, Exec. Dir. or Terry Peacher, M.D., Clin. Dir.; Harriet Cohn Mental Health Center; 1300 Madison St.; Clarksville, TN. 37040 Ph: (615) 648-8126

Knoxville/Oak Ridge—PSYCHIATRISTS for trtmt./supervisory posns. in Compre. CMHC in greater Knoxville/Oak Ridge area. Free standing Ctr. has all services incl. 44-bed Inpt. Unit. Loc. in TVA lake country, in a scientific research commty., near major univ. JCAH apprvd. Sals: $45,000 for bd. elig. and up for bd. cert. Contact: John F. Byrne, Ph.D.; Regional Mental Health Center of Oak Ridge; 240 West Tyrone Rd.; Oak Ridge, TN. 37830.

TEXAS

PSYCHIATRIC RESIDENCY—Terrell State Hospital affil. with the Univ. of Texas Southwestern Med. Schl. With TX. Lic. first & second yr.—$19,000; 3rd yr. $20,000; 4th yr. $21,000. Without TX. Lic. $17,600. Accredited for JCAH. Contact: Luis M. Cowley, M.D., Superintendent; Terrell State Hospital; P.O. Box 70; Terrell, TX. 75160 Apprvd. internship pref.

Austin—CHILD PSYCHIATRY RESIDENCY may be taken before or after Adult Psych. trng. Acad. prgm. in child dvlpmt., family therapy, genetic and metabolic disorders, behavior therapy, grp. therapy, psychopharm., and ethology. Basic clin. orient. in child dvlpmt. with intensive indiv. supervision in psychoanalytic and eclectic modalities and pediatric neurology. Research opptys. in genetic and metabolic disorders, child dvlpmt., linguistic anthropology, commty. svcs., and other fields. Exc. opptys. in tchng. admin., Inpt. and Outpt. clin. prgms. New 60-bed Inpt. unit for chldn. Liaison with grad. schools, med. schl. and commty. prgms. Stipends: first yr. $17,000; second yr. $18,000; third yr. $19,000; fourth yr. $20,000 with addit. frng. bnfts. Contact: Anthony P. Rousos, M.D., Director of Residency Training; Austin State Hospital; 4110 Guadalupe; Austin, TX. 78751

Austin—PSYCHIATRIC RESIDENCY in apprvd. 3-yr. prgm. Effective connections with univs., med. schools, prvt. clinics and commty. ctrs. Outstanding faculty and prgms. Stipends with TX. Lic. are $17,000; $18,000 and $19,000 per yr. with addit. frng. bnfts. For full info., write to: Anthony P. Rousos, M.D.; Director of Residency Training; Austin State Hospital; 4110 Guadalupe St.; Austin, TX. 78751

Big Spring—PSYCHIATRIST, Bd. Cert. or Elig. Sal. $38,000 to $42,800. TX. Lic. req'd. Building a better & more dynamic prgm. in State Hosp. Ideal family living town of 30,000, good schools, recreat., mild West TX. weather. Call or write: Priscilla Diffie-Couch, Acting Personnel Director; Big Spring State Hospital; P.O. Box 231; Big Spring, TX. 79720 Ph: (915) 267-8216 An EO/AAE.

Corpus Christi—PSYCHIATRIST—commty. psych. for MH/MR Center in 250,000 pop. cnty. 3 yr. psych. rsdncy. in accred. psych. prgm. TX. Lic. NTE $38,400. EOE. Reply: Director, Personnel Services; Nueces County MH/MR Center; 1630 S. Brownlee; Corpus Christi, TX. 78404

Dallas—Growing, innovative, eclec. Dept. of Psych. expands rsdncy. trng. pgm. Oppty. avail. for compre. trng. in child & adult psych., liaison & research. Openings PGY 1–4 incl. internship. Good stpnd. and generous frng. bnfts. Write to Director of Residency Training, R. S. Kiser, M.D., Univ. of Texas Health Science Ctr. at Dallas, 5323 Harry Hines, Dallas, Texas 75235.

Dallas—PSYCHIATRISTS (Bd. Cert. or Elig.) both full and part-time for rapidly expanding Dept. of Psychiatry at Univ. of Texas Health Science Ctr. at Dallas. Posns. incl. CHIEF OF CHILD PSYCHIATRY, CHIEF OF CONSULTATION LIAISON, and DIRECTOR OF CLINICAL SERVICES. Excel. oppty. Sal. and acad. commensurate with exper. and credentials. except frng. bnfts. An EOE. Send inquiries with current and complete CV to: K. Z. Altshuler, M.D., Chairman, Dept. of Psychiatry, 5323 Harry Hines, Dallas, TX. 75235.

