Psychiatric News

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In the unusual setting of APA's headquarters building in Washington, psychiatrist Frank Ochberg, M.D., is sworn in as Michigan's new commissioner of mental health by Chief Judge for the U.S. Court of Appeals, District of Columbia, David Bazelon, as Ochberg's wife Lynn looks on.

FDA Names First Drugs For Package Inserts

By B. S. Herrington

THE FOOD AND DRUG ADMINISTRATION has targeted a group of 50 to 75 prescription drugs—16 of them more or less commonly prescribed by psychiatrists—to be among the first to have patient information leaflets dispensed with the products in a major effort that would eventually lead to patient labeling for most drugs.

In draft regulations issued in the July 6 *Federal Register*, the agency has formally proposed to devise patient labeling based on information contained in physician drug inserts. They would, however, be written in nontechnical language and less detail. Commonly referred to as "patient package inserts," although they would be handed out by the pharmacist, the leaflets would describe in easily understandable terms a drug's indications and contraindications, adverse reactions and potential hazards, precautions for use, and special handling and storage. Encouragement for the patient to carefully read the information and closely follow the instructions for use would also be an important part of the design.

The proposed rules also provide for exemptions, several of which have been previously advocated by some psychiatrists. Physicians, for instance, would be able to direct that the pamphlets be withheld for certain patients for medical reasons, such as in cases in which the information would be detrimental emotionally. FDA underscores that this exception should be only rarely invoked, however, and not because it might lead a patient to refuse to take or to discontinue taking prescribed medications. It also exempts legally incompetent patients, persons needing emergency treatment, and patients who are blind or whose primary language is not English.

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Psychiatry Advanced In Medicare Testimony

By Margaret C. McDonald

THE AMERICAN PSYCHIATRIC ASSOCIATION, in recent testimony before the Health Subcommittee of the House Ways and Means Committee, gave the first public indication of the bold, assertive approach it plans to take in defending psychiatry's domain.

Testifying on proposed Medicare amendments to make CMHCs qualified providers (H.R. 3990 and H.R. 2369, a similar bill with more liberal outpatient coverage), Walter J. Tardy, Jr., M.D., told Congressman Charles Rangel's (D-N.Y.) subcommittee, "APA supports the concept of direct reimbursement to CMHCs only where the necessity for case management or supervision of a patient by a physician, preferably a psychiatrist, is set forth in the legislation." Tardy recommended deletion of a section of H.R. 3990 which would allow a psychologist to bill a Medicare provider directly for inpatient services, commenting, "Such provision would preclude an individual from receiving the entire spectrum of diagnoses and services available from the American health care system—such as are necessary to develop the most appropriate treatment plan."

The New York psychiatrist requested that the recent Virginia decision by U.S. District Court Judge D. Dortch Warriner reaffirming this position [*Psychiatric News*, May 4] be made part of the hearing record. Tardy quoted for the subcommittee some sections of the decision, including the following statements: ". . . but in the treatment of nervous and mental disorders, psychiatrists are capable of providing a full range of psychiatric treatments, not just psychotherapy. . . . It is undisputed that clinical psychologists are not qualified to diagnose nervous and mental disorders and to decide from what source these disorders stem. . . . It is also undisputed that the only method of making sure that a physical disorder does not complicate treatment by a clinical psychologist is regular contact between the psychologist's patient and a medical doctor." Tardy cited APA's opinion "that if direct reimbursement for other mental health care providers is to be considered, it should be done so with clear specificity for the circumstances surrounding nervous, mental, or emotional disorders which authorize differences for collaborative or individual independent responsibilities in the treatment of the elderly's mental health problems."

When queried by Rangel on what role psychologists should have, Tardy responded with his opinion that "psychologists can be competent at psychotherapy under the supervision of a psychiatrist who had made sure that

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News Digest

Willard Gaylin, M.D., co-founder and president of the Institute of Society, Ethics, and the Life Sciences, discusses feelings in the interview beginning *on page 3.*

* * *

Results of a new study confirm that lower doses of antipsychotic drugs work just as well as higher doses. Results of the study, reported at APA's recent annual meeting, are discussed in the article *on page 5.*

* * *

Certain life members and life fellows are exempt from the APA continuing medical education requirement. Full details are in the story *on page 10.*

* * *

One in four cases of bipolar illness is either mistakenly diagnosed or not detected at all, according to the article *on page 27.*

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JCAH: A New Structure

AS OF JUNE 30, the Joint Commission on the Accreditation of Hospitals (JCAH), as part of its massive reorganization efforts, officially terminated its four accreditation councils, including the Accreditation Council for Psychiatric Facilities. In their place will be a newly constituted, less autonomous JCAH entity—the professional and technical advisory committee (PTAC).

JCAH hopes, in tightening its structure, to centralize decision-making authority in its Board of Commissioners and to develop a set of consolidated standards that may be used in surveying facilities offering multiple services, which, in the past, have been subject to a separate survey for each service.

The JCAH face-lift began in October 1978 when its board of commissioners (BOC) authorized implementation of a major reorganization as the culmination of what JCAH president John E. Affeldt, M.D., has described as "a comprehensive study of the organization and operations of the joint commission which was conducted by the board's planning and organization committee, in conjunction with a team of selected consultants." The gist of that report was that decision-making power within the commission needed to lie with one body, the BOC, rather than be spread throughout a series of entities, in this case the accreditation councils. This advice meant that the accreditation councils would have to yield. Each of the four councils was composed of representatives of relevant organizations that paid for the number of seats they wished to have on the council, up to a maximum of three (the number APA had). The accreditation councils were empowered to develop standards, set up accrediting programs, and hear appeals. The JCAH board of commissioners, although it could remand council decisions for reconsideration, had no veto power on council decisions, a situation that spread much of JCAH's decision-making power among four bodies that could independently initiate contradictory policy.

In place of the accreditation councils, five professional and technical advisory committees (PTACs) will be established to interact with the various accrediting programs: psychiatric, mental retardation/developmental disabilities, long-term, ambulatory, and hospital accreditation. JCAH's George Coldewey, vice-president for

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Slogans

Guest Editorial

By Irwin N. Perr, M.D., J.D.

IN RECENT YEARS, legislative changes and judicial decisions have drastically altered the management of involuntary patients in governmental institutions. Partly this reflected anxiety about the basic civil rights of those deprived of freedom wherever that might be (e.g., mental hospitals, prisons, juvenile institutions), and partly a concern for how declining public monies were spent with a need for new levels of accountability. It reflected both the growing suspicion of autonomus systems with unchecked power and the numerous philosophical approaches toward the "disadvantaged" of all types.

In a pluralistic society, communicating in a simple, understandable fashion is a *sine qua non* in establishing a base for public support. For example, a controversial issue such as abortion accessibility has a mighty battle of sloganeers between those who favor the "right to life" and those who favor "freedom of choice."

Similarly, in developing mental health policy, key expressions have been crucial in spurring adoption of new policies. Such expressions or slogans may have little to do with the actual content or meaning of the policies that follow in their wake. The most significant governmental change in the last ten years has been the vast expansion of legal rights to mental patients. Those favoring these changes could accurately be called "due processors," reflecting the propounding of the extension of due process to an underrepresented powerless group. That term, however, would have little public relations value.

The expression, "right to treatment," resulted in a number of messages, ironically the least of which had ultimately to do with treatment. Right to treatment cases have generally dealt with due process, the right to a humane environment (physical surroundings, sufficient sinks and toilets, minimizing of crowding, etc.) and the establishment of minimal standards for staffing. The latter is closest to a concern for actual treatment, but it is not synonymous. "Right to treatment" frequently has meant only the opportunity for various groups to assert their claims to the mental health turf and an ill-advised egalitarianism of a poorly rationalized assortment of people who work in mental health settings, all lumped together as "mental health professionals," another expression that has spread more darkness than light.

In a society based on legal protection of various freedoms, successful slogans use the word "right." Thus the "right to treatment" conveys goodness as does the right not to have intrusive or hazardous treatments arbitrarily imposed. Transmitted into actual policy, this right makes sense when applied to psychosurgery, becomes less meaningful when applied to electroencephalotherapy (electroshock therapy), and ludicrous when applied to the everyday use of medication. Thus, when courts become arbiters of medical treatment, even with the best of intentions (the *Lima* case in Ohio and the *Rennie* case in New Jersey), chaos results.

A common element in recent legal change is the loss of medical input and the legal direction of actual treatment. Some courts are now practicing medicine, doing it badly, and, as the ultimate authority, unchecked without peer review. Many judges recognize the uncomfortable position of trying to be a medical authority based on a scattering of adversarial presentations. As the judge in the *Rennie* case acknowledged (but did not heed), "A little knowledge can be dangerous."

A major current shibboleth is the right to the "least restrictive alternative." Logically, this expression means the least amount of restriction of freedom compatible with the needs of the situation. The reality is that it is a beauteous expression affirming the need to counterbalance the use of police power and has resulted in an unthinking focus only on bodily freedom. The expression started with a concern for physical confinement and has in short order been extended to a variety of ordinary hospital mechanisms or treatment systems. Thus transfers between or within hospitals became subject to legal reviews (with the accompanying paralysis and delays characteristic of the law), and finally the concept has extended to medical treatment itself, first the choice of medication and then to adjustment of amounts.

Physicians need to communicate to courts the medical basis for treatment decisions and needs. Certainly patients, particularly those held involuntarily, should have the opportunity for adequate *and* appropriate treatment. Insufficient attention to this "right" has been discussed by Treffert in his review of patients who "died with their rights on."

This concern for the individual rather than a total focus on the process has been recognized in custody law where increasingly courts make decisions "in the best interests of the child." The right to care and treatment unfortunately must often conflict with the right to freedom. Frequently both cannot be simultaneously feasible or compatible. The decision must broadly be in "the best interests of the patient."

I would suggest that judges, in the exercise of judgment mandated to them, be encouraged to accept as an element of their determinations consideration of "*the most beneficial alternative*"—a principle not inconsistent with acknowledgment of the need for the least restrictive alternative but one that would also allow for a balancing of needs and rights and for review of the likely long-term benefits and risks. It is indeed ironic that where we once could say, "*Plus ca change, plus c'est la meme chose,*" we can now observe only that the more things improve, the worse they get. Perhaps adoption of the most beneficial alternative principle would once again allow for a humanitarian, intelligent, and helping intervention when it does become necessary. Psychiatrists involved in the legislative process, therefore, should encourage the inclusion of "the most beneficial alternative" as a mandatory ingredient in all new commitment laws. 8A-10

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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.

Medical Model

THIS IS TO COMPLIMENT you for your June 15 issue. It repaid careful reading. Three articles described psychiatry's present problems and explained the reasons for their development.

Alan Stone predicted that psychiatry's future position will be close to medicine. "It is the medical model which gives clinical coherence . . . to all the other models . . . the general practitioner of psychiatry, the pragmatic eclectic, must be respected and preserved or, like the general practitioner of medicine, will disappear into a growing number of narrower and narrower subspecialties. Organized psychiatry must resist that or we will all suffer."

Organized psychiatry does not seem to have heard because another article reported that the American Board of Psychiatry and Neurology changed its training requirement from the provision that at least one year of a four-year training program in psychiatry be spent in an approved program providing "supervised, direct responsibility for the general medical care of children and/or adults" to "*four-12*" months.

Either the way to preserve the general practitioner of psychiatry is to reduce the required training period in organic medicine from one year to four months or the medical model is something to which we pay only lip service. The latter seems to be the case. Psychiatric departmental chairmen and residency program directors who control the American Board of Psychiatry's decisions put their first priority on staffing their departments rather than on the quality of the psychiatrists they produce. They decrease the time spent by their residents on medicine, pediatrics, and surgery services to increase their time on the psychiatric units. They fear PGY one residents may switch their residencies from psychiatry to other specialties after service in other departments. If psychiatric residents spend too much time treating the organically ill there also may not be enough residents for academic psychiatrists to supervise. This might force academic psychiatrists in training hospitals to personally treat patients rather than to supervise others caring for them. Academic psychiatrists will, however, escape this fate by training non-psychiatric primary therapists to care for psychiatric inpatients (Glickman, L. The Demedicalization of Psychiatry, Psychiatric Opinion, May 1979).

The result of our deeds contradicting our words appears in a third article headed "Decline of Psychiatric Residents Subject of Probe." Soloman and Nathan found "that although all of the hospitals' staff held low opin-

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Gaylin on Feelings

By Margaret C. McDonald

PSYCHIATRIST WILLARD GAYLIN, M.D., co-founder and president of the influential Institute of Society, Ethics, and the Life Sciences in Hastings on Hudson, New York, hovers over the shoulder of American psychiatry like its conscience. Not content to let things lie, he picks them up, turns them over to examine the usually hidden underside, seeks a new perspective, and offers his assessment to all listeners—often causing them, in the process, to re-examine their own impressions. In the past, Gaylin has scrutinized such issues as war resisters, the judicial and parole system, and multiple aspects of medical and research ethics in such books as In the Service of Their Country: War Resisters in Prison, Partial Justice: A Study of Bias in Sentencing, Doing Good: The Limits of Benevolence, *and* Operating on the Mind: The Psychosurgery Conflict.

Lately, with the publication of a new book, Feelings: Our Vital Signs *(Harper and Row, 1979), he has turned his attention to what he calls the "small passions," which he feels have been sorely neglected by psychiatry and psychology. Shunning quantification as the oft-taken but perhaps wrong path, Gaylin reexamines "that elusive, neglected aspect of emotions called 'feelings' " by eschewing objective analysis in favor of "the shadow world of the inexact, the poetic, and the subjective." He recently discussed his feelings about feelings with* Psychiatric News.

Psychiatric News: **Let's begin where you begin the book, by saying, "Feelings are internal directives essential for human life. In addition, and not just in passing, they are their own rewards. They are the instruments of rationality, not alternatives. . . . Feelings become the guides to [rational] choice." To me that was the essence of what you are trying to say throughout the book.**

Gaylin: In many ways that which you have quoted almost summarizes the *raison d'être* of the book. . . . Feelings are the reason people go to therapy. They don't go because of failures. They only go because of their feelings about their failures. . . . But feelings have not been part of the theoretical structure, and they have not been a major part of the research area except for the primary emotions of fear and anger and the so-called grand emotions. But the small passions, which make up most people's lives, have not been. Now, in the book I try to offer an explanation why. One is, indeed, that psychology has been dominated by behaviorism, and behaviorism distrusts or disbelieves in feelings. . . . Secondly . . . , psychology has been very animal-oriented, and animals do not have a range of feelings. Now why psychiatry has neglected it is because psychiatry and psychoanalysis have in a sense been a part of medicine . . . and the scientific tradition in the heydey of empiricism, . . . of measurement and quantification.

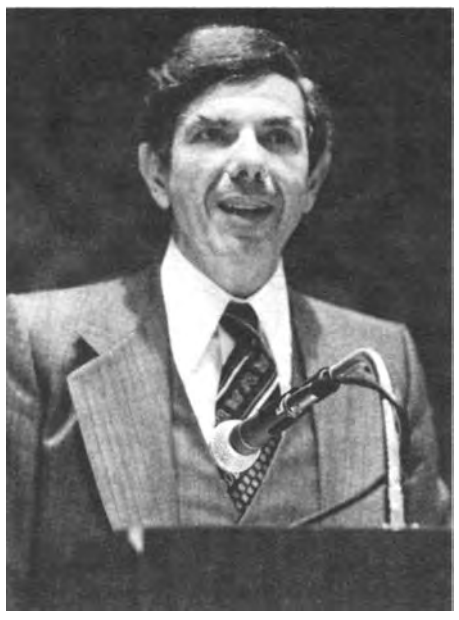
Psychiatric News: **And we can't quantify subjective material.**

Gaylin: There is no way. . . . The very nature of feelings is that there is no way to quantify them, and you have to take a 19th century analytic approach to them. . . . Certain misconceptions have arisen. One is that somehow or other emotion is the opposite of rationality and intelligence. One of the things I try to show is that emotions are essentially parallel to rationality and intelligence.

***Psychiatric News*: Why, then, have we failed to realize the inherent problems in trying to quantify everything and the misleading assumptions that can come from quantified data?**

Gaylin: I think we're beginning to. . . . Knowing that 80 percent of people do this and 20 percent do that gives you relatively little help in knowing what people ought to do, so there's been a reexamination of the value and objectivity of data. I think the physical sciences have introduced chance, relativism; and it may be that we'll see a second growing up of the social sciences. . . .

A second point I make strongly is opposition to the idea that there are good feelings and bad feelings. People



Dr. Gaylin

who are simply unknowledgable about human behavior have decided that guilt and anxiety are bad feelings. Now, obviously inappropriate guilt is a bad feeling, and inappropriate anxiety, but so is inappropriate joy and elation. . . . Guilt and anxiety are painful emotions. They are good. If we do not possess them, we are in real trouble. . . . Feelings are fine tuning in a sense. . . . They're like thermostats.

Psychiatric News: **Are you using the terms "feelings" and "emotions" synonymously?**

Gaylin: No. . . . Emotions are that broad range which includes physiology; the affect, which is visible to others; and the signal to ourself—the feeling. . . . I use anxiety to mean the vague sense that something is threatening our survival either because there's a disorder in the environment or there's a weakening of ourself. . . . And what I'm saying for the most part is that the feeling aspect is the signal to ourselves. The emotion is something that on the broader part signals the group. . . . In a sense, we tend to use anxiety when we don't know the source. . . .

Psychiatric News: **In relieving anxiety, I enjoyed your comment on spending money as "a particularly gratifying**

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Testimony

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the patient does not have a lesion or disease that is organic in nature. . . ." Rangel also asked Tardy if he would oppose a community mental health center headed by a psychologist or one that "did not include the services of a psychiatrist," and Tardy said that he would.

Rangel then called on Herbert Dörken, Ph.D., who was testifying for the Association for the Advancement of Psychology, to respond to Tardy's remarks, and the ensuing discussion clearly drew the battle lines in what is rapidly becoming an interprofessional turf war. Dörken responded by calling Tardy's remarks an "attempt to extend testimony unsupported by scientific fact and contrary to the array of federal law." He mentioned "recent California legislation to the effect that hospitals in California, any of them, psychiatric or general acute care, may appoint psychologists to the organized medical staff and many have. We have an attorney general's opinion that a psychologist may admit to a hospital and treat patients frequently therein."

In his formal testimony, Dörken pointed out that psychologists account for "the largest doctoral-level profession" in CMHCs, with approximately 5,500 Ph.D. psychologists working in the centers as compared with about 3,000 psychiatrists, according to his testimony. Dörken said that the term "medically necessary" appearing in both H.R. 3990 and H.R. 2369 "misleads and misdirects the HEW bureaucracy" and recommended that the term "medically or psychologically necessary" be substituted.

Speaking of the definition of providers' responsibilities in the CMHC setting, Dörken called it a "sensitive issue" but also a "political issue." He said, "It is the question of whether an efficient and economic mental health benefit can be provided to the public . . . over the objections of those who have sought to assure themselves a non-competitive position in today's health market.

"The *de facto* reality of mental health practice," he continued, "is that it is multi-disciplinary. The strict physician-supervision requirement that has been maintained in only one piece of national legislation, Medicare, is a bad joke." Dörken said the requirement was "undoubtedly intended" as a quality control measure to assure the necessity and appropriateness of care, but "in practice, however, it is an impediment to efficiency . . ." which ". . . promotes increased costs, leads to inappropriate services, and forces health professionals to operate under a legislatively-mandated system of fee-splitting or double billing." Dörken said the language of the two bills in question "perpetuates this fraud" by obliging in practice that "every CMHC will have to hire a physician to come in and sign off on the work of others." He recommended that psychologists be included within the definition of "physician," that psychologists be authorized to practice autonomously in both inpatient and outpatient Medicare settings, and that psychologists' services rendered in any setting be directly reimbursable.

If a psychiatrist-psychologist turf war is indeed raging on the floor of the House, it is unclear at this point just where related professions and associations will erect boundaries and draw alliances. In testimony on the same day by Irving H. Chase, speaking for the Mental Health Association, the chairman of MHA's health insurance task force seemed to side with the psychologists when he told the Rangel subcommittee, ". . . H.R. 2369 and H.R. 3990 both require that reimbursement be contingent on the treatment being diagnosed as medically necessary. We urge that the language be changed to read 'medically or psychologically necessary.'" However upon questioning by Rangel, Chase said, "Our position is that the team insofar as it relates to diagnosis and insofar as it relates to treatment should be a team decision involving all of the impressions in the center and that there should be a physician involved."

The position of the National Council of Community Mental Health Centers is even less clear. Speaking for NCCMHC, Chris Koyanagi pointed out that both bills "begin to address the concept of a team approach to treatment, but H.R. 2369 makes it clear that there is a distinction between the role of the physician in cases of physical illness compared to mental illness. H.R. 2369 used the term 'case managed by a physician' specifically to recognize the team concept. H.R. 3990 continues to use the words 'supervised by a physician' although the House report issued last year makes it clear that the intent is that 'this terminology be understood and applied within the framework of accepted prevailing practices followed by qualified community mental health centers in the provision of mental health services.' NCCMHC strongly believes that this change should be clearly included in the legislation itself and, if necessary, amplified by supporting report language."

Although the issue of which mental health professionals are qualified to provide which services must ultimately be faced four-square, the question seemed at times to overshadow the crux of the Medicare amendment hearings—better mental health care for the nation's elderly.

While APA commended the subcommittee for recognizing the need to reassess these needs, it did not support outright either of the bills at question but went with Congressman Thomas J. Downey's (D-N.Y.) Medicare Mental Illness Non-Discrimination Act (H.R. 3790) "cosponsored," Tardy told Rangel, "by more than 20 of your colleagues on a bipartisan basis." Downey himself, in later testimony before the Health Subcommittee, "applauded" Rangel's proposal, H.R. 3990, "for the steps it proposes in eliminating discriminatory treatment accorded mental illness under Medicare" but noted that his own bill "and a companion introduced by Senator Heinz (S. 1289) would bring mental health coverage completely in line with physical health coverage. And this," he said, "is what I believe our national policy should be." 8A-1

Meeting

THE CANADIAN Psychiatric Association will meet September 26-29 in Vancouver, British Columbia. Those wishing to submit a scientific paper should contact Dr. P. Hayes, Scientific Program Chair, Department of Psychiatry, University of Alberta, Edmonton, Alberta, Canada. General information is available from Dr. V. Banno, St. Paul's Hospital, 1081 Burrard St., Vancouver, B.C., V6Z 1Y6, Canada. 8A-4B

Lower Neuroleptic Doses Found To Be Effective

ALTHOUGH RAPID NEUROLEPTIZATION—administering high dosages of anti-psychotic drugs to stem psychosis—has been shown to quickly alleviate psychotic symptoms, results of a new study confirm that effective dosages may be less than those now commonly used.

Researchers reported at APA's annual meeting that, except during the first hour, lower doses of haloperidol (two mg) administered each hour intramuscularly and then orally worked just as well as higher ones (ten mg). And the difference during the first hour fell short of significance, said investigator Robert Neborsky, M.D., of the University of California at San Diego psychiatry department, although it might have clinical implications when behavior must be rapidly controlled in an emergency.