El Paso—One man psych. assoc. seeking a second associate interested in doing gen. or child psychiatry, plus any subspecialty work he may be qual. to do. Large office, ideal for two or three man grp. Exc. sal. plus lib. frng. bnfts. Inquiries should be addressed to: Ben Hill Passmore, M.D., P.A.; 2800 North Stanton; El Paso, TX. 79902

Fort Worth—ASSISTANT DIRECTOR FOR PSYCHIATRY. Immed. opng. for Asst. Dir. in Dept. of Psych. in 375-bed gen. tchng. hosp. in Fort Worth, TX. Tchng. and patient care prgms. are being developed through affil. with Dept. of Psychiatry of Southwestern Med. Schl. at Dallas. Psych. will assist Director to provide direct patient care, tchng. rotating residents, and clin. supervise acute and intermediate trtmt. prgms. in two units totaling 58 beds. Therapeutic milieu is eclectic with emphasis on interpersonal, humanistic and psychodynamic approaches. Multidiscpl. prof. staff incl. four masters level therapists. Many svcs. locally avail. for patient referrals incl. Outpt. clinic; partial hospitalization, alcohol trtmt., vocational dvlpmt. ctrs. and others. Fort Worth, TX. is a major and growing metro. area of 400,000 people and well known for its low cost of living. Many recreat. facils. for water activities, hunting, golf, amateur and prof. sports and more. Cult., educ., and entertainment opptys. are exc. Faculty appt. and remuneration will be based on clin. and acad. exper. Please forward CV with your initial response to: Director, Dept. of Psychiatry; Tarrant County Hospital District; 1500 South Main St.; Fort Worth, TX. 76104

Houston—CHILD PSYCHIATRIST: Acad. posn., open for person skilled in pediatric consult. and liaison. Applicant expected to head an expanded consult./liaison pgm. in a large prvt. pediatric hosp. and a consult./liaison tchng. svc. for child psych. residents. Posn. allows for prvt. prac. and attractive income in growing metro. area. Inquiries and CV to: Dr. Douglas B. Hansen; 1200 Moursund; Houston, TX. 77030. Ph: (713) 790-4850.

Houston—Private group eclectic orientation in & outpt. Bd. Cert. Pref., Sal. Nego. Contact: Mr. Rick Jacobus, 7777 Southwest Freeway, Suite 1004/Houston, Tx. 77074 or call collect (713) 772-4600.

UTAH

TIRED OF THE HASSLE OF URBAN LIVING? The Bear River CMHC is seeking a DIRECTOR of Psychiatric Services (CLINICAL DIRECTOR). The Ctr. is a relatively small, and recently funded, semi-rural CMHC loc. in the unspoiled, northern Utah Mtns. (skiing, fishing, camping, etc.) The clin. staff consists of six Ph.D. psychologists, three M.S. psychologists (2 ABD), four MH specialists (M.S.W., M.S.), two social service workers (B. SW.), two nurses (R.N.M.S., R.N.) and two consulting psychiatrists. Loc. primarily in the univ. commty. of Logan, the Director of Psych. Svcs. will: 1) share with the Director of Psychological Services supervision of all clin. svcs.; 2) provide commty. orient. psych. svcs. (trtmt. and prevention); 3) maintain med. accountability; and 4) provide leadership in defining the relationship (role) of psych. to other disciplines within the Ctr. Sal. range approx. $40,000–$44,000 dep. on quals, with a gen. frng. pckg. Bd. Elig. or Cert. If interested, send vitae and other supporting documents to: Dr. Bartell W. Cardon, Exec. Director; Bear River CMHC; 198 North Main; P.O. Box 683; Logan, UT. 84321.

VIRGINIA

DEPT. OF PSYCHIATRY, MEDICAL COLLEGE OF VIRGINIA, under new leadership, is expanding its clin., research, and trng. prgms. and is recruiting residents for advanced placement in its Rsdncy. Trng. Prgm. Openings avil. in rising PG-2, PG-3 and PG-4 yrs. Contact: Robert O. Friedel, M.D., Chairman; Dept. of Psychiatry; Medical College of VA.; P.O. Box 907; Richmond, VA. 23298.

PSYCHIATRIST, Bd. Elig. or Cert. is req'd. to join a team of 3 other psychiatrists to work in a very attractive, modern, financially sound MHC with highly qual. multi-discpl. team members. Exper. and interest in child psych. and/or behavior therapy is desirable but not necessary. Poss. acad. affil. dep. on quals. and exper. Liberal frng. bnfts. The facil. is loc. in a very desirable, Southeast cosmopolitan area within a few minutes from the beach and within a short driving distance from Richmond and Washington, D.C. Please send a CV to: Box P-849, *Psychiatric News*.

Charlottesville—CHILD PSYCHIATRY RESIDENCY. Addit. opng. avail. in estab. univ. trng. prgm. for Jan. 1979 or July 1979. Family and individual therapy emphasized. Intensive consult. exper. with peds., neuro., and juvenile and domestic relations court. Clin. research encouraged and expected. Must be Elig. for VA. Lic. Univ. town in Blue Ridge Mtns. Contact: A. Derdeyn, Director; Division of Child and Adolescent Psychiatry; Box 202; Univ. of VA. Med. Center; Charlottesville, VA. 22901 Ph: (804) 924-2234

Charlottesville—Univ. of Va., Dept. of Psychiatry is recruiting faculty with behavioral medicine and systems theory orient. Exper. in med. schl. tchng. req'd. To apply send CV to: W. W. Spradlin, M.D., Chairman; Dept. of Psychiatry; Box 203; UVA Medical Center; Charlottesville, VA. 22901 EOE/AAE

Colonial Virginia—GENERAL PSYCHIATRISTS II and CHILD PSYCHIATRIST to join an expanding multi-discpl. dynamic orient. grp. prac., emphasizing individual, grp., family psychotherapy and consult./liaison trtmt. modalities. Grp. in process of developing a prvt. 60-bed child and adols. hosp. in area loc. near historic Colonial VA. with easy access to VA. Beach and Outer Banks. Abundant recreat. opptys., exc. public and prvt. schools avail. Finances and frng. bnfts. nego. Please send CV and inquiries to: William M. Cseh, M.D.; Suite 202, 606 Denbigh Blvd.; Newport News, VA. 23602

Colonial Virginia—GENERAL PSYCHIATRIST & CHILD PSYCHIATRIST for staff of prvt. psych. hosp. loc. on waterfront. East VA. Med. Schl. affil. JCAH and Medicare accred. New 40 bed adols. unit & alc. rehab. and adult prgms. Pluralistic Rx. phil. Flex., dynam.-orient. appl's sought. Sal. $40,000+ dep. on trng. and exper. Tidewater VA. has fine climate and recreat. oppty. Wmsbg., Yorktn., Jamestn., VA. Beach nearby. Send CV and ltr. desc. exper. to: Douglas H. Chessen, M.D.; Bayberry Hospital; 530 E. Queen St.; Hampton, VA. 23669

Northern Va.—MH Inst., a 120-bed, open psychiat. hosp., loc. in a Va. suburb of the Washington metro. area, has need of a PSYCHIATRIST to operate a 20-bed inpt. unit. Prefer full-time but would consider a half-time psychiat. who would share a unit. Sal. is $33,000 to $50,000, dep. upon trng. and exper. Mal. ins. is totally furnished and hosp. ins., grp. life ins., and retirement are provided on a shared basis with the employer. Must have Va. lic. Please make inquiries of Robert E. Strange, M.D., Dir., 3302 Gallows Rd., Falls Church, Va. 22042. Tel. (703) 560-7700. EOE.

Richmond—CHIEF OF PSYCHIATRY SERVICE, VETERANS ADMIN. HOSPITAL. Dean's Committee VA Hosp. fully affil. with the Med. College of Virg. Acad. psych. qualifying for Sr. Faculty appt. Contact: Hunter McGuire, M.D., Chairman; Psychiatry Search Committee; Surgical Service (112); VA Hospital; Richmond, VA. 23249.