Neborsky also stressed that the best predictor of eventual improvement was response after the first and fourth hours. Although he noted that the dosages correlated highly with the anti-psychotic blood levels, he said the serum level required to alleviate symptoms varied with the individual.

Neborsky and his colleagues—David Janowsky, M.D.; Ethan Munson, B.A.; and Dennis Depry, LCDR, MC, USN—selected as their patient group 20 on-duty seamen, ages 18 to 27, who were in good physical health but had been referred for psychiatric hospitalization from their command or local dispensary. All displayed acute psychotic symptoms; diagnosis was further supported by the presence of four or more symptoms on the Brief Psychiatric Rating Scale.

In a strict, double-blind protocol, half the men were randomly assigned to the low dose treatment group, which received hourly for up to four hours two mg of haloperidol intramuscularly and then orally until symptoms abated. The other half followed the same treatment pattern but received ten mg. Later analysis revealed that the groups were similar at the outset in severity of pathology.

Altogether, during these first two phases of the study—which lasted no longer than 14 hours after the first injection—the low dosage group took between 9.0 and 10.2 mg of haloperidol, while the high dosage group ingested from 37.5 to 44.5 mg.

For the final six days, the "oral maintenace phase," low dose patients took an average of 12.5 mg. daily, while the high dose group received from 43.6 to 52.4 mg of the neuroleptic.

Both groups showed a significant decline in symptom checklist scores over the first hour. Although the higher dosage proved to be more effective during this initial time interval, by the end of the first phase the lower dose group had caught up. For all the patients, the drug alleviated symptoms of excitement and hyperactivity, hostility and uncooperativeness, hallucinations, suspiciousness, mannerisms and posturing, and loud and boisterous behavior. Neither somatic concern, anxiety, tension behavior, nor depressed mood improved significantly.

Regarding side effects, researchers reported that the drug was "remarkably safe" as to oversedation, orthostatic hypotension, or toxicity, but confirmed extrapyramidal reactions as "virtually inevitable."

Importantly, the results showed a correlation between behavior change over the first hour, first several hours, first 24 hours, and eventual response to treatment after seven days. This implies, say the researchers, "that a decrease in psychotic symptoms in response to an efficacious test dose may be a predictor of future clinical response."

Neborsky admitted in a telephone interview with *Psychiatric News* that he had been surprised by the results since his "bias was in the other direction" in favor of higher doses. Although he had noted in the study that both groups had received average haloperidol doses greater than the "accepted clinically efficacious equivalent of 400 mg chlorpromazine," he explained later that the prevailing clinical dosage for treating acute schizophrenia is between ten and 15 mg (equivalent to 500 mg and 750 mg chlorpromazine).

"The results of this experiment run counter to the tendency to clinically use high dose haloperidol," the researchers point out. "At the least, it would appear that the average acutely psychotic patients need less high doses of antipsychotic drugs during rapid neuroleptization than are usually given, and that giving a lower dose definitely costs less, and indeed could hypothetically be useful in preventing later development of tardive dyskinesia."

Neborsky says that the study "demonstrates dramatically" what other researchers have found, although it has not been adequately publicized nor synthesized into the working knowledge of clinicians.

8A-17

American Family Study

A MAJORITY of family members are in favor of a national health bill and believe it will help all Americans, but more than four out of ten are opposed to it on the grounds that it will be just another giveaway program that will cost the taxpayer money. And while families claim that they welcome more open discussion of the subject of alcoholism, it is still perceived not as an illness but as a sign of personal weakness. Out of a total sample of more than 1,200 adult family members, eight percent said that they drink more than they should, which approximates the national estimate of seven percent. These are some of the findings in a nationwide study sponsored by General Mills, Inc., and conducted by the research firm of Yankelovich, Skelly & White, Inc. Titled *The General Mills American Family Report 1978/79: Family Health in an Era of Stress*, the study examines the attitude of American families on a variety of issues concerning their physical, psychological, and emotional well-being. The complete 192-page report is being widely distributed and is available from General Mills, P.O. Box 1113, Minneapolis, Minn. 55440. 7A-27K

Strecker Award

GEORGE E. VAILLANT, M.D., a fellow at the Center for Advanced Studies on the Behavioral Sciences at Stanford, California, and professor of psychiatry at Harvard Medical School, has been named winner of the 1979 Institute of Pennsylvania Hospital Award in memory of Edward A. Strecker, M.D. Vaillant was cited for his long-term followup of several psychiatric disorders, his elaboration of means of coping with the problems and complexities of living, and his studies of the emotional health of physicians.

JCAH

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operations, outlined for *Psychiatric News* the major ways in which the new PTACs will differ from the old accreditation councils: *a*) organizations invited to have representation on PTACs will not pay for seats or have any financial obligation to JCAH; *b*) PTACs will have no autonomous decision-making power; and *c*) representation within PTACs will be more broadly defined than it was on the accreditation councils.

In addition to the five PTACs working with the various JCAH accrediting programs, a sixth PTAC will be set up to relate to JCAH staff and to deal with education, promotion, and publications.

Affeldt, writing to APA Medical Director Melvin Sabshin, acknowledged the BOC's recognition "that the participation of the various constituencies of the accreditation programs in the JCAH is vital to its growth and success," and advised of the board's vote to establish the PTACs "for the purpose of advising the various JCAH accreditation programs on standards, survey procedures, and related matters concerning each program." JCAH outlined the following PTAC functions:

- Advise and make recommendations to the program director regarding standards, survey documents, and survey procedures;
- Serve as a resource for appointments to accreditation decision appeal hearing panels; and
- Review all exceptional accreditation recommendations and those accreditation decisions in which unanimous agreement is not reached by staff, and make recommendations concerning such decisions to the accreditation committee of the board.

APA has been invited to have representation on four PTACs: psychiatric, mental retardation/developmental disabilities, long-term, and hospital. Representation on the hospital PTAC is seen as a major step forward for psychiatry as well as an example of JCAH's broadening base since it marks the first time that psychiatry has been included in advising on general hospital accreditation.

Each PTAC will be directly represented on the BOC's accreditation, standards-survey procedures, and policy advisory committees (the latter to be formed). The PTAC representatives to the accreditation committee will be non-voting members. Those chosen to sit on the standards-survey procedures committee may vote on all matters being recommended to staff but not on matters constituting a final action of the committee when it acts on behalf of the BOC. The PTAC representatives to the policy advisory committee will be full voting members. The reason for this variance in voting privileges for PTAC committee representatives is that since only the BOC itself can accredit programs, only board members may cast votes when the issue is one of accreditation.

Membership on each PTAC will be limited to 15, including representatives of invited organizations and selected individual at-large members. Members will serve a one-year term, subject to annual review and reappointment by the BOC. Although the number of terms served by an organization is not limited, the BOC will review each PTAC's size and composition annually and will revise "as

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CALL FOR PAPERS
COMPUTER APPLICATIONS IN MENTAL HEALTH: A SOURCEBOOK

Ballinger Publishing Company plans to publish a sourcebook of computer applications in the fields of mental health, mental retardation and developmental disabilities, alcoholism, and drug abuse. The sourcebook will include chapters that reflect the current state-of-the-art of the clinical uses of computer applications in the mental health field.

Abstracts of the chapters should include a description of the clinical application(s), the relevant patient population, the current stage of development and use by clinical personnel, the environments in which the application(s) have been implemented, the nature of the hardware and software which operates the application, samples of input forms and output reports, and future plans for development.

Abstracts of no more than five (5) pages should be sent by October 1 , 1979, to **Dr. Jeffrey L. Crawford, Information Sciences Division, Rockland Research Institute, Orangeburg, New York 10962.** The authors of those abstracts selected for inclusion will be asked to submit a more detailed chapter to the editors.

Aggression in Children— An Immediate Approach

"TODAY, when dealing with a youngster in a violent crisis, we need to become very well informed as to what is going on at this moment, right now, when the aggressive behavior occurs. This approach is the only one likely to provide useful suggestions for the staff that has to deal directly with the violent child. This type of immediate analysis prevents distortions of meaning or mistaken interpretations," according to Fritz Redl, Ph.D., speaking at the 14th symposium of the South Florida Psychiatric Society, on "Aggression in Children and Adolescents."

Redl discussed the problem from the standpoint of clinical management and with particular emphasis on what useful suggestions the therapist can make to those who are in charge of the child at school, at home, or in a residential facility. He pointed out that there are essential and crucial differences between the ideal atmosphere therapists try to create in the analytic situation and the more reality-anchored environments of the school, the home, and the residential facility. When the child expresses aggression in the usual therapy hour and within the "magic circle" of the play area, he experiences a wonderful feeling of relief. In that magic circle, puppets, for example, can be stricken down, physically punished, even killed in relative safety, he said. Outside the circle, however, aggression, no matter how symbolically expressed, is not tolerated.

Redl believes that an important question to ask about violent behavior is, "What's in it for the child?" "Who has done what and what does it mean?" He said that some aggression has to be permitted. When allowed by the therapist, such behvavior is "tax exempt" from his intervention; the same principle applies to the child's caretakers. He added that besides permitting a degree of aggression which does not imperil the child or others in his immediate environment, it is also important to convey to him that one expects that a time will come when some of the aggressive conduct will not have to happen because the child has crossed another developmental milestone.

Tolerating some obnoxious behavior tells the child that the therapist wants to be helpful and supportive, so that the child does not become inaccessible to treatment or exaggeratedly hard on other people, which amounts to the same thing, Redl said. "No one is going to hate you for this behavior, which at the moment cannot be helped," is the therapist's message, Redl said, "but I want you develop your own potential for controlling it as soon as possible."

On occasion, a high degree of molestation in the child's activity is not as necessary as the child believes. The behavior to be tolerated can then be negotiated and often scaled down almost instantly. He pointed out that persons outside the field, such as parents, teachers, or persons in charge of the day to day care of the child, have difficulty understanding this and question why any kind of aggressive behavior at all should be tolerated. What they fail to realize, Redl explained, is that it is almost impossible to absolutely suppress such behavior without causing further and more serious trouble. They need no instruction on how to eliminate naughty behavior; they need suggestions as to how to contain it within reasonable boundaries. Aggression in a young person should not be allowed to become extreme; however, it has to be kept at acceptable sublimation levels.

Yet, he continued, demands for sublimation must not be automatic or unreasonable; they have to be planned for in the overall treatment strategy. In addition, he said, a great deal of aggressive behavior in children is not necessarily the expression of intense anger or resentment but rather a reaction to something happening in the environment. At times it represents the child's attempt to protect himself against the fact that he is being mishandled. This becomes evi-

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Letters

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ions of psychiatry, the staff at the university [hospital] had the most negative attitudes. In view of that hospital's popular and well developed liaison service this might be evidence . . . that the presence or absence of psychiatric services may have nothing to do with the medical staffs' attitudes." Actually although Soloman and Nathan were either too kind or too discreet to say so, their data support the idea that the presence of a liaison psychiatry service *lowers* the opinion in which our colleagues hold us. Could it be that the penchant of our academic leaders for words rather than deeds, as well as exposing the internless products of our residency training programs to our nonpsychiatric colleagues, has given us our bad reputation with them as well as with medical students?

We can only hope that our leaders who specialize in residency recruitment will realize that we have to start with residents who have already become physicians by at least a year of training in organic medicine as a resident in the appropriate department if we hope to produce a psychiatrist whom other physicians will respect and students will wish to emulate.

Keep up the good work!

Lewis Glickman, M.D.
8A-7 Brooklyn, N.Y.

Recruitment

This letter is in response to an article in *Psychiatric News* of June 15, 1979, entitled "Decline of Psychiatric Residents Subject of Probe." During the past 27 years I have been closely allied to the psychiatric market as superintendent and chief medical director of the Madison State Hospital, Madison, Indiana. I, of course, have found that it is much more difficult to recruit trained psychiatrists and general physicians for employment in a state hospital. In spite of this, we have been able to keep our heads above water.

In my own opinion, the reason young physicians are losing interest in psychiatry is the fact that psychiatry itself has become antiquated through becoming social rather than medical.

Psychiatry today does not have the standing that it had 15 years ago.

Ott B. McAtee, M.D.
8A-9 Madison, Ind.

A Complex Question

Defining 'Human' and 'Person'

By Dorothy Trainor

HOW DOES ONE define "human" and "person" in the biomedical decision-making processes that affect health and lives in contemporary society?

There are many answers to this highly relevant question but little agreement. Further, the complexity of the question itself, of the issues involved, and the diversity of opinions thereon, is incredible. This fact was revealed at the North American Symposium on "Human" and "Person" held in Montreal. Yet the significance of these words can be seen in the question of "fetal personhood" in the abortion issue, the treatment of seriously defective neonates, fetal research, decisions concerning the terminally ill, etc.

The symposium was organized by David J. Roy, Ph.D., director of the Center for Bioethics, Clinical Research Institute of Montreal, and by Edward J. Keyserlingk of the Law Reform Commission of Canada. If clarification was not achieved, the discussions must have been at least consciousness-raising for the 200 participants from the U.S. and Canada, since all relevant disciplines were represented both as speakers and audience-participants. But, put together, the theologians, philosophers, medical specialists, including psychiatrists and nurses, lawyers, etc., could not arrive at a decision on the definition of "person" nor a consensus as to the stage of embryonic or fetal life at which "personhood" commences.

For this elite group to define "human" was not too troublesome. "Human" was seen mainly in biological terms, i.e., belonging to the species *homo sapiens*. The conflict began in earnest over the word "person" where one is describing a moral or social agent; and it continued in ethical, legal, medical, and philosophical terms—with a little anthropology thrown in—for the two-day meeting.

Co-organizer Roy opened the discussion with the comment that being "a person" incorporates a fundamental set of moral rules and a fundamental pattern of behavior as to what one should or should not do with repsect to being that person.

Richard Kamber, Ph.D., chair of the department of philosophy and religion, Susquehanna University, Selinsgrove, Pennsylvania, agreed that "person" does carry a moral weight and can be used in this context for some biomedical guidelines. He did not agree, however, that the potentiality for such personhood exists at any point in time in fetal life.

"Contradictions arise simply because we have this enormous body of knowledge, opinions, moral issues, etc., that can be brought to bear," stated Alex C. Michalos, Ph.D., director of the Social Indicators Research Program, University of Guelph (Guelph, Ontario). "They sometimes conflict so that we cannot decide what it is to be a person at any given point. Since being 'human' and 'a person' are open systems—not closed—we will never be able to eliminate possible contradictions. I think that the human predicament is that of coming to understand the world we live in and managing as best we can. There are no final solutions."

But Wendell Watters, M.D., professor of psychiatry, McMaster University, Hamilton, Ontario, who presented the humanistic view, found nothing wrong with seeking normative principles "as long as these are looked upon as principles that all the actors in the drama can utilize in coming to the most appropriate decision at a given time."

"The issue that I would like to see addressed by such a high-powered academic group is: What are the mechanisms by which these decisions are made at that point in time?"

Nonetheless, the ongoing discussions remained at a much more esoteric level than that. All applicable words and phrases to describe "person" were tested out and found wanting in some way. Operative themes suggested were consciousness, rationality, decision-making powers, responsibility, the ability to make moral judgments, the sentient individual, freedom of will, the ability to relate to others, and so on. Although all of these ideas were found to be germane to the person in certain ways, all fell down in the overall concept.

Not everyone agreed, of course, with the notion that there is conflict over the word "person" in the first place. Father Robert Barry of the department of religious studies, Providence College, Providence, Rhode Island, for example, found the DNA genetic component sufficient identification.

"Personhood is not properly ascribed on account of the existence of consciousness or some morphological or anatomical feature. This [identifiable genetic structure] definition permits ascription of personhood to the zygote at the moment of genetic coding," he said.

Co-organizer Keyserlingk then pointed out that the words "human being" are much more often used as a normative concept rather than "person"—the latter being used primarily in the legal sense.

"The Supreme Court of the United States in its famous abortion decision *Roe* v. *Wade* fastened upon the concept of 'person' because it is an important term in so far as the Constitution of the United States is concerned and not because it is an important moral concept," he said.

Thereupon, Rabbi Salomon J. Spiro of Laval, Quebec, thought that the whole discussion might more properly be turned upon its head.

"We are talking about 'human' and 'person' and talking about words with their intended meanings. Perhaps it is the other way around—that the words form the ideas."

Surprisingly, there was little mention of the soul despite the presence of the theologians and none concerning the Catholic doctrine of "immediate animation" at conception of the soul. This doctrine was mentioned, however, in written presentations provided. The one submitted by Richard Kamber suggested that the criteria for personhood are vague and even the doctrine of the soul is not a sufficiently useful guideline. The Catholic doctrine of "immediate animation" has not always been an unwavering position, Kamber pointed out, and was not officially incorporated into canon law until 1869.

"Both Augustine and Aquinas held explicitly contrary views, and more

See "Person," page 17

Life Members Exempt from CME Activities

LIFE MEMBERS and Life Fellows who were elevated to life status during or prior to May 1976 are exempt from the continuing education requirement. This exemption is based on a constitutional membership requirement rather than age, practice activities, and/or status. In brief, members who were elevated to life status were not expected to abide by a change in the constitution retroactively. Those members who were elevated to Life membership or Life Fellowship after the constitutional amendment was approved, however, must abide by it, as it was in force at the time of their elevation, to maintain their APA membership. Thus life status awarded after May 1976 did not remove the obligation of meeting the continuing education requirement.

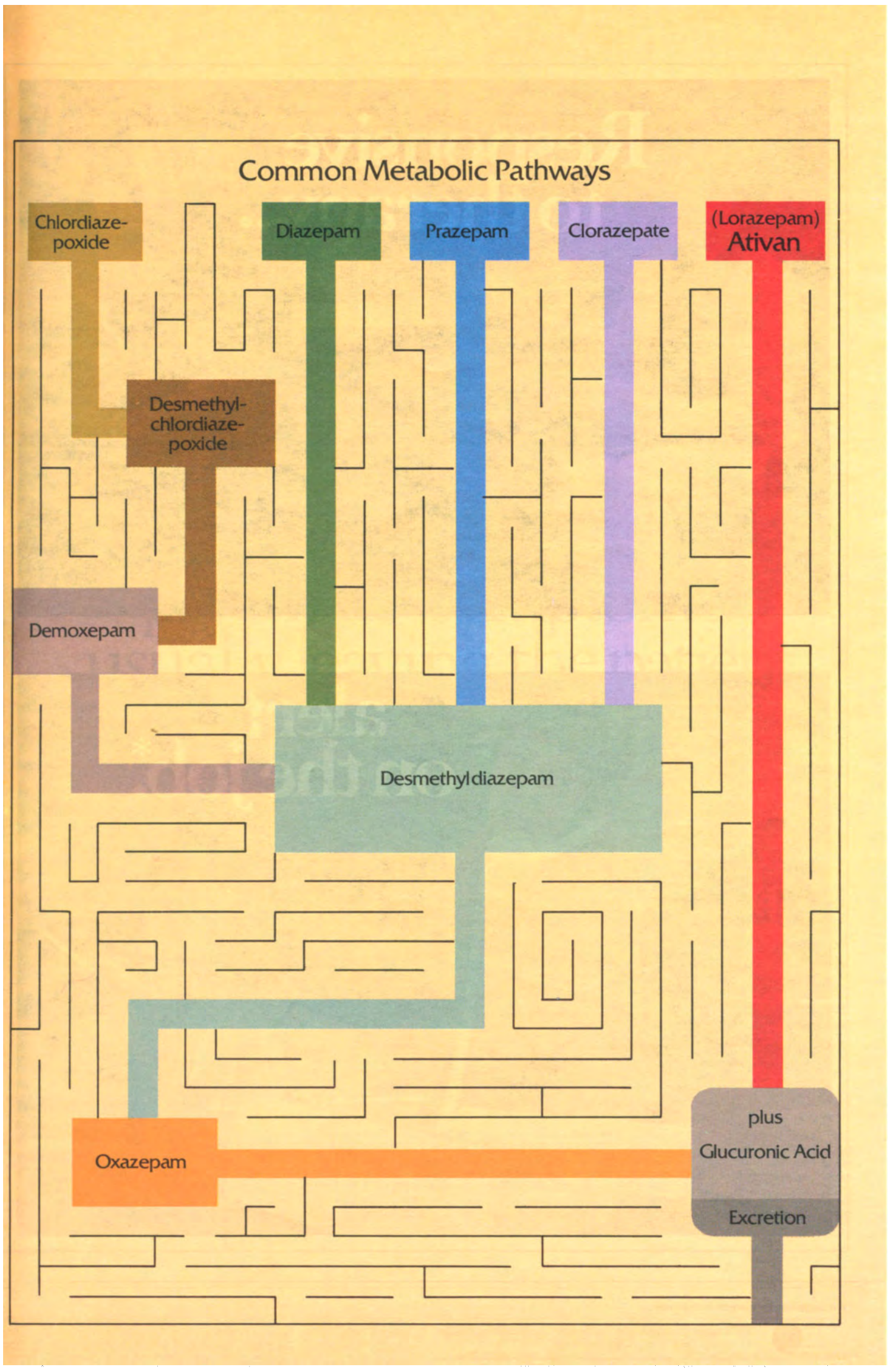
Some members, aware that many state medical societies and/or licensing boards are beginning to accept specialty societies' CME certificates as meeting the state continuing education requirements, have raised the possibility that Life members or Life Fellows might be exempt from their state medical society and/or licensing board CME requirement. Although this has not been specifically reviewed with the states, it is highly unlikely. Life members and Life Fellows (and other members who are exempt from the continuing medical education requirement because of illness, disability, retirement, etc.) will be exempted; they will not receive any certificate acknowledging participation in continuing medical education. Thus, without any such certificate, members cannot report and/or request reciprocity from their state medical society and/or licensing board. In addition, since the state licensing boards and medical societies set their own guidelines for continuing medical education, they would be the ones to determine exemptions because of age, status, practice activities, etc. APA has neither authority nor responsibility to determine this for the state organizations.

Thus, all Life members and/or Life Fellows who live in states in which there is a continuing medical education requirement for re-registration of medical licensure and/or membership in the state medical society should consult that agency to determine the requirements. In addition, those members who were elevated to life status since May 1976, must comply with the APA CME requirements.

Specific questions may be directed to the APA Office of Education or the executive secretary of members' district branches. 8A-2

Call for Papers

THE PROGRAM COMMITTEE for the 1980 annual meeting of the American Psychosomatic Society invites abstracts of original work to be considered for presentation. Contributions from the entire spectrum of the basic and clinical sciences related to the purpose of the society are invited. Deadline for submission is November 15, 1979. The program will also include a section of brief communications of ten minutes each, reporting up-to-the-minute findings. Deadline for these abstracts is February 1, 1980. Further information is available from Chair, Program Committee, American Psychosomatic Society, 265 Bassau Rd., Roosevelt, N.Y. 11575. 8A-4H



at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant, they should communicate with their physician about the desirability of discontinuing the drug.

In humans, blood levels obtained from umbilical cord blood indicate placental transfer of lorazepam and lorazepam glucuronide.