Roanoke—PSYCHIATRIST: Bd. Cert. or Elig. Outstanding full-time oppty. to direct Inpt. Svc. of a gen. hosp. and to participate in the tchng. of family prac. residents and med. students. Univ. of VA. faculty appt. avail. for qual. candidate. Prvt. prac. poss. Sal. $40,000+ frng. bnfts. Must have or be Elig. to obtain Lic. to prac. in Va. Contact: Marvin E. Perkins, M.D., Medical Director; Mental Health Services of the Roanoke Valley; 920 S. Jefferson St., Suite 500; Roanoke, VA. 24016 EOE M/F

Southwestern Va.—GENERAL PSYCHIATRIST AND CHILD ADOLESCENT PSYCHIATRIST to join lge. established pvt. practice including outpt. and inpt. therapy. Offices loc. in southwestern Va. serving lge. ref. area. Sal. nego. with many frng. bnfts. Reply: Box P-860, *Psychiatric News*

Tidewater—WANTED: GENERAL PSYCHIATRIST to join large estab. psych. prof. corp. in Tidewater, VA. Posn. involves location in semi-rural area adjacent to large metro. area. Emphasis on liaison with med. commty., hosp. consults., outpt. therapy, family, indiv., and grp. Full bnft. pgm. Sal. nego. Contact: Robert C. Bransfield, M.D.; 201 North Main St.; Suffolk, VA. 23434.

WISCONSIN

PRIVATE PSYCHIATRIC PRACTICE oppty. in a multi-specialty group of 29 physicians to fill a complement of 3 psychiats. Attractive income arrangements, ass. membership within one yr., pension, extensive frng. bnfts., no investment req. Excl. commty. of 50,000. Contact: E. H. Jochimsen, M.D., 1011 North 8 St., Sheboygan, WI. 53081. Ph: (414) 457-4461.

Cumberland—PSYCHIATRIST to join a CMHC serving 100,000 pop. in 5 rural counties of N.W. Wisc. Eclectic staff of 35, new Outpt. facil.; sal. $37,000 min. with full frngs. Vacation area with many recreat. activities. Call or write: Program Director; Northern Pines Unified Services Center; P.O. Box 518; Cumberland, WI. 54829. Ph: (715) 822-4747.

Jefferson—PSYCHIATRIST half time for pgsv. commty. psychiatry Human Services pgm. Emphasis on social systems, family and commty. resources as an alternative to hospitalization. Resp. for mental health, developmental disabilities, alcohol, drug abuse and child welfare prgms. Multidisciplinary team approach. Loc. with easy access to Madison, Milwaukee, Chicago. Wis. Lic. req'd. Sal. $26,000 to $30,000 with generous frng. bnfts. Contact Harold F. Borenz, M.D., P.O. Box 375, Jefferson, Wis. 53549.

Madison—Mendota Mental Health Institute: CHILD PSYCHIATRIST for 10-bed forensic unit for emotionally dist. adols. PSYCHIATRIST CHIEF for 20-bed tertiary care geriatric unit. PSYCHIATRIC CHIEF for 35-bed adult tertiary care unit. STAFF PSYCHIATRIST for expanding forensic psych. prgm. Mendota Mental Health Institute is a JCAH apprvd. 225-bed institute loc. in Madison which has been named one of the two top commtys. in the U.S. in which to live, contains the main campus of the Univ. of Wisc., and is the state capital. MMHI is a unique regional care facil. with close affil. with many univ. depts. and trng. prgms. Research poss. Wisc. Lic. req'd. Starting sal. to $50,235 dep. on quals. Lib. frng. bnfts. Malprac. covered. EOE. Contact: Dr. Lee Ecklund, (608) 244-2411, Mendota Mental Health Institute; 301 Troy Dr., Madison, WI. 53704

Madison—PSYCHIATRIST/DEPUTY DIRECTOR in pace setting tertiary care institute with 200 Inpts. and unique award winning demonstration prgms. for institutional care. Tchng., research, consult., faculty appt. Chief of Med. Staff, Bd. Cert. and min. 3 yrs. exper. in admin. Located in metro area of 200,000 with Univ. of Wisc. and state capital, clean industries. Sal. to $51,425 plus lib. frng. bnfts. Wisc. Lic. req'd. EOE. Contact: Dr. Lee Ecklund, (608) 244-2411, Mendota Mental Health Institute; 301 Troy Dr.; Madison, WI. 53704

New Richmond, St. Croix County, Wisconsin—PSYCHIATRIST/CLINICAL DIRECTOR for compre. MHC operating Inpt./Outpt. MH and Alcoholism Trtmt. Prgms., Prgms. for Developmentally Disabled incl. Adult Day Care and sheltered work. Exc. staff utilizing a compre. trtmt. and growth model. Sal. $35,000 to $50,000 with frng. bnfts., incl. such items as med. insur., malprac., prof. travel, etc. This new facil. is loca. 35 miles from Minneapolis/St. Paul, MN. and the Univ. of Minn. AA/EOE Send resume to: Gary D. Johnson, Administrator; St. Croix Health Center; Route #2, Box 16-A; New Richmond, WI. 54017 Ph: (715) 246-6991.