Nursing Mothers: It is not known whether oral lorazepam is excreted in human milk like the other benzodiazepine tranquilizers. As a general rule, nursing should not be undertaken while a patient is on a drug since many drugs are excreted in human milk.

Adverse Reactions: Adverse reactions, if they occur, are usually observed at the beginning of therapy and generally disappear on continued medication or upon decreasing the dose. In a sample of about 3,500 anxious patients, the most frequent adverse reaction to Ativan is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent adverse reactions are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, together with various gastrointestinal symptoms and autonomic manifestations. The incidence of sedation and unsteadiness increased with age.

Small decreases in blood pressure have been noted but are not clinically significant, probably being related to the relief of anxiety produced by Ativan (lorazepam).

Overdosage: In the management of overdosage with any drug, it should be borne in mind that multiple agents may have been taken.

Manifestations of Ativan overdosage include somnolence, confusion and coma. Induced vomiting and/or gastric lavage should be undertaken followed by general supportive care, monitoring of vital signs and close observation of the patient. Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection, U.S.P. Caffeine and Sodium Benzoate Injection, U.S.P. may be used to counteract CNS depressant effects. The usefulness of dialysis has not been determined.

Dosage and Administration: Ativan is administered orally. For optimal results, dose, frequency of administration and duration of therapy should be individualized according to patient response. To facilitate this, scored 1.0 and 2.0 mg tablets are available.

The usual range is 2 to 6 mg/day given in divided doses, the largest dose being taken before bedtime, but the daily dosage may vary from 1 to 10 mg/day. For anxiety, most patients require an initial dose of 2 to 3 mg/day given b.i.d. or t.i.d.

For insomnia due to anxiety or transient situational stress, a single daily dose of 2 to 4 mg may be given, usually at bedtime.

For elderly or debilitated patients, an initial dosage of 1 to 2 mg/day in divided doses is recommended, to be adjusted as needed and tolerated.

The dosage of Ativan should be increased gradually when needed to help avoid adverse effects. When higher dosage is indicated, the evening dose should be increased before the daytime doses.

How Supplied: Ativan (lorazepam) is available in scored 1.0 and 2.0 mg tablets in bottles of 100.

FDA

Continued from page 1

Deadline for comments on the proposed regulations is October 4, 1979.

The FDA action came as no surprise, and indeed was viewed by some consumer groups as already belated, as the agency has been looking into the usefulness of patient labeling and how best to design it since it first required information to accompany oral contraceptives in the early 1970s. In 1974 the agency began its patients' prescription drug labeling project in earnest, meeting with consumers, manufacturers, physicians, and pharmacists; sponsoring symposiums and conferences; reviewing the literature; and conducting studies.

Its wide appraisal found that while in 1973 only about half the population favors more information to supplement physicians' instructions about the drugs they take, more recent evidence suggests that at least two thirds now want to be better informed. Studies have pointed out that patients are not exposed to this information: 48 percent of respondents in one study said physicians did not discuss with them their most recent prescription, and another reported that length of therapy was discussed with the patient in only ten percent of the cases while dose frequency was mentioned in only 17 percent. Moreover, contends FDA, research shows that patients remember only about half of what the physician tells them orally about treatment, frequently don't understand but may be unwilling to ask for clarification, and fail to comply with the drug regimen as much as half the time.

On top of these surveys, a consumer consortium led by the Center for Law and Social Policy in 1975 petitioned the agency to require special warnings as well as supplemental instructions and precautions initially for drugs that pose dangers to pregnant or nursing women, drugs such as hypnotics and tranquilizers which are widely used and can be dangerous, and for those such as amphetamines which have been overprescribed and have serious side effects. In response to a notice to review this information, plus pros and cons offered by professional, trade, and consumer groups, the agency got more than 1,000 comments, 750 from consumers clearly in favor of patient labeling. Other comments from physicians, pharmacists, and professional and trade organizations ranged from full support to strong opposition.

Groups within APA have been split in their opinions. For instance, the Joint Commission on Government Relations earlier proposed further study of the effects of patient labeling before the government jumped wholesale into the business, expressing concern that the list of side effects might suggestively increase their reported frequency and that the list of indications might upset patients.

It also argued that the physician should have ultimate responsibility for explaining aspects of drug therapy to the patient. APA's Committee on Women, however, has stood firm in its belief that sufficient evidence already points up the inadequacy of patient knowledge and that women are too often prescribed psychotropic drugs as a substitute for more appropriate psychiatric treatment. The issue, committee members say, is informed consent. As yet there has been no firm position formulated by the organization this year.

FDA views the patient labeling as a

See "FDA," page 18

Talbott Lists 'Commandments' Of Treatment

JOHN A. TALBOTT, M.D., professor of psychiatry, Cornell University Medical College, and associate medical director, the Payne Whitney Psychiatric Clinic, and long time spokesman for the chronically mentally ill, spoke on the problems of deinstitutionalization at the APA annual meeting. Calling his paper the "ten commandments," Talbott outlined problems and moral imperatives for dealing with the chronically mentally ill. He pointed out that traditionally America's sickest psychiatric patients, those suffering from severe or chronic mental illness, were cared for in state psychiatric facilities. Now many patients are leaving these facilities, and Talbott detailed many problems.

Since the advent of the state hospital movement in the early 1800s, this system has been the site of most long-term psychiatric treatment. In 1955, the census of the nation's state hospitals reached a peak of 560,000, and since then there has been a steady and dramatic decline to its current level of under 170,000—a decrease of over 60 percent. Talbott noted that the new hopes for community care, new psychopharmacological agents, recent legal and legislative actions, as well as shifts in Medicaid, Medicare, and SSI which allowed states to shift the financial burden for patients to the federal budget, all played a role in this transition.

Key phrases such as "deinstitutionalization" and "return to the community" began to dominate talk of mental health services. Talbott noted that at first states and hospitals tried to meet the new needs of discharged patients through expansion and innovative programs but that this effort was soon exhausted. Giving an analysis of what went wrong, Talbott noted that at first the mentally ill became obvious even to the most ordinary citizen. "Most striking," he said, "was the dramatic appearance of large numbers of obviously mentally ill persons on city streets, persons who were dirty, who wore torn or inappropriate clothing, who hallucinated and talked to themselves or shouted to others, and who acted in a strange or bizarre way." Many patients were transferred to low-cost housing, proprietary homes, or rooms in deteriorating neighborhoods. Conditions were often scandalous. Many of the elderly were denied admission to custodial institutions and at times were held in acute care facilities for months. Talbott said that a shift occurred for hospital emergency rooms, which began to have to deal with social problems and the acute exacerbations of the chronically ill as well as acute mental illness. Two other phrases emerged, "falling between the cracks" and "the revolving door syndrome," he said. Back at the state hospitals where it was once thought that smaller patient loads would result in better care, there was a trend toward demoralization and deterioration. Talbott said, "The net result of the movement was that what had been achieved was not deinstitutionalization but transinstitutionalization. The chronic mentally ill patient had his locus of living and care transferred from one lousy institution to multiple wretched ones."

Talbott pointed out that the entire shift from hospital to community had in truth been fairly abrupt, without a "consensus on the idea" and that,

See "Talbott," facing page

Talbott

Continued from facing page

furthermore, there had been no "true testing of the philosophic underpinning," no tests of whether community care was actually more beneficial, whether a "less restrictive" setting was actually more healing.

Talbott contended that planning had been inadequate and that the hopes that community alternatives would develop had been ill founded. He also charged that no provision had been made to provide the services that were once part of the mental hospital program: medical and psychiatric care, social services, housing and nutrition, income maintenance or employment, vocational and social rehabilitation. Talbott stated that to ask patients with major ego deficits and residual dysfunctioning, often without families or friends, to fill these gaps was "the stuff of sheer fantasy." Furthermore, Talbott noted, often the patient was expected not only to find all of these services for himself but to coordinate them as well.

Deinstitutionalization also laid bare the public's prejudices and fears about the mentally ill, fears so great according to Talbott, that a broad coalition of health professionals, consumers, government officials, and business leaders should be forged to combat their effects.

Talbott outlined some needed and overdue steps to help correct the evils that currently exist. "There must be a reconceptualization of the problem of the treatment and care of the severely and chronically mentally ill." Talbott recommends a total system of supports which would enable a person to receive in the community the kinds of help otherwise found in an institution. For a time Talbott thinks double funding, for both institutions and community facilities, is needed and that this should be coupled with the concept of the money following the patient. He believes that medical/psychiatric money should be separate administratively from money for housing, food, income support, social services, etc. Talbott said this was especially crucial now that national health insurance is being planned.

Other suggestions include the beginning of a case management system utilizing existing manpower, a new research effort into the causes of chronicity, and appropriate services.

Talbott urged that barriers to full participation in health and mental health delivery systems be removed so that existing discriminatory eligibility and reimbursement practices against the chronically mentally ill are not perpetuated. Patients should have full civil rights and opportunities, including equal access to housing, education, vocational rehabilitation, income maintenance, and the right to adequate care in the community, said Talbott. 8A-3

Meeting

THE SOUTHERN Psychoanalytic Societies and the Atlanta Psychoanalytic Society are sponsoring a meeting October 19-21 in Atlanta. The meeting will feature a symposium with Merton Gill, Leo Rangell, and Leo Stone (M.D.s), discussing the issue of "Psychoanalysis and Psychotherapy, Similarities and Differences," 25 years after their symposium that was published in the *Journal of the American Psychoanalytic Association* in 1954. Further information is available from Ralph Roughton, M.D., Registrar, 1175 Peachtree St., Atlanta, Ga. 30361, (404-892-7561). 8A-4J

JCAH

Continued from page 6

deemed necessary to insure that the professional and technical expertise provided by the PTAC meets the needs of the accreditation program served," notes JCAH. Maximum tenure for a person representing an organization as well as for an at-large individual will be six consecutive years.

Although five PTACs are slated for implementation, there is some question about whether the mental retardation/developmental disabilities PTAC will get off the ground. When JCAH announced its reorganization plans, the Accreditation Council on Mental Retardation/Developmental Disabilities did not endorse the proposal, and its member organizations are considering establishing their own accrediting body. According to Coldewey, JCAH plans to go ahead with the MR/DD PTAC but is holding off on further action toward that end until it sees what the member organizations of the old MR/DD council decide to do.

The first meeting of the PTAC for the Psychiatric Facilities Accreditation Program, on which APA is represented by Francis deMarneffe, M.D., was held in early June. This meeting was organizational only, since the PTAC did not become operational until July 1. Mark Gould, M.D., representative of the National Association of Private Psychiatric Hospitals, was elected chair of the committee.

APA representatives on other PTACs are: hospital accreditation program—Robert Gibson, M.D.; long-term—John Talbott, M.D.; and MR/DD—Gerald Clark, M.D.

Further JCAH organizational changes include the formation of a policy advisory committee (PAC) to the board of commissioners to provide policy advice to the board and "serve as a forum for the exchange of information regarding national and professional issues affecting JCAH and its voluntary accreditation role," according to Affeldt. The PAC will be made up of "not more than 30 members, including a representative from each PTAC, representing organizations composed of individual, institutional, or agency providers, advocates of health and related human services, a coalition of such organizations, or national organizations whose interests are similar to those of JCAH as well as selected individuals." A major function of the PAC will be to recommend generic policies governing the accreditation process to the BOC.

As these immediate reorganization efforts begin to get underway, JCAH will be focusing its attention on longer-range items, including examination of BOC's composition and revision of JCAH's mission and scope statement. Preliminary recommendations of this study are slated to be presented to the BOC in August, with final action to be taken in December.

Meanwhile, a division of accreditation, incorporating the five categorical accreditation programs represented by PTACs, has been formed within JCAH. It will include a department on integrated surveys to focus in on surveys of multi-category facilities, as well as a standards department to identify similarities and differences within the various sets of standards and develop a set of "core standards." Donald C. Smith, M.D., is JCAH's vice-president for accreditation. A new manual of consolidated standards has already been published by JCAH and is scheduled to go into use in October.

8A-19

Appointments and Awards

MICHAEL PALLACK, PH.D., has been named the next executive officer of the American Psychological Association. He will officially assume his duties at the association's annual convention in September.

* * *

NANCY C. A. ROESKE, M.D., director of undergraduate curriculum and coordinator of medical education in the department of psychiatry at Indiana University, was presented the 1979 achievement award of the American Association of University Women Educational Foundation. The $3,000 award was presented at AAUW's biennial national convention in Albuquerque, New Mexico.

* * *

JACOB H. CONN, M.D., an assistant professor emeritus at the Johns Hopkins University Medical School, has been designated the first perpetual fellow of the Society for Clinical and Experimental Hypnosis.

JOHN DELUCA, former director of the New York State Division of Alcoholism and Alcohol Abuse, has been appointed director of the National Institute on Alcohol Abuse and Alcoholism.

* * *

ROBERT S. GARBER, M.D., president of the Carrier Foundation in Belle Mead, New Jersey, and a former APA president, was recently presented the Citation of Merit Award of the Malvern Institute, Malvern, Pennsylvania. The award has been presented to distinguished physicians for their work in medicine, particularly psychiatry, mental health, and addictions.

* * *

RAYMOND W. WAGGONER, SR., M.D., a consultant for the Michigan Department of Mental Health and a former APA president, was recently honored by the Michigan Psychiatric Society for his contribution to residential treatment of emotionally disturbed children. Waggoner also maintains a private practice.

* * *

MING T. TSUANG, M.D., professor of psychiatry and preventive medicine at the University of Iowa College of Medicine, has been selected to receive a Macy Faculty Scholar Award for 1979-1980. The award will help support a one-year sabbatical at the University of Oxford in England. He will use the sabbatical to analyze information gathered in the Iowa 500 project, a 40-year field follow-up and family study of about 500 persons diagnosed and treated at the University of Iowa Psychiatric Hospital between 1935 and 1944. He will also draw conclusions about specific characteristics of the three major psychoses.

* * *

THE FOLLOWING PERSONS recently took office at the Society for Liaison Psychiatry: LARRY S. GOLDBLATT, M.D., president; HAROLD D. ZUCKER, M.D., president-elect; ROBERT GRAYSON, M.D., treasurer; and JERRY FINKEL, M.D., secretary.

Spiegel Calls for More Care for Hispanics

JOHN P. SPIEGEL, M.D., well known for his studies of urban riots, spoke at the recent APA annual meeting on the importance of meeting the mental health needs of the large Hispanic minority in this country. According to Spiegel, ". . . [In] the coming decade Hispanics will constitute the largest minority group in the country." Spiegel asserted that the mental health needs of this group cannot be met by merely training more Hispanic professionals and that a great risk exists that lesser trained paraprofessionals will be moved into treatment positions. "Social justice and ethical policy" demand that more be done, said Spiegel.

Spiegel described a training program carried out at Brandeis University with NIMH support which trained non-Hispanic professionals—psychiatrists, social workers, psychologists, and others—to work successfully with Hispanic patients.

Spiegel pointed out that professionals should already be proficient in their fields and interested in cross-cultural issues. Another requirement was the ability to speak Spanish or a willingness to learn it. Furthermore, they needed to become familiar with specific sub-groups such as Puerto Ricans or Cubans. Research on cross-cultural issues and liaison with relevant cultural agencies was combined with the training program.

The program was carried out in a working class suburb of Boston. The main site was an outreach counseling center located close to the Puerto Rican area but reaching out to a number of other ethnic groups as well. Trainees worked with Portuguese from the Azores, with Italians, with Haitians, and others originally from the black Caribbean populations. The primary emphasis was on work with Puerto Ricans.

See "Hispanics," page 20

Countertransference— And Female Trainees

THE COUNTERTRANSFERENCE ISSUES that a female therapist must face, particularly those relating to sexuality, seem to be such a sensitive subject that many training supervisors—male and female alike—never raise them with their female trainees, thereby possibly reinforcing the childhood repression of the discussion of sexuality.

Three female psychiatrists, Christine Bienick, Gail M. Barton, and Elissa Benedek (M.D.s), have been doing research interviews with female therapists, seeking to assess whether there are indeed training gaps and how these may be compensated. Bienick presented preliminary observations from interview data at APA's recent annual meeting. "First," she said, "there seems to be ample confirmation of inadequate training in the handling of countertransference related to sexuality, whether in didactic sessions or during supervisory hours. Many supervisors seemed uncomfortable in dealing with these issues. Even those supervisors who were perceived as helpful generally waited for the trainees to raise countertransference issues, thereby creating a conspiracy of silence and perpetuating the childhood taboo of discussing sexual topics." Bienick reported that the data indicate that the sex of the supervisor does not seem to be related to skill in handling sensitive countertransference issues, "even though one might hypothesize that same sex supervisors might serve as better role models." The three psychiatrists found that women devised a range of coping mechanisms "from avoidance and denial to attempted discussion with supervisors or others, such as spouses or one's own personal therapist, but rarely with peers. Interestingly, while therapists did not appear to seek support from their peers during their training, subsequently some of them developed supportive and close friendships with other mental health professional women whom they met regularly for lunch and an informal discussion of clinical issues, including that of sexual countertransference."

It was clear for the three researchers that they might be cracking the lid of what had been a Pandora's box for many women therapists when they began their attempts to interview, individually or in small groups, female social workers, psychiatrists, and psychologists from a midwestern area, most of whom had already completed their training. They ultimately talked to 15. Bienick chronicled some initial responses to interview requests. "One older female psychiatrist declined to participate, stating that she worked primarily with female patients 'so of course I wouldn't have any sexual countertransference with them.' She added that her supervision experiences dealing with countertransference during residency were virtually nil . . . . Another woman, a young analyst, hesitantly said that she needed time to think the topic over because 'the issues were so very complex' and because she was concerned with breaking the doctor/patient confidentiality, even though it had been clearly pointed out that every effort would be made to prevent patient or therapist identification." Although she agreed to call back with her decision, there was no word until one of the researchers ran into her accidentally, at which point she apologized and expressed relief that enough other people were participating to make the project possible. She then acknowledged that she was "equally as concerned with confidentiality relating to her own disclosures as with that of her patients . . . . Certainly," noted Bienick, "there appeared to be a general concern with confidentiality regarding material pertaining to the therapists themselves . . . . This concern . . . contrasts with a general willingness of the same therapists to talk about the more didactic aspects of their training."

Bienick, Barton, and Benedek found that generally "the therapists' personal backgrounds were such that sexuality was not discussed in their families, openly or otherwise. One therapist indicated that at the age of 13 she was given a book on sex by her parents without preliminary or subsequent discussion about sexuality, menstruation, pregnancy, marriage,

See "Therapist," page 22

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Person

Continued from page 9

than a few contemporary Thomists favor a return to the older doctrine of delayed hominization."

That afternoon's discussions began and they dealt more upon the point in time when the fetus satisfies the conditions of being "a person." But, again, no consensus was achieved.

In the symposium literature given to participants, the organizers had suggested that the words "human" and "person"—as fundamental concepts—are in a state of crisis. "They no longer seem capable of smoothly integrating, arbitrating, or steering our complex cultural activity. Contemporary medicine and the broader domains of biomedical research are particularly appropriate areas at the present moment within which to examine 'human' and 'person' as normative concepts in decision-making." Yet, May Cohen, M.D., of the department of family medicine, McMaster University, Hamilton, Ontario, was the only one of the day's discussants who got down to cases in what was a well organized symposium.

Cohen addressed the actual problems involved in medical decision making, although her discourse pertained mainly to the abortion issue. For those who oppose abortion, she suggested, the issue becomes stripped of complexity, "but concepts of 'human' and 'person' are not decisive in determining individual decisions and how we should behave toward unborn life."

She found the abortion issue a complex one, having medical, legal, moral, biological, sociological, psychological and demographic connotations.

"Attempting to apply a single criterion to all situations in this dilemma leads to contradictions and insurmountable difficulties. . . . We must look at the morality of the omission as well as the commission of an act. The abortion issue forces us to look at the immorality of passing laws which inherently incorporate inequality in their application. And, finally, it makes us look at the basic question of whether or not our society really can accept the sexuality of humans as an important and integral part of their total humanity."

The afternoon's proceedings also dealt with the pluralistic society and its embracing principles—whether the credence of one group should be permitted to prevail—but they really foundered on the question of "potentiality" toward personhood of the fetus. The potentiality referred to is that potentiality which gives the fetus its unique value, for which there is no replacement. The opposing argument found potentiality not *actuality* at a given point in time. The defenders stuck to their guns, however, contending that potentiality does lead to that actuality. Close harmony was not achieved either on the issue of respect for unborn life. Concerning the validity of the overall "respect for life" concept, it was pointed out that all societies throughout history have sanctioned the taking of life in some ways. The examples given were capital punishment, ectopic pregnancies, and war.

A point raised was whether or not all participants arrived with their orientations set and perseverant? Therefore, could there be a reasonable discussion on the issues? In any event, this report can be only superficial. The following day's talks dealt with "human" and "person" at the terminal stage of life. The proceedings are to be published. The address of the Clinical Research Institute is 110 Pine Avenue West, Montreal, Que., Canada H2W 1R7.

7A-24

Administrative Psychiatrists

THOMAS T. TOURLENTES, M.D., chair of the APA Committee on Certification in Administrative Psychiatry, announced that the following candidates successfully passed the examination for certification recently conducted in Chicago in conjunction with the APA annual meeting: Kenneth D. Cohen, M.D., Bala Cynwyd, Pennsylvania; Thomas J. Conklin, M.D., Hartford, Connecticut; William B. Scholton, M.D., Denver, Colorado; J. V. Bastani, Lincoln, Nebraska; George E. Hamilton, Jr., M.D., Winston-Salem, North Carolina; Mayer C. Liebman, M.D., Towson, Maryland; and Charles A. Meyer, Jr., M.D., Augusta, Georgia. Personalized certificates attesting to special competency in administrative psychiatry will be awarded to all successful candidates.

The next certification examination will be given May 11, 1980, in New Orleans. Psychiatrists interested in receiving this recognition are invited to apply to the committee chair, Thomas T. Tourlentes, M.D., 2701 17th St., Rock Island, Ill. 21602, prior to January 31, 1980. A brochure is available on request containing detailed information pertaining to the examination. Telephone inquiries should be directed to Tourlentes at (309) 793-1904.

Candidates interested in participating in a review course should contact Seymour Kaplan, M.D., Director, Fellowship Program in Administrative Psychiatry, Albert Einstein Medical College, 1300 Morris Park Ave., Bronx, New York 10461, as soon as possible. Those who have completed formal application for the examination in administrative psychiatry will be admitted to this tuition-free weekend course, which is tentatively scheduled to begin in late fall. Continuing medical education will be awarded to all participants. 8A-4G

Psychotherapy Program

THE LENOX HILL Hospital in New York recently founded the Lenox Hill Hospital Psychotherapy Program, designed for postgraduate training in psychoanalytic psychotherapy. It will involve two years of course work, case seminars, and supervision. Those eligible for enrollment are practicing therapists with a master's degree in social work or a doctorate in psychology, psychiatrists who have completed their residency training, and individuals with special qualifications in psychotherapy. An advanced program is also offered in supervision and special issues in technique. Those eligible for enrollment are graduates of psychoanalytic and psychotherapeutic institutes, and others with advanced training. Seminars will meet on Friday mornings beginning October 1979. Program director is Robert Langs, M.D. Further information is available from Marvin Kaplan, M.D., Director of Education, Lenox Hill Hospital Psychotherapy Program Lenox Hill Hospital, 100 E. 77th St., New York, N.Y. 10021. 8A-4C

Child

Continued from page 8

dent if one is able to gain the confidence of a troubled child who, for example, attacks his teacher, verbally or otherwise, but is liable to confess that he does not hate the teacher.

If emergency help is not available in the classroom at the very moment when it is most needed, the child's reaction to the helplessness he feels may be stronger than warranted by the reality of the situation, Redl said. In effect, he continued, the approach to some of these events needs to be changed, and it must be realized that the child may be gaining something positive if he is indeed protesting against what he perceives as being "wronged" by adults. When this is the case, it is not an indication of a severe aggressive problem but shows the effects of a causal chain where the links are the following: *a*) the child reacting with half-way normal behavior, *b*) restlessness, which spills over to *c*) aggression, and *d*) a final manifest deviance of behavior. The last link has to be traced back to the etiological chain of events if therapists are going to be able to respond adequately, Redl believes.

Concluding, he said that what makes the child become angry is interesting but this knowledge is not sufficient to properly manage the behavior. The significance of the outburst becomes clear when the obvious question is asked, "What is in it for the kid *right now*!"

Redl is with the school of social work at Wayne State University. 8A-18

Fall Component Meetings

THE DATES of the APA fall component meetings have been changed in order to avoid conflict with Rosh Hashanah. The meetings have been moved forward one day, to begin on Wednesday, September 19, and to conclude by noon on Friday, September 21. A few components will begin meeting on September 18. The meetings will be held at the Baltimore Hilton. 8A-4A

FDA

Continued from page 11

"necessary adjunct" that would reinforce and augment patient consultations with physicians and pharmacists. It believes that consumers not only have the right to know a drug's benefits, risks, and directions for use, but that the greater dissemination of that information will promote safe and effective use.

The timetable for implementation is vague. It will probably take at least a year and perhaps as many as two or three before the first inserts actually reach consumers, according to FDA patient labeling specialist Steve Moore, although he added that FDA is aiming for "as soon as possible." Other events that could hinder or hasten implementation are the naming of a new FDA commissioner to replace the recently departed Donald Kennedy or possible passage of Senator Edward M. Kennedy's drug regulation reform bill, which is reported to have good chances in the Senate but so far has been inactive in the House.

The agency is proposing to initiate the labeling gradually and in two phases: Patient labeling guideline texts embodying the general regulations for the first ten products or classes of drugs will be published in the *Federal Register* for a 60-day comment period before final texts will be published. Manufacturers, who are to write and distribute the leaflets with their products, may deviate from the prototypes as long as they conform to labeling specifications. For the next set of up to 75, notices will say when drafts are available for comment. The FDA intends to thoroughly evaluate the effects of patient information for this first batch of drugs before setting dates for making labeling imperative for the remainder.

Psychoactive drugs or drug classes designated in the first phase include anti-cholinergics, barbiturates, chlordiazepoxide, clonazepam, dextroamphetamine, diazepam, disulfiram, ethclorvynol, flurazepam, glutethimide, levodopa/carbidopa, meprobamate, methylphenidate, and oxzeopam.

Regarding exemptions, the proposed regulations would permit dispensers, which in most cases would be pharmacists, to give patient leaflets to the parent or legal guardian of a mentally disabled person or of a child who cannot legally consent to medical treatment, although this is not binding.

Physicians would be allowed to note on a prescription that information be withheld from a patient for medical reasons, unless, as with oral contraceptives, the insert for a particular drug is directed to be given to everyone regardless of circumstance. Patients needing emergency treatment and those in hospitals and long-term institutions are also exempted because of practical problems in distribution; institutions, however, would have to inform patients that further information is available in some other form such as a hospital compendium. 8A-16

APA Video Presentations

THE SUBCOMMITTEE on video of the APA Program Committee invites submissions of video tapes for presentation at the annual meeting in San Francisco in 1980. Submissions which deal with any aspect of psychiatry are welcome. In particular, in keeping with the theme of the San Francisco meeting, the subcommittee encourages submissions dealing with the president's theme "work and love" or with the Asian American community.

The committee must have an edited tape for review. In the review process, the committee looks for tapes that convey information about psychiatric work in a clear and interesting fashion, and that are edited sufficiently so that they stand by themselves. Titles, introductions, and voice-over techniques are often very helpful, the subcommittee said. The subcommittee also encourages the use of the video tape medium for recording and editing encounters with patients but requires a signed consent form from any patients involved specifically, releasing the material for presentation at APA meetings.

David Spiegel, M.D., now chairs the subcommittee. Deadline for submission of tapes is September 10, 1979. They should be sent to APA headquarters at 1700 18th St., N.W., Washington, D.C. 20009, in care of Allan Beigel, M.D., chair of the program committee. The tapes will be reviewed in the fall, and submitters will be notified about whether the tapes will be included within several months of submission. 7B-9D

Married Bisexuals Still Show Same Sex Feelings

Is OUR ENTIRE societal approach to sexuality pathological? Is our indifference to certain human sexual problems in itself a kind of cultural pathology? It could be. This was one suggestion in the discussion period following the reading of a paper on bisexual men in a heterosexual marriage presented at the annual meeting of the Canadian Psychological Association in Quebec City. In the presentation, Eli Coleman, Ph.D., an assistant professor in the medical school, University of Minnesota, and a psychologist and sex therapist, stated that very little has been learned about this particular group.

"The concept that an individual may be married and yet have a significant amount of same-sex feelings seems to have eluded mental health professionals. For example, in assembling their original heterosexual study group, Masters and Johnson (1966) never considered including individuals who had varying amounts of same-sex sexual experience. . . . In their most recent study, Masters and Johnson were surprised to find that 23 percent of the male and female homosexuals had been previously married."

This latter finding, he said, seems to be consistent with the extensive study of Bell and Weinberg (1978), but the only systematic study that has looked specifically at married men with predominantly same-sex feelings was conducted in Belgium on 11 couples.

"There have been case studies of treatment reported but, basically, little is known about these men, their wives, or their relationships," Coleman stated.

Coleman went on to describe his own study of 18 men who, at the time of entering therapy, were married and expressed concern about their sexual identity. Each was placed in a bisexuality discussion group, which met for ten weeks and which attempted to create a better understanding of human sexual functioning, to share concerns, and to deal with same-sex and opposite-sex relationships.

As a result of this therapeutic intervention, eight of these 18 men decided upon divorce although, prior to treatment, five had already separated or were contemplating separation. The remaining ten decided to stay married, but three of this group thought their decision temporary. Hence, only seven of the 18 males definitely decided to re-commit themselves, Coleman reported.

"Only three of these men planned a monogamous relationship with their wives, two were going to act on their same-sex feelings without the wife's knowledge, and two were still undecided whether or not they would act on these feelings. No relationship developed which allowed extramarital activity for the husband with the wife's knowledge and consent."

But the situation brings up a number of problems which Coleman noted: What were the reasons for their getting married? What attempts were made to eliminate same-sex feelings? Did the wife have knowledge of her husband's same-sex feelings? What about marital and sexual conflicts, extramarital liaisons, effects on children, adjustment? Finally, what were the factors for success or failure following their decisions?

In therapy, Coleman found out that

See "Bisexuals," page 26

Hispanics

Continued from page 15

Although other studies have cited a high drop-out rate for Hispanics seen in therapy, this did not occur in this program. Patients and their families remained in treatment until, in many cases, the trainees left.

Complications occurred from the varying theoretical positions of the various trainees and at times from the dual supervision they were receiving, both from the training program and from their other professional training.

Research goals of accumulating family history information clashed with the trainees' emphasis on the day-to-day problems of the patients.

Spiegel stressed that a full understanding of the cultural patterns of the patients and a respect for those patterns were essential. For example, trainees tried to work within the prevailing value system of the Puerto Rican families and attempted to preserve the dignity and respect owed to the male head of the family. They honored the traditional submissiveness of the wife and mother—at the same time noting the sardonic undercurrent and opposition to male "machismo" that is often present. Within this structure they worked to make a little space in these families for increased freedom and increased comfort in their new country. It was found that great reduction in stress between generations could be achieved. Spiegel called this a function of the therapist as "culture broker" (a term devised by Hazel Weidman).

According to Spiegel, even in cases where severe psychiatric problems existed there was relief due to the sensitive recognition of both cultural patterns and illness.

Information on this subject is accumulating; Spiegel cited the *Latino Mental Health Bibliography and Abstracts* as having 497 references, although none is on training. He noted that this area is important and mentioned that an "interesting and novel" approach to training non-Hispanics for work with Hispanics is being carried out by Melvin Delgado in Worcester, Massachusetts.

8A-11

Isaac Ray Award

THE AMERICAN PSYCHIATRIC ASSOCIATION invites nominations for the Isaac Ray Award for 1980. This award, in memory of Margaret Sutermeister, is presented to a person (psychiatrist, attorney, or one from a discipline related to human behavior) who has made outstanding contributions to forensic psychiatry or to the psychiatric aspects of jurisprudence. The purpose of the award is to promote better understanding between the law and psychiatry. The award, which will be presented at the Convocation of Fellows at the APA annual meeting in San Francisco in May 1980, includes an honorarium of $1,500. The recipient also agrees to present his or her work at an institution of higher learning (or other suitable location) and to present the manuscript for publication. The presentation will be located and timed to give maximum exposure to students and practitioners of law and medicine and to other professionals. Nominations are requested, with the deadline of September 14, 1979, from any interested professional. They should be submitted to Jonas Robitscher, J.D., M.D., Chair, Isaac Ray Award Board, Emory University Law School, Atlanta, Ga. 30322. 8A-4D

Psychiatrists Discuss Their Parenting Skills

By Clarissa K. Wittenberg

IT WAS UNUSUAL to see small children crawling on a platform and scrawling on a blackboard during an annual meeting of the American Psychiatric Association. However, children—specifically children of psychiatrists—were the whole point of one workshop at the annual meeting. Suggested by Nada Stotland as an experiment, it was then supported by others who joined her on the panel as the beginning of a "children's scientific session" at the annual meeting. The main subject was the psychiatrist as parent, and the original plan called for their children to be the experts. However, relatively few children appeared and those who did were by and large too young to say much to the larger group. The concern of the adults present, both psychiatrists and their spouses, was evident; and their enthusiastic response showed they had a lot to say.

Is there a difference between psychiatrists as parents and any other group of well educated professionals? It seems so from the discussion. Not only are they extremely concerned and focused on their children and the process of parenting, but they appear to have a pattern of "blunting" an emotion or a fight by "analyzing it" or via a discussion of motives or simply by "talking it to death." The mention of the phrase, "that makes me very angry," brought a laugh of recognition to the audience. One wife, however, said she had learned to deal with that phrase an an evasion just as any wife must learn to deal with a husband's personal patterns of disagreement.

High credit was given to the experience gained by psychiatrists in interpersonal relationships and the positive carry-over into marriages and child rearing. Both men and women psychiatrists were seen as highly involved in their marriages and with their children.

Psychiatrists said they have to decide early on how to handle casual conversation at school about childhood pathology or specific questions about individual children. They also have to give up their mantle of authority when dealing with their own children as many report teachers to be inhibited in talking to them. One said he had the difficulty of having his own child hurt by a child patient of his. By and large, the group decided that it was best to separate their roles, parental and professional, as far as was practical and to appear at school simply as a parent.

The most interesting feature of the meeting was that of the emergence of women psychiatrists turning professional attention to their own concerns. Gail Barton, a participant in the panel, described herself as a "psychiatrist and the daughter of a psychiatrist." Her early experience with patients assigned on work therapy assignments to their home on the grounds of a state hospital taught her about such things as hallucinations. She felt she developed as a young child a precocious "in-touchness" with her own feelings and saw her father's profession as a positive one. What did worry her was her own mothering and the way her devotion to her demanding professional life meshed with her parental role. Knowing what she knows about psychological issues in child rearing, she has giv-

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Therapist

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etc. For the most part, her experience was typical of the other therapists interviewed. The supervision experiences described by the interviewees indicated that, in general, regardless of sex, supervisors likewise did not discuss sexuality comfortably. Especially in an undidactic context, one wonders whether training programs do not unwittingly recapitulate the childhood settings of repressed sexuality. Similarly, it may be that the women interviewed recapitulated childhood experiences when, as therapists, they did not discuss problems about sexual countertransference with peers and colleagues, much as they had not discussed these feelings with their mother or childhood friends."

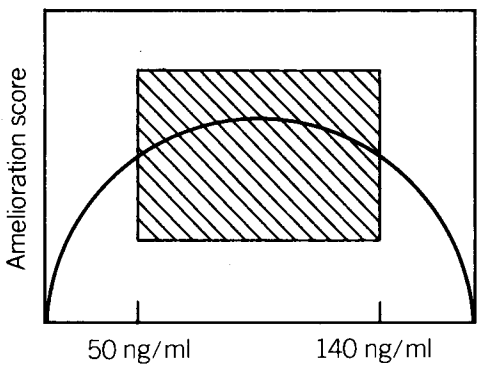
While specific details varied, several representative themes emerged from the interview material, the three psychiatrists found. One of these, reported Bienick, involved the female therapists' feelings of attraction to or fear of male patients: confusion about attraction to male patients in the therapist's age group, avoidance of accepting men as patients, and difficulty handling male patients who wished to date the therapist.

Some female therapists, Bienick and co-workers found, showed sex-role stereotyping in handling their patients despite their avowed sympathy with the women's movement. "One psychiatrist told how impatient she is with dependent patients, particularly if they are male. Another therapist found that in spite of her conscious intentions to be nonsexist herself, she tended to encourage female patients to cultivate physical attractiveness in contrast to encouraging male patients to focus on assertiveness and risk taking. The more experienced therapists explained that they had come to recognize their countertransference in sex-role stereotypy and were more articulate about their handling of such feelings."

Pregnancy and homosexuality seem to be particularly difficult issues for female therapists to deal with, reported Bienick, and once again they often seemed condemned to silence in supervision sessions. Discussing pregnancy, Bienick said, "One therapist was aware of intense anger at an unwed, pregnant teenager who did not want a baby she, an unmarried resident, wished for. In this case, her male supervisor was actively helpful by unobtrusively pointing out to her the possibility of such feelings. Another therapist, married . . . but unable to conceive children, deeply envied her patients' descriptions of their pregnancies. These feelings were not dealt with in her supervision, and she now recalls that it has affected her capacity to do therapy."

Homosexuality, in both male and female patients, likewise evoked countertransference issues often left unattended in supervision. "One psychiatric resident had unconsciously denied having any feelings about her male homosexual patient's sexual activity. She felt she had handled with perfect composure his accounts of lovemaking with a male partner, including oral and anal sex. One day when he described affectionately kissing his lover on the lips she did an internal double take as she finally broke through her denial of affect over her patient's sexual behavior. However, neither she nor her older male supervisor ever discussed her denial and recognition of her feelings . . . .

See "Therapist," facing page



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References:
1. Åsberg M, Crönholm B, Sjöqvist F, et al: Relationship between plasma level and therapeutic effect of nortriptyline. *Br Med J* 3:331-334, 1971.
2. Ziegler VE: Improved clinical response to tricyclic antidepressants: Provisions for faster, more effective, and safer therapy. Presented as a scientific exhibit at the 30th Institute on Hospital & Community Psychiatry of the American Psychiatric Association, Kansas City, Mo, September 18-20, 1978, p 9.
3. Sjöqvist F, Hammer W, Ideström C-M, et al, cited by Alexanderson B, Sjöqvist F: Individual differences in the pharmacokinetics of monomethylated tricyclic antidepressants: Role of genetic and environmental factors and clinical importance. *Ann NY Acad Sci* 179:739-751, 1971.

Therapist

Continued from facing page

"A female psychiatrist recalled that as a trainee she became anxious while treating a female homosexual. The transference which developed she felt was not essentially homosexual in origin but reawakened her anxiety connected with a former woman friend who had subsequently adopted a homosexual lifestyle. She feared bringing this up in supervision lest it be viewed as pathologic and by implication reflective of pathology in herself."

After detailing the range of problems, Bienick sought to recommend some solutions, many derived from survey material. Intensive supervision was clearly viewed as essential, with respondents generally expressing the need for the supervisor to initiate discussion of sensitive issues. "Such discussion," she pointed out, "need not be directed intrusively at the supervisee. A matter-of-fact discussion about a specific instance that is rather obvious and straightforward can be examined . . . . To help diffuse the potential one-way discussion of feelings which focuses exclusively on the trainee, some modeling by the supervisor, that is, sharing of similar experiences and feelings while they were trainees, would be helpful. Some interviewees, however, preferred that the supervisor not become transparent to them by sharing personal vignettes. All interviewees agreed on the need for the supervisor to be warm, open, and capable of dealing relatively comfortably with whatever material the trainee wanted to discuss about their therapeutic attempts and feelings."

Other suggestions included discussion groups with peers involving role playing, consciousness raising sessions for supervisors who are uncomfortable dealing with sexual countertransference issues, group supervision in an environment of trust and open sharing, and initial didatic presentations for male and female residents together.

Bienick commented in closing that the therapists interviewed for the research are all now supervisors themselves and "are consciously bringing up countertransference as a topic in their supervisory sessions. They find that their trainees viewed this as helpful and that it provides a stimulus for bringing many sensitive and difficult issues about the treatment process to the supervisory hour."

7A-16

Deaths

John Biggs, Jr., Wilmington, Del.
Neil D. Black, Syracuse, N.Y.
Asa William Deloach, Terrell, Tex.
Miklos Farago, Gowanda, N.Y.
Walter L. Ford, Waco, Texas
Gordon Owen Greene, Knoxville, Iowa
Victor Alberto Kessler, Fort Salonga, N.Y.
Peter O. Kwiterovich, Sr., Danville, Penn.
H. Peter Laqueur, Waterbury Center, Vt.
Earl Mericle, Indianapolis, Ind.
Walter Musta, Cleveland, Ohio
George J. Orlansky, Braintree, Mass.
Charles S. Rafky, Baltimore, Md.
Nathan N. Root, New York, N.Y.
Herbert A. Raskin, Southfield, Mich.
Bernard Schoenberg, New York, N.Y.
Vladimir G. Urse, River Forest, Ill.

Gaylin

Continued from page 3

means to alleviate anxiety, especially popular in this country." Is this a healthy coping mechanism?

Gaylin: I don't think so. I think it's a very limited one. It's a part of a materialistic society. I hate to see the corruption of all holidays. There used to be differences in the way you spent Christmas, Thanksgiving, July 4. . . . Now they all are excuses to go to Bloomingdale's and get something on sale. . . . It isn't the necessity to purchase. One looks for an excuse to purchase something for the privilege of going shopping.

Psychiatric News: **Another coping mechanism you mention—sexual gratification—you describe as "a great palliative." Do you and *how* do you prescribe it?**

Gaylin: Fortunately, you don't need a prescription. It's the leading non-prescription sedative or tranquilizer there probably is.

Psychiatric News: **But do we realize in the process that we're relieving anxiety?**

Gaylin: I think many of us do. It's an interesting thing with masturbation, particularly with a man where he has a gauge or measurement at hand. Many young men, say studying for an exam, will feel tense and anxious and will make the decision to masturbate or they'll want to eat something, which is another equivalent, and then they will have to find some way to arouse themselves . . . but the sequence is clearly that the desire to masturbate precedes sexual arousal.

Psychiatric News: **Here's another quote I really like: "Of all the virtues, candor has always seemed to me, with the possible exception of humility, the least attractive."**

Gaylin: That quote has gotten me into terrible trouble with some of my best friends. . . . Now, candor, or frankness, which I think of as the same thing, to me has a different connotation from truth-telling.

Psychiatric News: **Frank implies bluntness?**

Gaylin: Exactly. Candid and frank imply not just bluntness but it's the distinction between truth-telling and some sort of assumption of the need to announce the truth. . . . There is an arrogance to it, and more often than not candor is not in the service of truth-telling but is in the service of cruelty or hostility.

Psychiatric News: **Going on to your discussion of guilt and shame, you say, "Guilt wants exposure, needs expiation and forgiveness." You call it "the noblest and most painful of struggles because it is between us and us." Guilt is alleviated by confusion; is shame?**

Gaylin: No. . . . Guilt is the sense of wrong-doing. . . . Shame requires an audience, if only an imagined audience. The distinction . . . is superbly drawn in *The Scarlet Letter,* where Hester feels shame and the Reverend Dimmesdale feels enormous guilt. He's not exposed, so there's no shame there at all; but it's guilt that he feels, and the guilt is even worse. Ironically, shame—it's like nudity—the shame wants covering up; it wants some surcease from the spotlight.

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Gaylin

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Guilt almost demands a confessional. Shame wants forgiveness . . . a rectification of honor, the restoration of privilege.

Psychiatric News: **There seems to be much more guilt these days than shame.**

Gaylin: I think that's true . . . because we're so individually oriented and so little group-oriented. In other civilizations where the group is all important, it's shame. . . . And don't forget also the whole Christian theology, which is very individual-oriented, has put emphasis on guilt.

Psychiatric News: **We're up to the chapter on pride, where you say, "How . . . did a nice emotion like pride get elected to the first of the seven deadly sins?" I think we need to define pride. You say, "Self respect, self esteem, and self confidence are essential elements of adaptation and are functional." You say, "Humility ought to be a sin for it leads to despair and encourages a tolerance of inequity and injustice." What about vanity?**

Gaylin: I think the answer is really simple, that morality, like all education, was a function of a privileged few in classical periods. And every patriarch emphasized *hubris*. . . . They wanted to remind those in power of their commonness and to warn them against thinking of themselves as too much like the gods. In a day like ours where there's nobody who is powerful anymore, where we all feel semi-impotent, where we all feel frustrated and restricted; in a society where power, freedom, seems so limited, then pride is of essential importance so that we recognize that we are not just cogs in a machine. . . .

Psychiatric News: **So it's a survival mechanism.**

Gaylin: Yes. . . . Now vanity is an interesting one. Vanity is pride for the wrong reasons. We use vanity mostly in terms of physical things. . . . For the most part, we feel proud of the things we have done rather than what we are. . . . To feel proud about what we are—"Gee, I'm a good boy"—it's not good, it's goody-good.

Psychiatric News: **So we take pride in our products. But what if our products aren't honorable?**

Gaylin: Then, like any other emotion, pride is not working well. . . . The thermostat isn't working. . . . And that kind of thing . . . requires a technician; it may be a psychiatrist. The crucial thing, though, is not to divide the feelings into good and bad ones.