WYOMING

Evanston—FORENSIC PSYCHIATRIST—Come help us with the court ordered evaluations of defendants under the insanity pleas and the trtmt. of patients with behavioral disorders. Must be at least Bd. Elig., no skeltons, and good health. Exper. in forensic psych. req'd. New $3 million 70-bed unit with a new 30-bed wing under construction. Exc. supporting staff and consults. JCAH apprvd. 365-bed hosp. Sal. up to $46,000 per yr. plus free housing, exc. frng. bnfts. and paid malprac. insur. Exc. recreat. opptys. locally and only 85 miles from Salt Lake City, Utah for skiing, night life, and cult. opptys. Write with full CV to: William N. Karn, Jr., M.D., Wyoming State Hospital; P.O. Box 177; Evanston, WY. 82930 or call (307) 789-3464

POSITIONS WANTED

PSYCHIATRIST interested in entering a partnership. Extensive exp. in pharmacological therapy, outpt., alcoholism, adults and children. Area N.Y. City and N.J., Bergen County. Reply: Box P-863, *Psychiatric News*

PSYCHIATRIST, 37 y.o., all U.S. trained, seeks posn. in grp. prvt. prac. Avail. mid-1979, prefer metro. area in West or Southwest. Broad exper. in acute hosp. and consults.; special int. in forensic, crisis, and geriatric. Would consider part-time CMH with prvt. prac. oppty. Reply Box P-859, *Psychiatric News*

PRACTICES FOR SALE

PSYCHIATRIC PRACTICE AND OFFICE FOR SALE: New Jersey seashore resort area with close proximity to both Philadelphia and N.Y.C. Many recreat. facils. Increasing patient pop. with relative shortage of psychiatrists. Well-estab. prac. in new modern med. office blg. next to hosp. Will introduce socially and professionally. Reply to: Box P-848, *Psychiatric News*.

Midwest—Well estab. 15 yr., gen. Psych. prac. Hospital beds avail. Sufficient for 2 psychiatrists. Will introduce. Must sell for health reasons. Very lucrative. Reply Box P-857, *Psychiatric News*

RURAL MIDWEST PSYCHIATRIC PRACTICE FOR SALE—Exc. oppty. for young practitioner interested in group therapy, T.A.—Gestalt, med. consult. and commty. psych. No other psychiatrists presently prac. in area. Yearly gross approaching 100,000 potential is greater. Loc. in small college town; large metro. area 1½ hrs. driving distance. Beautiful country, exc. outdoor recreat. Very easy terms. Avail. with full case load and office facils. Dec. 1, 1978. Present psychiatrist returning to acad. life. Reply Box P-856, *Psychiatric News*

COURSES & WORKSHOPS

Jan.-June 1979: TRAINING PROGRAM IN GROUP PSYCHOTHERAPY sponsored by NYU Post-Grad. Med. School, 550 First Ave., N.Y., N.Y. 10016 Fridays, 9:00 A.M. to noon. Fee $450. Directed by Edward Pinney, M.D. and Samuel Slipp, M.D. with distinguished guest faculty. Curric. modeled on trng. guidelines of Am. Group Psychotherapy Assoc. Suitable for psychiatrists, psychologists, psychiatric nurses and social workers, pastoral counselors and guidance counselors. For info. or course brochure write or call (212) 679-8745 (24 hr. telephone).

Nov. 11–12, 1978—VIDEO TRAINING WORKSHOP, Sat. & Sun. in N.Y.C., conducted by Milton M. Berger, M.D. on "Video Techniques in Psychiatric Training and Treatment" covering basic equipment, legal and ethical issues, preparation of patients for impact of self-image confrontation, replay techniques, equipment demonstrations, multi-level communications and systems, anatomy of a video production. Write to: HEALTH & EDUCATION MULTI-MEDIA, INC.; SUITE 4B, 50 EAST 72 ST.; N.Y., N.Y. 10021 Ph: (212) 288-2297 for prgm. and/or catalog of 35 videotapes cassette prgms. on Human Development; Family and Group Therapy; Communication; Stress; Schizophrenia; Sex Education, Therapy and Counseling; Hypnosis; Neurology; Art Therapy.