Psychiatric News: **Going on to "upset"—you say "to be in a state of high irritability means that a lesser than usual stimulus is able to elicit a response. The threshold of response has been lowered." Upset and anxious seem to be related.**

Gaylin: I don't think so. It's interesting that you say that because some people say that upset means angry. Upset can be anxious, angry, guilt, fear, anything. . . . Upset means you know something's not working right. What's going to break through you don't know. It can be anxiety; it can be rage. If I snap at my secretary . . . I'm likely to say, "I'm sorry, I'm just upset today." What that means is my

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Bisexuals

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each of these men was aware of his same-sex feelings to some degree prior to marriage, but few understood themselves to be "gay." "Confusion" was an apt description, he said, concerning their same-sex preference, but only 11 had acted this out. Most of this premarital activity could be labeled as normal exploratory adolescent sexual behavior except that, for these individuals, it had a very different meaning. While some of the specific motivation to marry varied, the overall motivating factors were love of wives, family and societal pressures, and negative feelings about gay life.

All reported attempts to eliminate same-sex feelings and said that these feelings were a source of guilt. Eleven of them had undergone psychotherapy in an attempt to dispell the same-sex tendency, and therapy had gone on from six months to 17 years in the individual cases.

"Obviously, none was successful," Coleman pointed out. "While these men felt extreme guilt over their feelings and behavior, only one had a history of psychiatric hospitalization. Many reported suffering from depression and anxiety over the years, but it was clear, except for one man, none suffered from any serious psychopathology."

Coleman said that only four of the wives knew of their husband's same-sex bent prior to marriage, and one of them thought these feelings to be normal. Two thought that this would not be a factor in the marriage. By the time of the reported research, however, only four of the women concerned were unaware of their husband's sexual pattern and these four were advised during the treatment process.

"It was just as difficult for the wives to accept their husband's same-sex feelings as was acceptance for the husband. But "the scope of this study did not include much information about the wives' history, reactions, or adjustment. Wives were recommended to a spouse's support group, but only six were able to talk with other wives about the situation. More information needs to be gathered on these spouses," Coleman advised.

Apparently, sexual problems were common in all these marriages. Nonetheless, there was a surprising number of relationships where there seemed to be a satisfactory frequency of sexual activity, and only three men had a history of erectile failure. All but two had had liaisons with men outside the marriage, and one of these two had not had a same-sex experience either before or after getting married. The frequency of same-sex activity varied greatly from a single incident to at least weekly sexual encounters.

Twelve of the 18 men had children and expressed love and admiration for them. No immediate effect upon the children was noted, Coleman said, and the decision to leave or not to leave the marital relationship did not seem to be directly related or influenced by the children's involvement—although six of these 12 were in the divorcing group.

"Adjustment to same-sex feelings was not and is not an easy matter for any of the men studied. Following treatment, each was more accepting of his own-sex feelings, and this seemed to help in terms of adjustment. Making decisions to stay or leave the marital relationship was helpful in that it ended anxiety or in-

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Diagnosis for Bipolar Illness Said Erratic

ONE THIRD TO ONE HALF of persons with manic-depressive illness probably don't get professional help, while nearly one fifth in treatment for the disorder don't have it, according to the best estimates in a recent HEW-contracted report. Moreover, physicians misdiagnose one in four by failing to detect bipolar illness or mistakenly diagnosing it in others, says the report.

The final product, delivered by Policy Research, Inc., in Baltimore, Maryland, summarizes the "best available information" on the prevalence, diagnosis, treatment, and economics of bipolar illness in the U.S. It is the first of three projects funded by HEW—the others are malignant melanoma and rheumatic heart disease—to determine just how well physicians are using the most up-to-date accurate knowledge on specific illnesses.

In an innovative approach, HEW-chosen experts on each of these dimensions of bipolar disorder provided data and information in one or more areas, which, along with sources and citations, were tabulated. Then an independent team rated just how well the cited sources validated the responses. Based on a summary of the original answers, as well as the validation ratings, experts had a chance to confirm or revise their first estimates and rate on a four-point scale the degree of certainty of their answers.

Principal investigator Peter G. Goldschmidt, M.D., said that the firm used the expert team approach rather than a traditional literature search because they wanted the answers to the "really necessary" questions that bear on health care decision making. What they found is that the best available knowledge on these questions isn't very good, at least empirically speaking.

For example, studies were cited to support only 35 of 202 unique data points in the original responses. Of these 35, only 13 actually appeared in the cited articles and only eight of these were even weakly justified by it. Three failed to support the answer

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decision. Adjustment to a new same-sex lifestyle or recommitment to marriage has not been easy either, but each reports a sense of optimism for the future," Coleman stated.

However, he added, the effectiveness of these adjustments is difficult to ascertain and remains hidden in the future. His preliminary clinical impressions were positive for some but, for others, he felt that their lives would continue to be a struggle. For the men who were going to retain their marriages, he found no clear model of success but more known factors for the same-sex relationships. Coleman's paper closed with suggestions regarding important ingredients for adjustment with respect to both courses.

"However, we need more information and we need to know more about non-patient populations. There is, of course, some question as to whether these findings can be generalized to non-patient populations or even to other clinical populations," he concluded.

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Bipolar

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and two others contradicted it. Moreover, the experts rated 70 percent of the final estimates as being of "uncertain validity"—defined as "some probability the data are invalid" and "substantial risk" of their being wrong—while only 14 percent were considered valid.

NIMH project advisor Robert Hirschfeld, M.D., was disheartened by the results. "It is distressing that the quality of the information in bipolar illness is as poor as it is," he told *Psychiatric News* in a telephone interview, particularly, he added, since that disorder was selected because they thought more was known about it than any other psychiatric condition.

Hirschfeld stopped short of confirming Goldschmidt's praise of the model as a good one for policy making but did endorse it as useful in "assessing the state of the art."

However flawed, the report contains the best information around and spotlights deficiencies ripe for future investigation and improvement of physician skills. Of the estimated 383,000 persons who had a manic or depressive episode in 1976, only 45 percent were in treatment for it; of 360,000 so afflicted who did not have an episode, only 11 percent got maintenance therapy. Ironically, those most likely to have an episode—women aged 35 to 54—were least likely to be in treatment; while the contrary was true for men 15 to 34 years of age.

Experts estimated that the illness began in 34,000 persons that year. Had it gone untreated, they collectively would have lost 225,000 years of life and 361,000 years of major life activity, costing society about $1 billion. Taking into account costs of treatment and residual loss, the actual cost was trimmed to $441 million and they are recouping 144,000 life years and 225,000 major activity years.

In less global terms, a 25-year-old woman with bipolar illness that goes untreated can expect to sacrifice 9.2 years of her life and 14.2 of major life activity, while with optimal treatment she would cut that to 2.7 life years and 10.2 of life activity.

It is likely, the report continues, that research clinicians using Research Diagnostic Criteria will miss ten percent of patients who are manic-depressive and falsely label six percent as having it. Using them as the standard, specialists such as psychiatrists probably have a false negative rate of 15 percent and false positive of ten percent; primary practitioners miss almost double that (28 percent) but falsely label about the same number (nine percent).

Altogether, given the 34,000 who statistically would have been expected to suffer the disorder in 1976, probably 5,400 would have gone undetected and 2,700 would have been wrongly diagnosed as manic-depressive. Should private practitioners and specialists improve their diagnostic accuracy, however, the report said misdiagnoses could be cut in half. Among ways it suggested to do this are to make physicians, especially generalists, more aware of the problem and criteria for diagnosis; improve history taking, specifically detailing accurate family history of bipolar illness, previous episodes of affective disorders, and changes in symptoms; and to better differentiate its diagnosis from schizophrenia.

It highlights as "essential diagnostic interventions" a half-hour long history, contact with family and friends,

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Bipolar

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and a half-hour physical examination. Experts cited G. Winokur, P. Clayton, and T. Reich's book *Manic Depressive Illness* (C. V. Mosby & Co., 1969) as the single best education review of bipolar disorder.

Turning to treatment, the team agreed that in 1976 some 52 percent of the costs went to proven interventions and 20 percent to unproven ones; moreover, 20 percent paid for unnecessary treatments and five percent for harmful therapy.

Optimal treatment, which only somewhat more than a quarter of the patients received in 1976, according to the report, costs less than the "usual" treatment: "One out of every three dollars being spent is considered unnecessary," it says.

To improve their treatment, the report recommends that physicians learn better diagnostic skills and when to seek psychiatric consultation; that they more finely hone their use of lithium, by, for instance, obtaining blood levels at follow-up and making more available the TCA blood level assay; and improve patient management and research of the disorder.

Lithium carbonate was the only "essential" treatment the report listed for a manic episode although it named as helpful haloperidol, chlorpromazine, ECT (if poor drug response), supportive psychotherapy, family therapy, and hospitalization. And it considered ECT as initial therapy, analytic psychotherapy, occupational and recreational therapy useless.

For a depressive episode, on the other hand, essential therapeutic interventions are tricyclics and hospitalization, if severe, the experts opined. MAO inhibitors, lithium carbonate, ECT, and individual supportive psychotherapy may also do some good; but major tranquilizers or sedatives were considered futile.

More specifically, in the case of individual analytic psychotherapy, four team members rated it useless and three possibly harmful for a manic episode. It was considered "controversial" in depressive illness: One member thought it helpful, three harmful, and two unproven.

Hirschfeld thought these statements much more definitive than justified by empirical evidence, however, and considered it important enough to return to Goldschmidt for revision,

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World Congress

THE FIRST WORLD Congress on Behavior Therapy will be held July 13–17, 1980, in Jerusalem, under the auspices of the American and European Associations for Behavior Therapy (AABT, EABT). The congress plan represents an attempt to integrate world work in behavior therapy and related disciplines under the general theme "Behavior Therapy Contributions to Person and Society." Researchers and practitioners are invited to submit a proposed symposium, paper, or workshop for consideration. Individual or symposium papers should represent original contributions and be substantially different from papers published or presented by the authors elsewhere. Deadline for submission of abstracts is December 1, 1979. Further information is available from Dr. M. Rosenbaum, World Congress on Behavior Therapy, P.O. Box 3054, Tel Aviv, Israel. 7A-27E

Children

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en great thought to child care arrangements. She is aware of her husband's important role in parenting and seemed hopeful that her professional commitments would not endanger her little girl. She is also conscious of the advantages that men have, saying, "I really need a wife," and noted that her father took a year off to go to England and study for his boards, an impossibility in Barton's view for a mother with small children.

Nada Stotland raised the issue of women in residency training and suggested that child rearing is so valuable an experience for a psychiatrist that it should be a valid "elective" for either men or women and that remedial work be given for non-parents. Currently working as a ob-gyn consultant, having left child psychiatry, she noted that she has become intolerant of some psychiatric constructs such as the "genic" mother. She asked if anyone knew what it felt like to be called an "ulcer-genic" mother and have a child with ulcers? She suggested that the women now in psychiatry need to speak up and that if both fathers and mothers had time off for care of new babies they would realize soon that "parents cannot control everything." She also cautioned against the attitude that if "something is wrong it is the mother's responsibility."

Edward Futterman, a child psychiatrist, noted he had at first "supervised his wife's care of their child," not realizing he was actually a partner. He sees some children of psychiatrists in his practice and believes this is because they seek help more quickly rather than because there is a high incidence of pathology. And with regard to the complaints about "talking," he noted wryly. "It's better than having

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calling also for the report to better delineate the method by which results were determined. "We do not have good data on the efficacy of psychoanalytic therapy on unipolar and bipolar depression," he told *Psychiatric News*, "so you can't make categorical statements. It is pretty clear that lithium is the treatment of choice for mania."

Improved treatment would save money by cutting costs of treating those who don't have the disorder; benefits were estimated at 17 percent. Perfecting detection rates would increase health benefits by seven percent but cost money to do. Whether to do either is a matter of policy resting on such questions as its probability of improvement, cost versus savings, and availability of funds.

Their expert team thought $20 million could be channeled productively over the next five years into bipolar research; in view of overall medical research priorities it trimmed that amount to $16 million.

The 17 team members were Boris M. Astrachan, M.D.; Haroutan M. Babigian, M.D.; Richard Dorsey, M.D.; Ronald R. Fieve, M.D.; Barry Gurland, M.D.; Donald G. Langsley, M.D.; Heinz E. Lehmann, M.D.; Peter Lewinsolm; Benjamin Lipzin; Jerome Myers; Arthur J. Prange, M.D.; Dean Schuyler, M.D.; John J. Schwab, M.D.; George J. Warheit, Ph.D.; George Winokur, M.D.; Myrna Weissman, Ph.D.; and William Zung, M.D. —B.S.H. 7B-12

Sex Orientation Of Therapist Considered

THE PROS and cons of pairing client and therapist in terms of sexual orientation is a topic of private discussion but rarely a focus of serious attention, the annual meeting of the Canadian Psychological Association was told. In fact, only one study has been reported in the literature in which the variable of client-therapist sexual orientation has been identified and included as a relevant factor.

"The most obvious reason for the omission of sexual orientation from studies of client-therapist similarity has been the invisibility of gay professionals and psychotherapists. It has been traditionally assumed in clinical research that a heterosexual orientation is the only suitable orientation for therapists," according to psychologist Martin Rochlin, Ph.D., who is in private practice in West Hollywood, California.

However, now that gay issues are much more to the fore and since increasing numbers of homosexual mental health professionals are publicly identifying themselves, Rochlin suggested in his paper that the sexual preference of the therapist is now a practical as well as a theoretical matter.

Rochlin's presentation mainly dealt with a review of about 12 studies that attempted to explore the ingredients of therapeutic effectiveness. In these studies—among numerous variables—such items as class, racism, religion, culture, self-experience, and stereotypical bias were discussed. On the matter of stereotypical bias, Rochlin cited Calia as observing that "generalization leads to categorical prescriptions and the attendant loss of the client's uniqueness and worth."

Going on to the factor of sex orientation, as already mentioned, Rochlin found little to report: "Research data on the effects of pairing sexual orientations of client and therapist are sparse but suggest that such pairing facilitates effective counseling and psychotherapy for gay clients."

This data, which Rochlin also reviewed, consisted of the one published study, an unpublished student project on lesbians' experience in therapy, and an excerpt from a book by Saghir and Robins *(Male and Female Homosexuality)* which stated that about one third of the homosexual clients interviewed had negative feelings about their therapy. The conclusion drawn by Rochlin was that it is time for serious consideration of the suitability of non-gay therapists for gay clients.

To defend this stand further, Rochlin quoted Masters and Johnson (1979) as observing that "the available evidence certainly supports the homosexual population in their general contention that if they expected the worst from health care professionals, they would be rarely disappointed." Szasz also found, he pointed out, that the homosexual has been exploited as "the model psychiatric scapegoat."

The paper was read by Janet Taylor.

8A-5

Sands Appointed

HARRY SANDS, M.D., director of research at the Postgraduate Center for Mental Health in New York, has been named executive director of the center.

Briefly Noted

Ittleson Research Award

THE AMERICAN PSYCHIATRIC ASSOCIATION is now accepting applications for the 1980 Blanche F. Ittleson Research Award for outstanding research accomplishment in child psychiatry. Funded by a grant from the Ittleson Foundation, the award is intended to honor the memory of Blanche F. Ittleson, a friend of the mental health cause over many decades and a particularly dedicated supporter of the mental health and well-being of children. The award carries with it an honorarium of $2,000 and a gold plaque. The award is given annually to an individual child psychiatrist or group of investigators in the field for the published results of research which has led, or strongly promises to lead, to a significant advance in promoting the mental health of children.

Applicants must be U.S. or Canadian citizens, and the results of their research must have been published within the last three years prior to submission to the award board, appointed by the APA president, which is responsible for selecting the award winner on the basis of the published reports submitted. All entries must be submitted in six copies. Deadline for submissions is November 15, 1970. Any entry received after that date will automatically be considered for the 1981 award, unless withdrawn by the applicant. The 1980 award will be presented to the winner at the APA annual meeting convocation in San Francisco on May 5. Entries should be submitted to Reginald Lourie, M.D., Chair, Blanche F. Ittleson Award Board, 1700 18th St., N.W., Washington, D.C. 20009. 8A-4E

Symposium

THE CENTER FOR PREVENTIVE Psychiatry in White Plains, New York, and High Point Hospital in Port Chester, New York, are sponsoring a symposium October 13 in White Plains on infant psychiatry. Keynote speaker will be Eleanor Galenson, M.D., clinical professor of psychiatry at the Albert Einstein College of Medicine. Morning presentations will include "Early Identification of Infant-Mother Systems in Distress," by Elsie R. Broussard, M.D.; "Diagnosis and Treatment of Impaired Adaptive Behavior in the First Year of Life," by Wagner H. Bridger, M.D.; and "Perinatal Influences on the Family," by Robert J. Harmon, M.D. Afternoon workshops will deal with "Research Issues in the First Year of Life," "Techniques of Preventive Intervention Used in Working with Neonates at High Risk," and "Methodology Related to Assessment of Mother-Infant Attachment at 12 Months of Age." Physicians will receive seven hours of Category I credit toward the Physician's Recognition Award through the continuing medical education department of the Albert Einstein College of Medicine. The fee is $35. Further information and a reservation form are available from the Center for Preventive Psychiatry, 340 Mamaroneck Ave., White Plains, N.Y. 10605. 8A-4F

Annual Symposium

THE FOURTH ANNUAL Symposium sponsored by the Thistletown Regional Centre will be held September 20-21 in Toronto on "Pharmacotherapy with Emotionally Disturbed Children." Guest speakers will be Madga Campbell, M.D., associate professor of psychiatry and director of the Children's Psychopharmacology Unit, New York University Medical Centre, School of Medicine; James M. Perel, M.D., associate professor of clinical pharmacology and chief of research, New York State Psychiatry Institute, Columbia University; C. Keith Conners, M.D., professor of psychiatry, Department of Psychiatry, Western Psychiatric Institute and Clinic, University of Pittsburgh, School of Medicine; and Gabrielle C. Weiss, M.D., clinical director, Department of Psychiatry, Montreal Children's Hospital. Further information is available from The Secretary, 1979 Thistletown Symposium, 51 Panorama Court, Rexdale, Toronto, Ontario M9V 4L8. 7A-27R

Symposium

THE EDITORS of *Advances in Alcoholism*, a monthly publication of the nonprofit Raleigh Hills Foundation, have announced a symposium October 15-16 in Newport Beach, California. This meeting offers 14 credit hours in Category I toward the Physician's Recognition Award of AMA and for the certification program of CMA. The symposium is cosponsored by the University of California at San Diego, School of Medicine, and the Raleigh Hills Foundation. Further information is available from Robert E. Schmitz, M.D., Raleigh Hills Foundation, 881 Dover Dr., Suite 20, Newport Beach, Calif. 92663, (714-645-4310). 8A-4I

Children

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a father who hits you over the head."

John Steffeck, a child psychiatrist, asked how many professionals had explained their work to their children and how many children had visited their parents' offices or playrooms. It seemed from the discussion that psychiatry is a hard field to explain and that talk often bogs down on key words such as "*talking* about *problems*." Children generally have some difficulty in finding the difference between their "talks" and their "problems" according to some present at the workshop. Steffeck noted that his children are sometimes jealous of his child patients and that at times he wonders if his patients do not drain him so that his ability to pay attention to his own children and play with them is limited.

The meeting broke into smaller groups and then re-convened. It was felt that the children present had much more opportunity to express themselves in these small groups. Some of their impressions and added thoughts of the adults present were discussed in the last portion of the meeting.

The beginning of the "children's session" was applauded with the general conclusion that APA should do more for children at the annual meetings. It was suggested that having eminent psychiatrists talk to the children or having historical material presented might be highly valuable for parents and children in building an understanding of the field.

8A-12

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Regional Psychiatric Centre
Saskatoon, Saskatchewan

Applicants are required to fill the positions of Clinical Director and Staff Psychiatrists at the Regional Psychiatric Centre in Saskatoon, Saskatchewan. The Regional Psychiatric Centre is a hospital serving the mentally ill of the Correctional Service of Canada and is affiliated with the University of Saskatchewan. An active research department is part of the establishment and it is planned that the Centre will be used to train post-graduate students of many disciplines.

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The Province of Nova Scotia invites applications from Certified Psychiatrists for five positions presently available in the Cape Breton Mental Health Services. This is a rapidly expanding Centre providing outpatient, day hospital and inpatient services for a population of 160,000. Positions are available in presently established services and as well will provide involvement in the development of new programs.

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For further information please write (or call) Dr. F. R. Townsend, Administrator, Psychiatric Mental Health Services, Department of Health, P.O. Box 488, Halifax, Nova Scotia, B3J 2R8. Phone: (902) 424-4232.

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PN

Gaylin

Continued from page 25

normal order of controls is out of whack . . . I have a sense that I'm in a vulnerable state, that I'm low threshold.

Psychiatric News: **So it's a predisposition to an unknown small passion?**

Gaylin: That's right. . . . Any stimulus which normally we could handle is liable to provoke a response that is greater than warranted. . . . Granted, most often it's fear or anger that's going to break through.

Psychiatric News: **What about the appropriate ventilation of anger? How does one get rid of the upset, just wait for it to ride over?**

Gaylin: Well, I think the upset is a warning to us, and we often protect ourselves by warning people. . . . The knowledge that we are not ourselves, not in our normal control, often tells us to defer things or, if we can't, to direct ourselves to the nature of what's upsetting us or unsettling us and find out about it.

Psychiatric News: **Your next chapter is on feeling tired.**

Gaylin: That's one that's very familiar to almost any psychiatrist. Feeling tired is rarely physiological; . . . chronic tiredness is a sign of depression.

Psychiatric News: **You cite as the two major causes of depression "the loss of confidence in ourselves as executives of our future and the loss of respect for ourselves as suppliers of pleasure in the life that may remain for us. When we feel tired," you say, "we feel temporarily used up, and when we feel depressed we feel permanently used up." OK, what should we do?**

Gaylin: Certainly you know that with depression there is very little you can do for yourself. That is a serious, serious clinical phenomenon that always demands professional attention. The problem with depression is that it's both a clinical word that psychiatrists use, and it's a lay person's word. We psychiatrists know that every time a person says he's depressed, he's not depressed. We don't call feeling blue or feeling down or feeling frustrated necessarily depression. So here I'm referring to clinical depression, which is a sense of one's own bankruptcy of resources. . . . To recognize that tiredness means that you simply are feeling depressed . . . often can direct you to . . . push yourself toward more pleasurable things.

Psychiatric News: **You say that when a person feels tired or depressed what is needed is "more activity not less, or to be more precise, more activity of a different quality. Energy must be used, not conserved, but used for loving, playing, and doing." But can't part of the depression come from the fact that those activities aren't available?**

Gaylin: They may not be, but I'm not sure they aren't. . . . Sure, if you're alone and you want love and there's not a loved person there, that's a very unfortunate thing. . . . But what I'm warning about is that sometimes the tiredness is misconstrued, and what people do then is withdraw. . . . Exactly the opposite is demanded.

Psychiatric News: **In discussing boredom, you go through classical boredom, religious boredom, sloth, weariness, dreariness, melancholy, ennui. What do we have today when we say, "Well, I'm bored"?**

Gaylin: I draw the distinction between ennui, which I think of as a kind of passive, decadent European kind of emotion. . . .

Psychiatric News: **1930's Berlin.**

Gaylin: Exactly. Or Proust's Oblomov, lying there weary with sighs. It's an emotion of the leisure class. . . . I think our boredom tends to be a jumping out of the skin, racy kind of thing. And there is a good example of the thermostat. If you're sitting in front of a boring television program, it's almost like an electric shock that jumps you up. Now you don't know what it is but it's saying, "Turn the damn set off, get a book, make love, go for a walk, do something other than this."

Psychiatric News: **We have to talk a little about television. You refer to it as our "bridge from boredom to ennui." You say fantasy is a defense against boredom. Fantasy is exactly what television lacks, but isn't fantasy constructive only up to a certain point?**

Gaylin: Exactly, exactly. Fantasy is a halfway point—that's a classical Freudian position. It serves in a sense to give an illusory gratification, but it must not be a substitute for the real thing. It's a temporary measure, and if it becomes permanent, then you are vulnerable for neurosis.

Psychiatric News: **We have three minutes left to discuss feeling good.**

Gaylin: One thing I go into in discussing feeling good is an attack on a concept called "happiness," and this is the idea that there is a kind of "California mellow," laid-back thing called happiness which somehow or other is freedom from all kinds of pain, anguish, torment, guilt, etc. One of the implicit things, although I never explicate it in the chapter on goodness, is to show that there is not a polarity between pain and pleasure any more than there's a polarity between love and hate. We are complicated human organisms; and the most profound pleasures almost always incorporate anxiety, hurt, pain, suffering, sorrow, etc. In a sense, it's an attack on some concept of happiness which I don't know to exist. Now why do I say it's destructive? It directs people in the wrong way, it compares a person to a potato as though the potato is at the better state.

Psychiatric News: **"California mellow" is almost the present day ennui.**

Gaylin: That's where I have that quotation, which I think is an important one, "The opposite of love is not hate but indifference." So I think that's one of the implicit things I try to get over in the idea of feeling good, that feeling good does not involve often a great deal of anguish, effort, and energy. . . . But I'm reluctant to analyze pleasure. Some things are to be experienced without analysis or indeed cognition. In psychoanalysis we rarely if ever analyze success for our patients. Health is its own excuse for being and is accepted gratefully by both parties. 7A-7

Boren Named

CHARLES W. BOREN, M.D., formerly associate director of medical education at the Institute of Living in Hartford, Connecticut, has been named director of medical education.

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Anchorage—Bd. elig. PSYCHIATRIST to help develop and deliver psychiatric svcs. for a transcultural pop. Would be joining an estab. psychiatric outpt. svc. based in a 170-bed Indian Health Svc. multispecialty referral hosp. Present staff includes a child psychiatrist, psychologist, and 6 psychiatric nurses. Travel to the outlying villages would be req'd. on consul. basis. Orientation is eclectic with emphasis on ambulatory outpt. care. Lib. frng. bnfts. incldg. cost of living allowance. Excel. recreat. opptys. For more info. contact Dr. Kenneth Petersen, Medical Director, Alaska Native Medical Center, P.O. Box 7-741, Anchorage, AK 99510, (907) 279-6661.

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TIRED OF COLD WINTERS AND UPTIGHT LIFESTYLES? CONSIDER: MEDICAL DIRECTOR, PHOENIX, AZ. Prgsv. CMHC loc. in a rapidly growing sun-belt state seeks a Bd. Elig. or Bd. Cert. psychiatrist respon. for directing med. svcs., provision of some direct svcs. and assuring the quality of clin. care provided in compre. ctr. with 1.8 million budget. This facility serves a culturally and ethnically diverse pop. of 160,000 in urban Phoenix. Sal. nego. to $50,000 dep. upon exper. and trng. Send resume or call Steven Scott, Ph.D., Executive Director, Phoenix South Community Mental Health Center, 1424 South 7th Ave., Phoenix, AZ 85007 (602) 257-9339.

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CALIFORNIA

CHILD PSYCHIATRIST wanted. Posn. avail. now. Dynamic pvt. incorporated psychiatric group with opptys. for inpt. and outpt. therapy. Desirable living in rapidly growing Southern Ca. area. For more info. call Nicki Pontrelli 213-619-3281 and send CV to 1201 West Lambert Rd., Suite 201, La Habra, CA 90631.

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Los Angeles Area—PSYCHIATRIST WANTED to join estab. grp. prac. in charming L.A. suburb. Excel. oppty. for energetic indiv. beginning prvt. prac. career. Hrs. completely flex. Income commensurate with effort. Calif. Lic. req'd. Contact: Hillcrest Guidance Clinic Medical Group, 201 S. Mission Dr., San Gabriel, CA 91776 Ph: (213) 284-3226.

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Patton—PATTON STATE HOSPITAL has opening for FORENSIC PSYCHIATRIST. Applic. should be Bd. Elig. or Cert. in Forensic Psychiatry. Sal. to $44,964 with extra income for MOD duty. The hosp. is east of L.A. with over 700 Penal Code patients. Contact Mr. Robert Martinez, Executive Director, Patton State Hospital, 3102 East Highland Ave., Patton, CA 92369; Ph: (714) 862-8121, Ext. 321.

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Fort Lyon—PSYCHIATRIST—WELCOME TO COLORADO. Bd. Cert./Elig. Psychiatrists enjoy mild, dry, clean Colorado climate. Excel. oppty. to work in a prgsv. Neuropsychiatric and gen. Med. Ctr. where you can make contributions in prgms. such as substance abuse, rsdnt., admissions, acute care, and rehab. exit. Sal. commensurate with exper. and trng. plus incentive bonus. Malprac. protection. Lib. frng. bnfts. Quarters avail. Tennis courts, movies, swimming pool, bowling, and horse stables are avail. Contact: Chief of Staff, VA Medical Center, Fort Lyon, CO 81038 (303) 456-1260 Ext. 333. EOE.

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New Haven—YALE UNIV. DEPT. OF PSYCHIATRY SCHOOL OF MEDICINE in conjunction with the Yale Law School, Yale New Haven Hosp., Whiting Forensic Institute and State Criminal Justice System seeks PSYCHIATRIST at PGY-5 level or above starting 7/1/79. Oppty. for exper. in preparing testimony in both crim. and civil proceedings involving multi clin. placements. Prgm. includes research opptys. and didactic courses in Law and Med. Schools. Send CV and names of three refs. to: Dr. Howard Zonana, Dept. of Psychiatry, 152 Connecticut MHC, New Haven, CT 06519. An AA/EOE.

Newington—Posns. for PSYCHIATRISTS in inpt. svc. of Regional Hosp. Multidiscpl. approach. Excel. opptys. for advancement. Convenient beautiful location close to excel. schls. and cult. ctrs. in central Conn. Excel. frng. bnfts. Write Vincenzo Cocilovo, M.D., Superintendent, Cedarcrest Regional Hospital, Newington, CT 06111.

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DISTRICT OF COLUMBIA

EXECUTIVE DIRECTOR—A United Way affiliated agency that provides svcs. to emotionally disturbed chldrn. aged 6-12 yrs. on an annual budget of 1 million dollars seeks a competent MH professional with administrative exper. or trng. to serve as Executive Director. The Executive Director is accountable to the Bd. for ensuring that Bd. policies and directives are implemented in conformity with all legal req's. Specific respons. include the following: (1) Recommend prgms. and budget to the Bd. before implementation. (2) Maintain expenditures within limits of the Bd. approved budget. (3) Hire staff adequate to effectively manage the approved prgms. and ensure the delivery of a high quality svc. (4) Create a work environment in which employees can perform most effectively. (5) Negotiate agency contracts. (6) Alert the Bd. to potential difficulties and recommend a course of action. (7) Act as agency spokesperson to the public and to funding sources. Send resume to: Executive Committee, Hillcrest Children's Ctr., 1325 W St., N.W., Washington, DC 20009.

FLORIDA

The Bd. of Directors of the North Florida MHC, Inc. seeks to fill the posn. of EXECUTIVE DIRECTOR. The Ctr. is a medium sized, free standing CMH prgm. serving a six county rural area in North Fla. The Ctr. is also the recent recipient of a new Initial Operations Grant from DHEW. Operations will include a 1.6 million dollar budget and approx. 90 employees. Applicants must hold at least a masters degree in a core MH discipline and have five yrs. of exper. in a CMH setting. Two yrs. of the five must be in a highly respon. administrative/supervisory setting. Sal. is open and competitive. Please send resume and transcripts to: Chairperson of Search Committee, North Florida Mental Health Center, 302 South Marion St. Bldg. C, Lake City, FL 32055. Applications must be received by Aug. 10, 1979. The North Florida MHC is an AA/EOE.

Lakeland—Prvt., non-profit CMHC has an immed. opening for an addtl. FT, Fla. lic. PSYCHIATRIST to join multi-disciplinary staff in providing full range of outpt. svcs. to chldrn. and adults in crisis intervention, day trtmt., and aftercare prgms. Frng. bnfts. include malprac. insur., generous retirement plan, health and life insur., etc., sal. competitive. Send resume to: W. G. Kremper, Ph.D., Director, PEACE RIVER CENTER FOR PERSONAL DEVELOPMENT, INC., 1745 Highway 17 South, Bartow, FL 33830 (813) 533-2738.

Macclenny—CLINICAL DIRECTOR, Bd. Cert. Psychiatrist. Directs all MH prgms. in a progsv. JCAH accredited state mental hosp. Loc. in a rural commty. 25 mins. from Jacksonville, Fla. Frng. bnfts. include on-ground housing; paid vacation, sick time and retirement; state supplemented group 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—Several recently established psychiatrist posns. are avail. for a new prgsv. MH prgm. in a JCAH accred. state mental hosp. loc. in rural commty. twenty-five mins. west of Jacksonville, Fla. Frng. bnfts. include paid vacation, sick time and retirement; State supplemented group life and health insurance; pleasant working conditions. Sal. range: $28,500-$45,400 depending upon the posn. and applicant's quals. Contact Janos Kurucz, M.D., Clinical Director, Northeast Florida State Hosp., Macclenny, FL 32063. Phone (904) 259-6211. An EOE.

GEORGIA

Psychiatrist looking for an ASSOCIATE for full or part time practice, both inpt. and outpt. care, with a CMHC using multidisciplinary team approach. Catchment area is predominantly rural with 140,000 pop., 1½ hrs. from the Gulf of Mexico and midst world famous lake bass fishing. Sal. range: full time $60-80,000. Contact M. G. Middleton, M.D., P.O. Box 1018, Thomasville, GA 31792. Phone (912) 226-7070.

Savannah—CLINICAL PSYCHIATRIST—The Chatham/Effingham Compre. MHC provides a wide variety of prgms. which offer professional challenges and opptys. for professional growth. Historic Savannah, a city of approx. 200,000, loc. on the Atlantic Coast, is famous for it's beauty, livability and amenable climate. Excel. Bnfts.: Free Malprac. and Admin. Liability Insur., Lib. Sick and Annual Leave Prgm., Excel. Retirement Prgm., Grp. Term Life and Health Insur. Sal.: Up to $45,306 Ann., dep. upon quals. with periodic increases. Call or write: Ms. Frankie Hallman, P.O. Box 14299, Savannah, GA 31406, (912) 356-2432. An EOE.

ILLINOIS

Four well-trained exp. bd. cert. psychiatrists and one equally well-trained clinical Ph.D. psychologist are looking for a PSYCHIATRIST to join us in our busy Midwestern practice. We have a friendly commty. with a good schl. system and many cult. and recreat. advantages incl. two Universities. We will provide an exc. sal., books, trips, insurance, dues, and many other bnfts. We are growing and anticipating adding two clinical Ph.D. psychols. and one or two social workers in the next year. We are all members of a med. schl. faculty and there is an oppty. to teach med. students if desired. We are looking for a psychiatrist with good trng. who is bd. cert. or who intends to become bd. cert. Applics. must be exp. in psychotherapy, chemotherapy, inpt. and outpt. psychiatric trtmt. Additional trng. in other therapies, forensic psychiat., agency consul., etc. are desirable. We're proud of our group and we'll provide an exc. oppty. for the right person. Reply Box P-876, *Psychiatric News*.

MEDICAL DIRECTOR PSYCHIATRIST—The Family Svc. & CMHC for McHenry County is seeking an experienced, commty.-oriented psychiatrist to become MEDICAL DIRECTOR of our rapidly expanding MH prgms. McHenry County has been approved for fed. funding from the **National Institute of MH** to develop a compre. system of MH svcs. in McHenry County. This funding is projected to begin July 1, 1979. Respons. of the Medical Director include overall med. respon. for pts. of the Ctr.; direct psychiatric svcs. incldg. diag. evals., chemotherapeutic assessments, hosp. consuls., crisis intervention, and consul. with other clin. staff; opptys. avail. for consul. and education activities in the commty. as well. Primary duties will also include the dvlpmt. of local inpt. psychiatric beds within McHenry County. The Ctr. is a multi-prgm. CMHC utilizing an interdiscpl. team approach in the delivery of svcs. to the rsdnts. of McHenry County, a suburban county in Northern Ill. of 140,000 pop., approx. 55 miles northwest of Chicago. M.D. Degree, licensed to practice medicine in Ill. req'd. Applicant must be Bd. Cert. in Psychiatry. POSN. IS FULL-TIME. Excel. frng. bnfts. in a rapidly growing, expanding suburban commty. Sal. competitive and commensurate with exper. Send complete resume, refs., and sal. reqs. to: J. Scott Campbell, ACSW, Associate Director, Family Service & CMHC, 3409 W. Waukegan Rd., McHenry, IL 60050, (815) 385-6400. The Ctr. is an EO/AAE.

Ph.D. CLINICAL PSYCHOLOGIST to do clin. testing, participate in research on eval. of psychotherapy, teach behavioral science to med. students. Must have research, tchng. and clin. exper. E.O.E. Reply Box P-948, *Psychiatric News*.

INDIANA

THE INDIANA STATE HOSPITALS, at various locations throughout the State, have current and exceptional openings for PSYCHIATRISTS of most exper. levels. The sal. schedule now ranges from $37,726 to $50,544, with incremental increases. Frng. bnfts. are broad and generous. An adjunct prvt. practice is poss. and acad. affiliations can be discussed. While the Hospitals primarily seek full-time Physicians, part-time associations may be poss. Please reply, with a copy of the CV to: FORREST ASSOCIATES, P.O. Box 472, Murray, KY 42071 or call collect: (502) 753-9772. Forrest is retained in support of the Hospitals.

Large VA psychiatric hosp. in central Indiana with growing med. prgms. seeking PSYCHIATRISTS, INTERNAL MEDICINE AND GENERAL PRACTITIONERS. Excel. bnfts. under Civil Svc., living quarters on grounds, sal. commensurate with quals. Foreign degrees acceptable. Loc. in growing commty. within 1-3 hrs. of major metro. areas. Inquiries to Chief of Staff, VA Medical Center, Marion, IN 46952. EEO employer.

THE OTIS R. BOWEN CTR., a new and beautiful Compre. CMHC serving 5 counties, loc. in WARSAW, IN. (less than 1 hr. from Fort Wayne and South Bend, 3 hrs. from Indianapolis, and 3 hrs. from Chicago), a summer resort area containing over 100 lakes in the County, numerous denominational churches, golf courses, recreat. facils., tennis, boating, and fine cuisine has immed. need to fill the following open posns.: 1 STAFF CHILD THERAPIST (Min. Sal. $15,000 p/a); 2 STAFF SOCIAL WORKERS (Min. Sal. $15,000 p/a); 2 STAFF THERAPISTS (Min. Sal. $15,000 p/a); 1 CLINICAL PSYCHOLOGIST (Judicial Aid Prgm.) (Min. Sal. $16,000 p/a); 1 CONSULTATION & EDUCATION SPECIALIST (Min. Sal. $13,000 p/a); 1 VIDEO THERAPIST (Min. Sal. $15,000 p/a); 1 HALF-WAY HOUSE COORDINATOR (Min. Sal. $16,000 p/a); 1 M.D., BD. ELIGIBILITY OR CERTIFICATION IN PSYCHIATRY (Min. Sal. $45,000 p/a). All posns. require quals to be licensed or cert. in IN.; Med. lic.; ACSW certification, certification by State Bd. of Examiners in Psychology or elig. (Ph.D); and exper. and/or trng. relevant to the open posn. Outstanding frng. bnfts. All sals. nego. EO/AAE M/F. An excel. career oppty. to serve a MHC loc. in the heart of the "Golden Triangle" of Industry. Req'd.: Resume and request for application. Please contact: Mrs. Tammy Light, Coord., Personnel Services, Otis R. Bowen Center, 850 N. Harrison St., P.O. Box 497, Warsaw, IN 46580. Ph: (219) 267-7169, Ext. 243.

Jasper—The Southern Hills MHC, an estab. Community Prgm., in this city, has a current opening for a PSYCHIATRIST, to supervise Inpt., Partial Hospitalization and related activities. Entry sals. nego. from $45,000 upwards dep. on quals. and exper. Candidates should have commty. exper. and motivation for practice in a non-urban setting which provides professional satisfaction and an attractive life-style, plus a moderate cost of living. An adjunct prvt. practice can be discussed. Please respond with a copy of the CV to: FORREST ASSOCIATES, P.O. Box 472, Murray, KY 42071 or call collect (502) 753-9772. Forrest is retained in support of the Ctr.

South Bend—There is a current opening for a SENIOR STAFF PSYCHIATRIST in a large and well-estab. Community Prgm. loc. in this city. The successful candidate will practice under the direction of the Medical Director—Psychiatrist and be involved in Diagnostic, Trtmt., and Consultative svcs. Entry sal. is nego. in the $46,000-$52,000 range (dep. upon individual quals. and exper.) plus excel. frng. bnfts. An acad. affiliation is poss. as well as an adjunct practice. Exper. in a commty. setting and motivation for practice with a multi-discpl. staff are important. Please respond with a copy of the CV to: FORREST ASSOCIATES, P.O. Box 472, Murray, KY 42071 or call collect (502) 753-9772. Forrest is retained in support of the Ctr.

IOWA

Clarinda—WANTED: PSYCHIATRISTS with or without subspecialty int. Sal. nego. from $36,400 to $48,880. Frng. bnfts. and deferred compensation avail. Info. concerning institution and commty. avail. on request. Contact: Supt. Mental Health Institute, Box 338, Clarinda, IA 51632, or call collect (712) 542-2161. EO/AAE.

Des Moines—Bd. cert. or elig. PSYCHIATRIST for FT posn. on 54-bed acute care psychiatric unit. Primary respons. will involve supervision and tchng. med. students and rsdnts. rotating through the inpt. svc. Posn. will carry clin. faculty appt. with med. college. Compensation is from $50-55,000 per annum with excel. frng. bnfts. incldg. 4 weeks paid vacation with up to 2 addtl. weeks to attend expense paid CME activities. Hosp. loc. in large prgsv. metro area with abundant recreat. and cult. opptys. incldg. newly completed civic ctr., art and science ctr., several colleges and univs. and nearby lakes. For further info. call collect or write Greg Rohs, M.D., Dept. of Psychiatry, Broadlawns Medical Center, Des Moines, IA 50314. (515) 282-2450. EOE.

Iowa City—FACULTY POSNS.: ASSOCIATE, INSTRUCTOR OR ASSISTANT PROFESSOR, requires M.D. and full psychiatric trng., must have research commitment as well as tchng. interests. Contact George Winokur, M.D., Head, Dept. of Psychiatry, Univ. of Iowa College of Medicine, Iowa City, IA 52242. EO/AAE.

Knoxville—PSYCHIATRIST-EXCEL. PROFESSIONAL OPPTY., Large Neuropsychiatric Hosp., immed. vacancies for Bd. Cert./Elig. Psychiatrist. Strong support staff and facils. Enjoy bnfts. of 30 days paid vacation, 15 days paid sick leave (accumulating) per annum; lib. retirement plan; health and life insur.; malprac. shelter; moving expenses paid; HIGHLY COMPETITIVE SAL. to $50,000 with quals., lic. in any state. Contact: Chief of Psychiatry, VA Medical Center, Knoxville, IA 50138. Phone: (515) 842-3101, ext. 216. EOE.

KANSAS

EXECUTIVE DIRECTOR of a Compre. CMHC with four affiliates serving 10 counties. Master's degree or above in MH discipline req'd. and demonstrative administrative ability plus five yrs. exper. in MH-three of which shall be administrative in nature. Loc. in an attractive univ. commty. of over 50,000. Deadline for re-

ceiving applications is 1 Sept. 1979. Apply to: Chairperson, Search Committee, Pawnee Comprehensive MHC, 215 Southwind Pl., Manhattan, KS 66502. Pawnee CMHC is an EOE.

Independence—PSYCHIATRIST, Bd. Cert. or Elig. Sal. $45,000 to $50,000. Primary duties include serving as Medical/Clin. Director of outpt. affiliate and alcohol-drug prgm. as well as direct clin. work. Both units are loc. in Independence. Independence has excel. recreat. prgms. and schls., incldg. a junior college. 2 excel. fishing and recreat. lakes within 5 miles. Good hunting. Compatible staff and good frng. bnfts. Write or call collect to John P. White, D.O., Medical Director, Psychiatric In-patient Unit, Mt. Carmel Medical Center, Pittsburg, KS 66762. Ph. (316) 232-1050. EOE.

KENTUCKY

PSYCHIATRIST—Compre. MHC in attractive semi-rural area, 45 miles from Louisville, seeks a psychiatrist interested in CMH to work in inpt. and outpt. settings. Ability to work with empirically oriented, multidiscipl. staff desirable. Sal. range competitive, plus poss. prvt. prac. option. Send vitae to: J. W. Osbourne, MSSW, Executive Director, North Central Comprehensive Care Center, 907 N. Dixie, Elizabethtown, KY 42701, phone (502) 769-1304.

PSYCHIATRIST—F.T., Bd.-cert. or Bd. elig. to participate as Staff Psychiatrist in prgsv. CMH-MR prgm. in beautiful Appalachia, S.E. Kentucky. Posn. avail. immed. Advancement to posn. of Medical Director potential. Sal. competitive, dep. on exper. Generous frng. bnfts. incldg. retirement, vacation, sick leave, professional conference fees and moving expenses. Real oppty. to practice commty. psychiatry. Agency JCAH Accredited. Contact: Ralph Lipps, Reg. Personnel Mgm., Cumberland River CCC, P.O. Box 568, Corbin, KY 40701, or phone (606) 528-7010.

Hopkinsville—STAFF PSYCHIATRIST opngs. in 450-bed JCAH accred. psychiatric hosp. EXC. relationship with CMHC, outstdg. frng. bnfts. with univ. affil. poss. Ky. Lic. req'd., completion of 3 yrs. apprvd. rsdncy. Sal. $37,641 to $45,861, higher sal. poss. according to exper. and Cert. with poss. of addtl. income by PT employment for other agencies. Please write or call Calvin N. Turns, Chief of Staff, Western State Hospital, Hopkinsville, KY 42240. Ph.: (502) 886-4431. An EOE M/F/H.