HYPNOSIS CLINICS—The Lafayette Institute of Behavior Therapy & Crisis Management is now installing Automated Multiple Unit Hypnotherapy clinics in prvt. practices throughout America. Minimal investment yet you may expect your income to double within a few years while extending the ranges of your effectiveness in helping patients. Request fee schedule from the: Lafayette Institute of Behavior Therapy; 4416 Johnston St., Lafayette, LA. 70503

PSYCHOANALYTIC TRAINING IN NEW YORK CITY—The Instit. for Psychoanalytic Trng. and Research (IPTAR) chartered by the Bd. of Regents of the Univ. of the State of N.Y., provides an integrated two evening-a-week curric. based on the Developmental Freudian approach; the foundation for all psychoanalytic psychotherapy. Prgm. leads to a Cert. in Psychoanalysis and Elig. for IPTAR Membership Society. June 15 is the closing date for applications for the acad. yr. beginning in Oct. Late registration may be consid. with a $20 late fee. For Bulletin write: Dr. Joseph Rechetnick; 79 West 12th St.; New York, N.Y. 10011.

MISCELLANEOUS

A DIFFERENT VACATION! Perfect weather; sunny every day; low humidity; yr. round temp. in low 80s; cool breeze at night. Where? On the lush, tropical isle of St. Vincent in the lower Caribbean! Great privacy on 20 acres of uncrowded seafront, casually landscaped with many varieties of exotic foliage; deserted beaches with fascinating shells; 10 cottages with max. capacity of 20. Owned and hosted by an alert young couple who appreciate and serve superb food. Grp. rates are avail. For more info. call: Gerald Ikelheimer (212) 675-5820 or write: Rawacou, Stubbs Bay, St. Vincent, W.I.

ALCOHOLISM PROGRAM with Psychiatrist of 16 yrs. exper. Innov. effective, therapeutic prgm. Confidential, dignified environ. Ideal setting, luxurious lake front lodge, mtn. countryside. The Rhinebeck Lodge for Successful Living; R.D. #1; Rhinebeck, N.Y. 12572. Ph: (914) 266-5777 or (212) 279-2727.

AUTOGENIC TRAINING—self regulation of internal states. Relaxation and pain control. Somatic visualization techniques and affective imagery. Produced by Vera Fryling, M.D. Basic 60 min. self trng. cassette: $10.95 Send to: Center for Stress Control; 33 Quail Ct.; Walnut Creek, CA. 94596 Professional seminars given monthly.

INTERVIEW AND REPORT GUIDES FOR PSYCHOLOGICAL ASSESSMENT. The Guides, and accompanying text, provide the clinician with specific inquiries and report vocabulary to be used in response to a variety of assessment problems, incl: eval. of adults, chldn., and families; intellectual functioning; organicity; psychosomatic involvement; and day-care-center prognosis and progress. Also, incl. are materials useful in educating referral sources, in orienting patients to psychotherapy, and more. $5, plus 50¢ postage, from Dick Inglis, Ph.D.; 325 Newell St.; Walla Walla, WA. 99362

Maine: If you are coming or are interested we would be glad to help: Maine Psychiatric Association, Pres. Stephen Soreff, M.D., 22 Bramhall St., Portland, Maine 04102; (207) 871-2215

TEACHING/TRAINING AIDS: "PERCEPTIONS"—a series of 60-minute videotapes on Family Therapy, featuring Satir, Minuchin, Whitaker, Framo, Paul, the Duhls, and others. Avail. for sale or rental in ¾" color U-Matic cassettes or ½" b/w EIAJ format. For brochure, write the Boston Family Institute, Dept. C-36, 1170 Commonwealth Ave., Boston, MA. 02134. Ph: (617) 731-2883.

TUTORING, comprehensive, by mail. REVIEW OR WRITTEN-ORAL BDS. EXAMINATIONS. Psychiat.-Neurology. Manuscripts, Microscopic & Gross Specimens. Recordings, Inq. of Albert V. Cutter, Inc., 121 South Long St. (Rear), Williamsville, N.Y. 14221.