Lexington—CHILD PSYCHIATRIST, Full-time faculty posn., Dept. of Psychiatry, Univ. of Kentucky. The Div. of Child Psychiatry operates a busy outpt. clinic, pediatric liaison Child Fellowship and Gen. Psychiatry Resident supervision along with med. student tchng. Clin. research opptys. Oppty. to do commty. work, urban and rural. Sal. and bnfts. competitive. Lexington is in the heart of Bluegrass Country and an hrs. drive from Appalachia. Small city living with many big city advantages, Lexington has been named one of the 20 most desirable commtys. in which to live in the U.S. by National Geographic. Contact Robert G. Aug, M.D., Dept. of Psychiatry, Univ. of Kentucky Medical Center, Lexington, KY 40536, Ph: (606) 233-5929.

Lexington—CHILD PSYCHIATRY FELLOWSHIP avail. at the Univ. of Kentucky Med. Ctr. in the heart of Bluegrass Country. Dynamic orientation with excel. oppty. for lrng. and growing in areas of clin., acad. and research child psychiatry. Enthusiastic, multidisciplinary faculty for indiv. clin. supervisory exper., and didactic prgm. geared to meet indiv. career goals. Inpt. exper. avail. in addition to a variety of CMH care facils. Ample oppty. for tchng. exper. Lexington has been named one of the 20 most desirable commtys. in which to live in the U.S. by National Geographic. Contact Robert G. Aug, M.D., Dept. of Psychiatry, Univ. of Kentucky Medical Center, Lexington, KY 40536, Ph: (606) 233-5929.

Lexington—PSYCHIATRIST III—Practice in Lexington in a prgsv. JCAH accred. psychiat. hosp. with 300 pt. pop. Local Univ. Med. Ctr. and CMHC systems avail. for affil. Requirements include Ky. license and 3 yrs. apprvd. rsdncy. Usual work week 37.5 hrs. Excel. frng. bnfts. Sal. $37,641-$41,599. Higher sal. commensurate with exper. and Cert. Addtl. income from PT empl. with local CMHC and other agencies avail. Lex. has been named one of 20 most desirable commtys. in which to live in US by National Geographic. Direct Vitaes to: Daniel Nahum, M.D., Chief of Staff, Eastern State Hospital, 627 West Fourth St., Lexington, KY 40508. Ph. (606) 255-1431, ext. 256.

Louisville—The Dept. of Psychiatry and Behavioral Sciences has an opening for a PSYCHIATRIST to serve as Assistant Director of Outpt. Svcs. in a prvt. hosp. setting. Duties include direct pt. svc. and research, supervising of rsdnts., and tchng. med. students. Applicants must be Bd. Elig. or Bd. Cert. Exper. in outpt. psychiatry and tchng. are desirable. Please circulate this notice among members of your dept. and your colleagues. Candidates should submit a CV to: John J. Schwab, M.D., Professor and Chairman, Dept. of Psychiatry and Behavioral Sciences, School of Medicine, Univ. of Louisville, P.O. Box 35260, Louisville, KY 40232, The Univ. of Louisville is an AA/EEO.

MAINE

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. Aroostook 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.

Maine: If you are coming or are interested we would be glad to help: Maine Psychiatric Association, Pres. Juergen Homann, M.D., EMMC, 489 State St., Bangor, ME 04401; (207) 947-3711, Ext. 421.

MARYLAND

ADULT AND CHILD PSYCHIATRIST for expanding multidisciplinary group practice doing inpt. and outpt. tchng. and child., adol., adult and family, individual and grp. with both major med. ctr. and psychiatric hosp. affiliations. Excel. professional and financial opptys. Reply Box P-942, *Psychiatric News*.

CHILD PSYCHIATRIST needed. New Clinic forming in Western Montgomery County. Call Dr. Gary Brecher (301) 424-4710.

CLINICAL DIRECTOR—The Patuxent Institution, a major and internationally known rehab. ctr. for emotionally disturbed offenders, loc. between Washington, D.C. and Baltimore, Md., has an opening for a full-time Clinical Director and for a half-time STAFF PSYCHIATRIST. Administrative skills, exper. in forensic psychiatry and interest in research and ethical issues pertaining to the care of incarcerated pops. are desirable. Affiliation with Univ. of Maryland and Johns Hopkins Univ. Contact: Werner A. Kohlmeyer, M.D., Patuxent Institution, Jessup, MD 20794. (301) 799-3400. EOE.

PSYCHIATRIST for staff posn. at small, prvt. psychiatric facil. in western Md. with multidiscpl. staff incldg. six psychiatrists (two child psychiatrists) with Eval., Rsdnt. Pt. (Adult and Adol.), Partial Care, Outpt., Satellite and Commty. Consul. and Education Prgms. Contact person: Paul Rodenhauser, M.D., Director of Professional Services, Brook Lane Psychiatric Center, P.O. Box 1945, Hagerstown, MD 21740.

Baltimore—OPENING FOR CHILD PSYCHAITRIST—The Div. of Child and Adol. Psychiatry at the UNIV. OF MARYLAND SCHOOL OF MEDICINE has avail. an opening for a full time faculty posn. to fill the posn. of **Training Director.** The Univ. of Maryland is an EO/AAE. Interested individuals should send letter of application and CV to: Richard M. Sarles, M.D., Acting Director, Division of Child and Adolescent Psychiatry, Dept. of Psychiatry, Univ. of Maryland School of Medicine, Baltimore, MD 21201.

MASSACHUSETTS

CLINICAL DIRECTOR, Child Inpt. Psychiatric Unit-Bd. elig. child psychiatrist to develop and manage a multidisciplinary child inpt. unit as part of a CMH system. Sal. and academic appt. nego. Address inquiries to Meg Manderson, Coordinator of Children's Services, Dept. of Psychiatry, UNIV. of MASS. MEDICAL CTR., 55 Lake Ave. North, Worcester, MA 01605. An AA/EOE.

LIAISON CONSULTATION PSYCHIATRIST—Full time posn. avail. for a bd. elig. Psychiatrist. Duties include tchng. and supervision of med. students and psychiatric rsdnts. as well as direct patient care. Sal. and academic appt. nego. Address all inquiries to Stanley Walzer, M.D., Professor and Chairman, Dept. of Psychiatry, UNIV. of MASS. MEDICAL CTR., 55 Lake Ave. North, Worcester, MA 01605. An AA/EOE.

PSYCHIATRISTS WANTED for dynamic commty. and acute inpt. programs. Opptys. for varied experiences, clinical consultation and teaching. Openings in outpt. clinic adult and children's services; Adult Day Treatment Program; Acute inpt. service. Salaries nego. Contact Sylvester R. Sheridan, M.D., Tri-City Area Medical Director, 15 Ferry St., Malden, MA 02148. Tel. 617-321-1060. An EOE.

Boston—PSYCHIATRIST: Consul.-liaison posn. half time (20 hrs.) in a modern 284-bed prvt. rehab. hosp. that has excel. working conditions and well-developed rehab., lab., and support svcs. Opptys. avail. for tchng. and research; we are academically affiliated and participate in med. schl. tchng. Competitive sal. and excel. frng. bnfts.; free parking; convenient to public transporation and major commuter arteries. Oppty. for prvt. prac. on hosp. premises. Applicants should have trng. and exper. in consul.-liaison psychiatry and be able to meet conditions for med. schl. acad. appt. Send resume to: Richard J. Weintraub, M.D., Acting Director of Psychiatry, Mass. Rehabilitation Hosp., 125 Nashua St., Boston, MA 02114. Tel. (617) 523-1818. **A prvt. nongovernmental hosp. for extensive rehab. care. An EOE M/F.**

Boston—PSYCHIATRIST for part time (4-12 hrs.) consul.-liaison posn. in a modern 284-bed rehab. hosp. that has academic affils. and excel. working conditions; convenient to public transportation and major commuter arteries. Sal. competitive and based on exper. Advanced Fellows can be considered. Send resume to: Richard J. Weintraub, M.D., Acting Director of Psychiatry, Mass. Rehabilitation Hosp., 125 Nashua St., Boston, MA 02114. Tel: (617) 523-1818. **A prvt. non-governmental hosp. for extensive rehab. care. An EOE M/F.**

Boston—PSYCHIATRISTS to work as moonlighters on nights, weekends and holidays in a busy gen. medical surgical hosp. Send resumes to Box P-951, *Psychiatric News*.

Fitchburg—STAFF PSYCHIATRIST—Half time salaried posn. in 20-bed inpt. unit in regional referral ctr. Serve as team leader for ten pts. and staff supervisor. Also excel. oppty. for prvt. prac. and univ. tchng. appt. if desired. Lovely area one hr. from Boston. Call or write Philip J. Sandler, M.D., Burbank Hospital, Fitchburg, MA 01420, Phone (617) 345-4311.

Lynn—The Greater Lynn CMHC, a compre. CMHC loc. 30 mins. north of Boston, has vacancies for STAFF psychiatrists to provide svcs. to its 24 bed Inpt. Unit, its Outpt. components and the Emerg. Svc. Team. Opptys. exist on part-time or full-time basis. Candidates should possess an exposure to and exper. in commty. psychiatry and be Bd. elig. or Cert. Sal. is commensurate with exper. and generous frng. bnfts. are provided. Submit CV in confidence to Rita Lash, Employee Relations, Union Hospital, 500 Lynnfield St., Lynn, MA 01904. An EO/AAE.

Westfield—PSYCHIATRIST: Bd. Cert. or Bd. Elig. at rapidly-growing, dynam., full-svc., commty. oriented DMH clinic loc. in the Berkshire foothills, easily accessible to Boston and NY and near the Amherst-Northampton 5 coll. area. FT and PT posns. avail. in Adult Svcs. & Day Trtmt. Respons. incl. dvlpmt. of new prgms., dir. trtmt., consul., tchng. & supervision. Contact Carl Saviano, M.D., Med. Dir., Westfield Area MH Clinic, 20 Broad St., Westfield, MA 01085. 413-568-1421.

MICHIGAN

Detroit—RESIDENTS IN PSYCHIATRY—Newly approved 4 yr. Psychiatric Trng. Prgm. at Henry Ford Hosp., a prvt. 1,100 bed gen. hosp., major affiliation with Univ. of Michigan. Prgm. offers full range trng. with Inpt. Unit 34 beds, OPD over 20,000 visits per yr., active Consultation Svc., Nat'l. Sleep Lab., Affective Disorders Prgm., Nat'l. recognized Chronic Pain and Epilepsy Prgms. Posns. avail. at all levels. Lib. stipends and frng. bnfts., life insur., sick leave, etc. Housing avail. Apply to: Darin de Lorenzo, Ph.D., M.D., Dir. Res. Educ., Dept. Psychiatry, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, MI 48202.

Flint—ASSOC. PSYCHIATRIST WANTED AS A FUTURE PARTNER IN MY MOST SUCCESSFUL O.P.C. BD. ELIG. OR CERT. A PLUS. 50-50 HOSP. AND OFFICE PRAC. 12 MOS. OF A COOPERATE EFFORT WILL PRODUCE A FULL PARTNERSHIP. FLINT IS A GREAT COMMTY. TO RAISE A FAMILY AND ENJOY ALL OUTDOOR ACTIVITIES, 450,000 AREA POP. THIS 12 MO. O.P.C. OPPTY. INCLUDES A FIRST YEARS SAL. IN EXCESS OF $65,000 PLUS ALL FRNG. BNFTS. SEND CV TO: GEORGE WM. WRIGHT, M.D., P.O. BOX 7179, FLINT, MI 48507 OR CALL ME COLLECT 1-313-239-7691 FOR IMMED. RESULTS.

Lansing—TWO PSYCHIATRY POSNS. are avail. with CMH-(1) EMERGENCY SVCS.—to join a multidiscpl. staff providing court screening, diag., and emerg. svcs. The individual selected for this posn. will perform psychiatric evals. on pts., be respon. for some involuntary certifications, and will perform other functions related to emerg. svcs. and court screening. Hrs. will generally be **day shift** with very limited on call reqs. (2) OUTPATIENT—to join a multi-discpl. staff involved in providing outpt. and aftercare psychiatric svcs. This individual will also assist other psychiatrists employed by the agency in planning and dvlpmt. of CMH psychiatric svcs. Major respons. include consul. with staff and direct trtmt. of outpt. and aftercare clients. Contact Personnel Office, Tri-County Community Mental Health Board, 407 W. Greenlawn, Lansing, MI 48910, 517-374-8000, ext. 273.

Newberry—PSYCHIATRIST to join us on staff of small (census approx. 180) State MH Inpt. Facility. Loc. in a rural setting in Michigan's beautiful Upper Peninsula. Sal. $50,404-$55,561 dep. upon exper. and quals. Excel. Civil Service frng. bnft. pkg. Limited housing avail. at moderate cost. Must be able to obtain permanent Mi. lic. Contact Steven A. Myers, M.D., Chief of Clinical Affairs, Newberry Regional MHC, Newberry, MI 49868.

MINNESOTA

CHILD PSYCHIATRIST FT to help organize and deliver child psych. svcs. for dvlpng. MH prgm. of 22-yr. old multi-spec. grp. (HMO) serving 125,000 in the Twin Cities. 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.

Minneapolis—PSYCHIATRISTS (2, FT) for further expansion of young MH staff in well established multispec. grp. (HMO) serving 125,000 in the Twin Cities. One posn. involves coordinating inpt. svcs. although some outpt. work is included. The clin. activity of the other adult psychiatric posn. involves nearly exclusively outpt. work. Both posns. can have consultation-liaison as well as supervisory functions and require at least bd. eligibility and proficiency in dynamic psychiatry and psychopharmacology. Sal. and frng. bnfts. are excel. 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 or call collect (612) 371-1661.

MISSISSIPPI

Vicksburg—Full-time STAFF PSYCHIATRIST for growing CMHC. Two outpt. clinics in two-county, semi-rural area, both 50 miles from Jackson, state capitol and site of univ. med. facils. Need team-oriented person interested primarily in direct pt. svc. Provide inpt. trtmt. at up to three local hosps. and outpt. care. Total ctr. caseload 800. Few administrative respons. Excel. back-up from rest of clin. staff. Must be bd. elig., able to be licensed in MS, and live within catchment area. Prvt. pract. permitted. Have no full-time psychiatrists on staff and none in catchment area. Sal. $40,000 to $60,000, dep. on quals. and exper. Excel. frngs. Send vita to: Director, Warren-Yazoo Mental Health Service, P.O. Box 1418, Vicksburg, MS 39180.

MISSOURI

Bd. Cert. or elig. PSYCHIATRIST, Correctional Institution Hosp. setting at U.S. Bureau of Prisons, Medical Ctr. for Fed. Prisoners 300 bed psychiatric svcs. Office of Personnel Management bnfts. and retirement-Sal. up to $47,500 dep. on quals. Excel. schls. and recreation area. U.S. citizenship. May be licensed in any state, Territory of the U.S. or District of Columbia. Pop. over 100,000. Contact Personnel Officer, U.S. Medical Center for Federal Prisoners, Springfield, MO 65802. Ph. (417) 862-7041. Qualified applicants will receive consideration for appt. without regard to race, creed, color, national origin, sex, political affil., or any other nonmerit factor.

STAFF PSYCHIATRIST: Immed. opening to work with bd. cert. medical director and experienced staff psychiatrist. Compre. CMHC serving 5-county area with pop. of approx. 100,000. CMHC has 51 staff and is dept. of new 252-bed regional med. ctr.; compre. med. specialties avail. Scenic univ. city of approx. 46,000, 100 miles south of St. Louis. Sal. up to $60,000. Bnfts. include 1 week CME, professional fees, med. insur., 3 weeks' vacation. Extra bnfts. for bd. certification. An EOE. Inquire: Morty Lebedun, Director, St. Francis Mental Health Center, 211 St. Francis Dr., Cape Girardeau, MO 63701 (314) 334-9631.

Kansas City—FULL-TIME posns. for PSYCHIATRISTS for a compre. MH facility to provide and supervise clin. svcs. to adult Inpt. and Outpt. and Alcohol and Drug Svcs. Consul. and liaison svc. in the Univ. of Missouri-Kansas City School of Medicine tchng. hosp.; tchng. of med. students and psychiatric rsdnts. and grad. students in MH related fields. Faculty appt. with UMKC-School of Medicine. Sal. Range: $38,000-$55,000. Acad. rank and sal. depend on exper. and quals. Resume to: Charles B. Wilkinson, M.D., Executive Director, Greater Kansas City MH Foundation, 600 East 22nd St., Kansas City, MO 64108.

St. Joseph—PSYCHIATRIST. Requirements: Completion 3 yrs. rsdncy. or few years experience with psychiatric patients. Missouri license or eligibility for temp. license required. 750 bed psychiat. hosp., geog. unit system. Exc. retire., sick and vac. bnfts. Sal. $40,000-$50,000 depending on quals. and exp. $2,200 differential for specialty bd., addit. bnfts. for on-call duties. Exc. school system, friendly commty., 30 mins. K.C. Int. Airport. Apply Nicholas Bartulica, M.D., Supt., Box 263, St. Joseph, MO 64502. EEO/AA.

St. Louis—PSYCHIATRIC RESIDENCY POSITIONS: first, second, and third yrs. Dept. of Psychiatry St. Louis Univ. Medical Ctr. is currently accepting applications for all levels of rsdncy. trng. Possibility of starting on 1/1/80 or 7/1/80. A broadly based, stimulating, eclectic prgm., with special effectiveness in tchng. consul./liaison psychiatry, dynamic psychotherapy, and milieu therapy. Contact: Charles K. Hofling, M.D., Prof./Dir. Res. Trng. Prgm., Dept. of Psychiatry, St. Louis University, 1221 S. Grand Blvd., St. Louis, MO 63104.

Springfield—CHILD PSYCHIATRIST to work in broad range of consultative and trtmt. activities. GENERAL PSYCHIATRIST posn. needs person with a desire to work in area of forensic and inpt. svcs. Diversified clin. staff of 30, city of 191,000 in Ozarks Lake Country. Sal. $45,000-$55,000 range, plus exceptional frng. Send resume to: P.O. Box 1611, SSS, Springfield, MO 65805.

MONTANA

Helena and Butte—Bd. Cert. or Bd. Elig. (ABPN) PSYCHIATRIST to join a staff of 4 psychiatrists in prgsv. rural CMHC with a high quality multidiscpl. staff in beautiful scenic mountainous area with hunting, fishing, skiing, and other outdoor recreation. Posn. involves providing psychiatric svcs. to all phases of estab. prgms. with limited travel involved. Sal. range mid $40,000's dep. on exper. Excel. frng. bnfts. incldg. paid health insur., paid educational leave, plus help with relocation expense. Send resume to: Brian Davis, M.D., Clinical Director, 512 Logan, Helena, MT 59601 or call collect to: C. Joe Harrington, MSW, Executive Director—(406) 442-0310.

NEBRASKA

Grand Island—PSYCHIATRIST VACANCY: Mid-Nebraska CMHC has an opening for a bd.-cert. or bd.-elig. psychiatrist to serve in the MNCMHC svc. network. Current licensure or eligibility for licensing in the State of NB. is req'd. Sal. is quite competitive. Opptys. for prvt. prac. can probably be developed. Mid-Nebraska CMHC is loc. in a commty. of 35,000 people. Outdoor recreat. activities are avail., as well as ample cult. expers. Competitive frng. bnfts. include mal-prac. insur. EOE. Apply: Mr. D. H. Smith, Mid-Nebraska CMHC, Box 1763, Grand Island, NB 68801.

Omaha—ASSISTANT PROFESSOR, ASSOCIATE PROFESSOR or PROFESSOR interested in short-term trtmt. of adult inpts. Duties include tchng., clin. supervision, and research. Sals. comparable. Med. svc. plan permits sal. supplementation through prvt. prac. Starting date July 1, 1980, or before. Send CV and bibliography (publications not essential at assistant professor 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. An EOE M/F/H.

NEW HAMPSHIRE

Concord—PSYCHIATRISTS—New Hampshire Hosp. is seeking two psychiatrists, either A.P.A. diplomate or elig., for senior staff psychiatric posns. in this JCAH accred. hosp. One posn. is in gen. adult psychiatry and the other is in Forensic psychiatry. This is the only public psychiatric hosp. in N.H., consisting of 800 beds, organized on a geographic unit system, plus specialty units for Chldrn., Adols., Forensic, Geriatric, and Medical/Surgical. Professional Staff includes 23 psychiatrists/physicians, 28 psychologists, 42 social workers, 40 medical consultants, and 134 R.N.s. The facil. is situated in Concord, pop. 35,000. There are excel. educational, social and recreat. facils. Only an hr. or less from mtns. (skiing), lakes, Boston,

and the Atlantic Ocean. Permanent N.H. Med. Lic. req'd. Sal. to $40,630, dep. on education and exper., with poss. faculty appt. at Dartmouth Univ. Med. Schl. Inexpensive housing for applicant and family avail., plus perquisites of ample leave for illness, vacation, and education. Excel. retirement bnfts. at extremely low cost, plus death bnft. at one yr's. full sal. without cost. Free med. insur. Call collect Stephen N. Harnish, M.D., (603) 271-2414, or write, with CV and refs., to N.H. Hospital, 105 Pleasant St., Concord, NH 03301. An EOE.

NEW JERSEY

Bd. Elig. and Bd. Cert. PSYCHIATRISTS with a N.J. lic. wanted for a public psychiatric hosp. in the N.Y. metro. area. The hosp. is fully approved by the JCAH and has many innovative and interesting trtmt. prgms. Sal. $34,000-$46,000. Good frng. bnfts. avail. Please send resume with application. A personal interview will be necessary. Send inquiries to: Dr. Felix A. Ucko, Medical Director, Essex County Hospital, P.O. Box 500, Cedar Grove, N.J. 07009.

NEW MEXICO

Albuquerque—CHILD PSYCHIATRIST for Director, New Mexico Children's Psychiatric Ctr., and senior faculty member, Div. of Child Psychiatry, UNM Schl. of Medicine. Must be cert, or elig. for certification in child psychiatry. Exper. essential in working therapeutically in inpt. settings with severely disturbed psychotic chldrn. up to fourteen yrs. of age. Administrative exper./ability to integrate developmentally oriented psychotherapy, milieu and psychopharmacologic trtmt. prgm. with educ. and sensory-motor remedial prgms. req'd. Interests in research/tchng. important. Sal. nego. based on quals. Address inquiries to: Irving N. Berlin, M.D., Director, Division of Child Psychiatry, UNM School of Medicine, Albuquerque, NM 87131. AA/EOE.

NEW YORK CITY & AREA

The Pediatric Psychiatry Svc. at Memorial Sloan-Kettering Cancer Ctr. in N.Y.C. in association with the Dept. of Psychiatry at Cornell Univ. College of Medicine is offering a FELLOWSHIP in consul.-liaison child psychiatry. A developmental framework is used to understand and teach psychological impact of life-threatening illness in the med. setting, utilizing cancer as a singular disease which occurs at all ages of the life cycle. Clin. research activities are fostered in the study of adaptation to illness and psychologic correlates. The fellowship is avail. to second yr. trainees and those who have completed child psychiatry trng. The prgm. offers exper. in pediatric liaison psychiatry, work with chldrn. and adols. with cancer, their parents and pediatric oncology staff. Addtl. exper. in long term supervised psychotherapy in a child psychiatry setting will also be provided. Applications should be directed to Dr. Yehuda Nir, Director, Pediatric Psychiatry, Memorial Sloan-Kettering Cancer Ctr., 1275 York Ave., New York, NY 10021. Phone (212) 794-8237.

PSYCHIATRIST POSN.: Fellowship in psychoanalytic trng. combined with ideal post-rsdncy. clin. prgm. Intensive super., practical courses. Also: prgms. in grp., family, child therapy, CMH consul., social rehab., research. Sal. dep. on number of clin. svc. hrs. Contact: Henry G. Grand, M.D., Director of Psychiatry, Postgraduate Center for Mental Health, 124 E. 28th St., New York, NY 10016.

PSYCHIATRISTS, full-time or part-time, all levels. 350-bed tchng. hosp. is presently recruiting Psychiatrists for new 25-bed inpt. unit and MH Clinic serving adults and chldrn. Join us in our new dept. in a challenging, innovative prgm. with opptys. for professional advancement and input. Send CV to: Renzo S. Basili, M.D., Dir. of Psychiatric Services, St. John's Episcopal Hosp., 480 Herkimer St., Brooklyn, NY 11213.EOE.

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 oriented trtmt. prgms. for adults and children. Full or part-time. Diagnosis, trtmt. and supervision. N.Y.S. Lic. req. Write: North Nassau Mental Health Center, 1691 Northern Blvd., Manhasset, NY 11030 (516) MA7-7535.

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.

Port Chester—STAFF PSYCHIATRIST-Lic., Prgm. of intensive psychotherapy; dynamic therapeutic setting; oppty. to learn and advance; good sal. and prvt. prac. privileges; tchng. appointment avail. if qualified. Write: Alexander Gralnick, M.D., High Point Hospital, Port Chester, NY 10573 or call (914) 939-4420.

NEW YORK STATE

PSYCHIATRISTS—to work in a children's psychiatric facil. with med. schl. affil. and faculty appts. possible. We are a N.Y.S. facil. delivering compre. inpt. and outpt. svcs. to chldrn. and adols. in the Mid-Hudson Region. Immed. vacancies in the Counties of Westchester, Rockland, Orange and Sullivan. Child psychiatric trng. or exper. preferred. Sal. $40,230 to $47,833, dep. upon quals., with generous N.Y.S. Civil Svc. frng. bnfts. Resume to: Personnel Officer, Rockland Children's Psychiatric Ctr., Orangeburg, NY 10962, or phone collect: (914) 359-7400, Ext. 2829. AAE.

Albany—PSYCHIATRIST, FAMILY PRACTITIONER, OR INTERNIST needed to participate in the design and implementation of inpt. and outpt. geriatric prgms. for a nine county region. Good collaborative working relationships with local providers already in place—with unified svcs. and staff sharing arrangements in various counties. Faculty appt. at Albany Medical College affords dvlpmnt. of this unit into a first-class geriatric tchng. ctr. in medicine, neurology, and psychiatry. Loc. in Albany, N.Y.—close to Montreal, Boston and N.Y.C., and with ready proximity to exciting cult. and recreat. facils. Sal. $40,000-$47,000 dep. on quals. plus added income through overtime pay, consuls., and prvt. prac. N.Y.S. lic., + completion of rsdncy. + 1 yr. post rsdncy. exper. req'd. Inquire: Bernard Berkowitz, M.D., Director, Capital District Psychiatric Center, 75 New Scotland Ave., Albany, NY 12208 (518) 445-6825.

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. Rsdnt. pop. approx. 600 incldg. chldrn. and alcoholic units. 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. We are an EOE.

Rochester—DIRECTOR OF PSYCHIATRIC EDUCATION AND TRAINING. Major posn. avail. for a qualified Bd. Cert. Psychiatrist respon. for overall direction of a fully accredited three (3) yr. psychiatric rsdnt. trng. prgm. Includes clin. supervision of rsdnts., tchng., research, and liaison with prgms. in Neurology, Court Svc., Child Guidance, and Ambulatory Psychiatric Svc. Prgm. is affil. with the Dept. of Psychiatry, Univ. of Rochester Schl. of Medicine and Dentistry. Many educ. opptys. N.Y. state lic. req'd., sal. dependent on quals. Frng. bnfts. include pension plan, med. insur., 11 paid holidays, vacation and sick leave credits plus 5 personal leave days. We are an EEOE. Qualified applicants should contact Girish V. Shah, M.D., Director, Rochester Psychiatric Center, 1600 South Ave., Rochester, NY 14620.

Rochester—STAFF PSYCHIATRIST (I & II). Posns. avail. for staff psychiatrist in psychiatric hosp. units offering activities in inpt. and outpt. prgms. Hosp. serves urban and rural pop. Close working relationship with CMHCs and Univ. Dept. of Psychiatry. Approved three (3) yr. rsdnt. trng. prgm. Many educ. opptys. Min. qual. for Psychiatrist I-N.Y. state lic. and Bd. eligibility. Psychiatrist II-N.Y. state lic. and Bd. certification. Sal. range Psychiatrist I-$40,200–$45,025 dep. upon quals. and work exper. Psychiatrist II-$43,560–$48,707. We are an EEOE. Qualified candidates should send applications to Girish V. Shah, M.D., Director, Rochester Psychiatric Center, 1600 South Ave., Rochester, NY 14620.

Saratoga Springs—There is a current and outstanding oppty. for a PSYCHIATRIST with the Saratoga Hosp. MH Unit—a component of the well-recognized compre. MH svcs. for Saratoga County. Duties will be divided equally between Inpt./Hosp. liaison svcs.; and Outpt. and Consultative svcs. in the coordinating clinic. The entry sal. is nego. dep. upon individual quals., exper., and relationship with the Hosp. As desired, the psychiatrist may be employed by the Hosp. or can, if he wishes, affiliate by contract. An adjunct prvt. prac. can be carried and an academic affiliation is encouraged. Please respond, with a copy of the CV, to FORREST ASSOCIATES, P.O. Box 472, Murray, KY 42071 or call (collect) (502) 753-9772. Forrest is retained by the Hosp.

Willard—We have openings for well trained PSYCHIATRISTS interested in inpt. and commty. psychiatry work. Loc. in the beautiful Finger Lakes Region of N.Y. on the East shore of Seneca Lake; 10 colleges, incldg. Cornell Univ., within a 30-mile radius. JCAH accred. Staff sals. dep. on quals.: $34,312-$40,374. Frng. bnfts. incldg. pension plan, med. insur., 11 paid holidays, vac. and sick leave credits, plus 5 personal leave days. Write: Director, Willard Psychiatric Center, Willard, NY 14588.

NORTH CAROLINA

Asheville—100 bed prvt., psychiatric hosp. fully accred. by JCAH, begun in 1916, is adding new prgms. and needs bd. cert. PSYCHIATRISTS due to expansion. Philosophy of the hosp. is eclectric. Sal. open. Asheville is a resort town loc. at 2200 ft. in the 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, NC 28803. Ph: (704) 253-3681.

Greensboro—One full-time, PHYSICIAN III, Guilford County MH Prgm. Near Duke, UNC and Wake Forest Med. Schls.; 4 local colleges and univs. with many cultural advantages to Greensboro area; advantage of city living in clean, well-planned atmosphere with excel. local schl. system; near mtns. and coast; Greensboro area pop. 157,000 and growing; 11 prvt. psychiatrists in city; balanced with multi-discpl. one-county compre. MHC; contracted inpt. with full psychiatric staff: 4 full-time, 2 half-time plus Area Clin. Director. REQUIREMENT STANDARDS: Graduation from an accred. schl. of medicine and completion of rsdncy. or specialty trng. and one yr. of exper. in the prac. of medicine; OR graduation from an accred. schl. of medicine and four yrs. of exper. and the prac. of medicine; OR an equivalent combination of educ. and exper. Elig. for licensure to prac. medicine in N.C. and so licenses before permanent appt. Comp. sal. and frng. bnfts. plus extra pay for on-call if desired; Contact: Aldo W. Mell, M.D., Area Clinical Director at 1 (919) 373-3630 or Guilford County MHC, 300 North Edgeworth St., Greensboro, NC 27401.

Hickory—Enthusiastic Bd. cert. or bd. elig. PSYCHIATRIST to work half-time at prgsv. state hosp. (Broughton Hosp., Morganton, N.C.), half-time at innovative CMHC, (Hickory). Outstanding oppty. to provide leadership in expansion of commty. based svcs. and coordination with state hosp. Excel. work environment in both settings. Hosp. affiliated with Bowman Gray School of Medicine, has quality med. staff, active CME and research prgms. Excel. frng. bnfts. incldg. vacation, holidays, sick leave, life insur. and paid malprac., loc. in the foothills of Blue Ridge Mtns. with excel. recreat. activities one hr. from Charlotte. Sal. range nego. dep. on quals. and exper. Contact James C. Johnson, M.D., Clinical Director, Broughton Hosp., Morganton, NC 28655, (704) 433-2566.

Wilson—Patient care oriented Bd. Elig. PSYCHIATRIST to join two others in providing physician svcs. in a compre. CMHC. Excel. location for family oriented person. City has modern hosp., a local medical commty. numbering 55, 4 yr. college, technical institute and a new shopping mall. Hour and half to some of the finest sailing on the East coast. Conservative and busy prgm. with stable, well-trained personnel. Call John White, Area Director, Wilson-Greene MHC, collect or write, P.O. Box 3756, Wilson, NC 27893. EOE.

NORTH DAKOTA

Fargo—Medical School faculty posn. avail. in the Div. of Psychiatry-Behavioral Science. Posn. open is PSYCHIATRIST in V.A. Hosp. Must manage pts. with major psychiatric illness hospitalized in a V.A. gen. hosp. as a first step in the dvlpmnt. of a univ. inpt. tchng. unit. Bd. cert. or elig. psychiatrist req'd. 50 miles from Minnesota lakes, near Minneapolis and Winnipeg, good hunting/fishing. We are an EOE. Send CV to R. Gardner, M.D., Chairman, Division of Psychiatry-Behavioral Science, Dept. of Neuroscience, Univ. of N.D. School of Medicine, Medical Education Ctr., 1919 North Elm St., Fargo, ND 58102.

OHIO

PSYCHIATRIST—POSNS. AVAIL. IMMEDIATELY. Bd. cert. or elig., at VA Medical Ctr., Chillicothe, Ohio, 960-bed medical ctr. with 480-bed Medical Svc. and 480-bed Psychiatry Svc. having excel. ambulatory care, psychiatric care, acute medical and geriatric svcs. JCAH approved. OSMA approved cont. med. ed. prgm. for AMA Recognition Award. Excel. sal. and Federal bnfts. Medical Ctr. loc. in southern Ohio natural recreation and scenic area. Financial assistance in moving. EEOE. Contact: Paul F. Fletcher, M.D., Chief of Staff, VA Medical Center, Chillicothe, OH 45601. (614) 773-1141, Ext. 202.

PSYCHIATRIST, recent graduate approved rsdncy., wanted for a large multispecialty group. Write Theodor Bonstedt, M.D., Director Psychiatry, Health Maintenance Plan, 2915 Clifton, Cincinnati, OH 45220—or call (513) 872-2091. EOE.

Dayton—CHILD PSYCHIATRIST: 84 bed JCAH-accred. children's psychiatric hosp. is seeking a highly qualified child psychiatrist to assist in the trtmt. of disturbed chldrn. ages 6-18. Sal. is in the upper 40's. This posn. is State Civil Svc. and there are no contributions to Social Security. The hosp. is associated with the newly estab. Wright State Univ. med. schl. and faculty appt. is poss. This posn. will provide the selected candidate with several attractive options for the future. For further details contact R. Carey (513) 258-6217 or send resume to Dr. Francis Wright, Dayton Children's Psychiatric Hosp., 141 Firwood Dr., Dayton, OH 45419.

OKLAHOMA

PSYCHIATRISTS wanted for variety of excel. clin. and senior admin. posns. incldg. Assistant Commissioner, State Director of CMH, Hosp. Superintendent, Area Director, Clin. Medical Director and Staff Psychiatrist. Medical school faculty appt. avail. Call collect: J. Frank James, M.D., Commissioner, (405) 521-2811.

PENNSYLVANIA

PRESIDENT—Compre., nationally recognized, day and residential, educ. and rehab. org. headquartered in Greater Philadelphia, is seeking a President respon. for main campus and seven satellite facils. throughout the country. Requires strong administrative and management skills, knowledge of mental retardation and developmental disabilities, exper. with residential and commty. svcs., and familiarity with prvt. and public funding. Respon. to Bd. of Directors for overall operations. Excel. frng. bnfts. Sal. nego. Send resume to Box P-950, *Psychiatric News*.

PSYCHIATRIST—BD. CERT. OR BD. ELIG. MENTAL HOSP. IN METROPOLITAN AREA. EASY ACCESS TO N.Y., PHILADELPHIA, AND CLOSE TO POCONO RESORT AREA. GOOD SAL. WITH EXCEL. FRNG. AND RETIREMENT BNFTS. RESIDENCE AVAIL. PA. LICENSE REQ'D. CONTACT GEORGE E. GITTENS, M.D., ACTING SUPERINTENDENT, CLARKS SUMMIT STATE HOSPITAL, CLARKS SUMMIT, PA 18411; (717) 586-2011.

PSYCHIATRIST to work FT/PT in sub. CMHC. Sal. nego. Send CV or contact Mr. John O'Loughlin, Director, CLS, Inc., 225 S. Lansdowne Ave., Darby, PA 19023, or call (215) LE4-3636, EOE.

Carbondale—ADULT PSYCHIATRIST, Pa. license req'd. Full-time MHC employment. Varied respons. Newly federally funded CMHC providing full range of svcs. loc. in Northeastern Pa. close to Pocono resort area. Sal. nego. Full bnfts. incldg. malprac. insur. Contact: J. Michael Shovlin, M.D., Medical Director, NORTHEAST TRI-COUNTY MH/MR CENTER, INC., 141 Salem Ave., Carbondale, PA 18407—phone 717/282-1732. An EOE.

Carbondale—CHILD PSYCHIATRIST with trng. and interest in child care and programming to join three other psychiatrists and outstanding clin. staff of 80. Prgsv., developing, compre. MHC loc. in Northeastern Pa. close to Pocono resort area providing yr.-round varied recreation opptys. Expanding med. commty. in rural area with all specialties represented. Salaried and prvt. prac. opptys. nearby. Sal. commensurate with trng. and exper., extensive bnfts. Send CV to: Director, Children's Services, NORTHEAST TRI-COUNTY MH/MR CENTER, INC., 141 Salem Ave., Carbondale, PA 18407—phone 717/282-1732. An EOE.

Philadelphia—PSYCHIATRIST—Large urban CMH/MRC is seeking a Full Time Staff Psychiatrist for its 26-bed short term Adult Psychiatric Inpt. unit. Will provide primary pt. care incldg. complete psychiatric evals., perform exams. of involuntary pts. and completion of necessary documents prior to court proceedings, testify in MH court proceedings on involuntary pts., and provide tchng. and supervision to psychiatric staff and interns about diagnosis, pt. management and trtmt. The candidates should be Bd. elig. or Bd. cert. Starting sals. are from $29,200 to $36,800 with excel. work environment and bnft. pckg. Clin. appts. at Penn. Hosp. and the Univ. of Penn. Med. Schl. Candidates should respond to Laurel S. Lipshutz, Director, Psychiatric In-Patient Unit, HALL MERCER CMH/MRC of Pennsylvania Hospital, 8th & Locust Sts., Philadelphia, PA 19107. (215) 829-3474. EOE, M/F.

Philadelphia—STAFF PSYCHIATRISTS—Full or Part time posns. immed. avail. Our hosp. is looking for psychiatrists with fresh ideas and strong convictions on public sector MH care. We are located in pleasant, residential Northeast Phila. and can offer the area's unparalleled opptys. for professional growth and development. Good sal. and bnfts. Regs. are Pa. State lic. and bd. cert. or elig. Contact, in strict confidence: Franklyn R. Clarke, M.D., Superintendent, Phila. State Hospital, 14000 Roosevelt Blvd., Phila., PA 19114, (215) 671-4101.

Reading—PSYCHIATRIST—Expanding 331-bed acute care hosp. in Eastern Pa. seeks psychiatrist to assume leadership of its 20-bed, short-term psychiatric unit. Hosp. has family prac. rsdncy., med. schl. affil. and offers a wide array of clin. svcs. $12 million bldg. prgm. now in progress, and approval for a 16-bed, subacute, 21-day residential alcoholism rehab. unit has been received. Reading, Pa. offers family-oriented, pleasant living and is loc. within easy reach of Phila., NYC and DC. Inquiries and CV to: Office of Medical Director, Saint Joseph Hospital, Reading, PA 19603; call (215) 376-4901.

Torrance—PSYCHIATRISTS AND PHYSICIANS—Bd. cert. or Bd. elig. Pa. Licensure req'd. Immed. openings. Excel. oppty. to work in developing new prgms. in a state hosp. Sal. competitive. Limited housing avail. Excel. frng. bnfts. 40 miles east of Pittsburgh, Pa. Call 412-459-8000 or write to Ray Bullard, M.D., Superintendent, Torrance State Hosp., Torrance, PA 15779. An EOE. M/F.

SOUTH CAROLINA

Columbia—CHILD PSYCHIATRY FELLOWSHIP affil. with the Univ. of S.C. School of Medicine. Estab. Med. model eclectic prgm. with strong prgms. in Consul./Liaison with Primary Care Specialities, Psychopharmacology, Inpt. Adol. Care, Diagnostic Nursery School, and Outpt. Therapies. Large full time faculty with excel. support from Pediatric Neurology, Psychoanalysis, Child Psychology and Social Work. Candidates must be interested in and capable of tchng. med. students. Clin. research encouraged. Modern facils. loc. in Sun Belt with yr. round outdoor activities. Sal. from $19,251 to $26,546; openings in Jan. and July 1980: Write to: Richard K. Harding, M.D., Training Director, Child Psychiatry, William S. Hall Psychiatric Institute, Box 119, Columbia, SC 29202. Phone: (803) 758-8320. EOE.

Florence—PSYCHIATRIST II in rapidly growing CMHC serving a three county area. Immed. opening for commty. oriented psychiatrist to join multidiscpl. staff in providing direct clin. svcs. to adults on Outpt. and Inpt. basis. Outpt. svcs. include work with crisis intervention and emerg. svcs. Oppty. to provide insvc. trng. and commty. educ. as well. Ties with tchng. institutions being established in psychiatry. Florence has a 4 yr. college, a vigorous Little Theater and a new 300 bed Regional Hosp. Prvt. affil. avail. State employee frng. bnfts. Sal. range $31,445-$44,368. EOE. Contact and send CV to C. Raymond Kiefer, M.D., Director, 2100 W. Lucas St., Florence, SC 29501. Phone (803) 662-1401.

SOUTH DAKOTA

Huron—PSYCHIATRIST—Bd. cert. or elig. for full-time posn. in vibrant, non-profit, well estab. CMHC. Full range of outpt. svcs. and variety of alternative inpt. care, crisis care, medications, consul. with med. commty., and clin. supervision. Refreshing rural environment and emotional rewards. Can be PHS posn. Sal. nego. and competitive. Write Val Farmer, Ph.D., 1552 Dakota South, Huron, SD 57350.

Rapid City—PSYCHIATRIST/MEDICAL DIRECTOR—For West River MHC loc. in the heart of the beautiful Black Hills of S.D. near Mt. Rushmore National Memorial. West River MHC is a newly-funded ctr., currently expanding and developing all prgms. Beautiful new office bldg. Outdoor recreation includes snow skiing, camping, backpacking, water skiing, fishing, etc. The Black Hills are incredibly beautiful. Contact: Gary W. Selvy, ACSW, Executive Director, P.O. Box 6001, Rapid City, SD 57701, (Office—605-343-7262, Home—605-348-5818).

TENNESSEE

Excellent opportunity for GENERAL or CHILD PSYCHIATRIST in a private in-patient and/or out-pa-

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Antiparkinsonian agents are seldom required with Mellaril® (thioridazine)... drug-induced akathisia, tremor, and other extrapyramidal side effects are minimal

If the medication literally contains jitteriness for the patient, if he can't keep still while he's sitting, can't keep steady while he's at work or recreation —that's hardly helpful to him or the physician. Yet akathisia and other extrapyramidal reactions are quite common with many major tranquilizers, often even requiring antiparkinsonian agents to counter these unwanted drug-induced symptoms.

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1. 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.

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.

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.

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tient setting. Ideal location. Moderate climate. Reply Box P-924, *Psychiatric News*.

Chattanooga—There is a current oppty. for a PSYCHIATRIST to join an estab., prgsv. and expanding commty. prgm. in this SUNBELT location. Entry sal. ranges from $40,000 to $55,000, dep. upon individual quals. and exper. level, plus generous frngs. Adjunct practice and academic affil. are poss. Please respond to FORREST ASSOCIATES, P.O. Box 472, Murray, KY 42071 or call (collect): (502) 753-9772. Forrest is retained by the prgm.

TEXAS

PSYCHIATRY RESIDENCY AVAILABLE at Houston's Texas Research Institute of Mental Sciences, loc. in the heart of the famed Texas Med. Ctr. Applicant must have to be Elig. to obtain a TX. Lic. First yr. stipend: $16,000; or optional $20,000 with state career obligation. TRIMS features compre. prgms. in all facets of svc. research, and trng., along with affils. with local med. schools and other institutions. For info. contact: Ed Johnstone, M.D., Texas Research Institute of Mental Sciences, 1300 Moursund Ave., Houston, TX 77030. (713) 797-1976, ext. 275 or 419.

Austin—STAFF PSYCHIATRIST for the Ranch Trtmt. Ctr. of The Brown Schools. The Ranch is an estab. 120 bed JCAH accred. facility loc. in Austin. Full time posn. includes providing trng. and supervision to professional staff, conducting pt. evals., developing trtmt. plans, and evaluating and prescribing psycho-active medication. Applicants should be qualified in child psychiatry and exper. in a residential setting is helpful. Send resume to: Personnel Director, P.O. Box 4008, Austin, TX 78765. EOE.

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

Houston—THREE PGY IV POSNS. avail. with the Dept. of Psychiatry, Univ. of Texas Med. Schl. at Houston. Prgm. currently being expanded; eclectic faculty; personalized career development at a major med. ctr. Applics. should contact Dr. Richard C. W. Hall, M.D., Director, Residency Training, Univ. of Texas Medical School at Houston, Dept. of Psychiatry, P.O. Box 20708, Houston, TX 77025, or call 713-792-5538. EOE/AA.

West Texas—BIG SPRING STATE HOSP.—STAFF PSYCHIATRIST, Bd. Cert. or elig. Tx. Lic. req'd. JCAH fully accred. facil. Psychiatric/Medical active trtmt. prgm., utilizing trtmt. team approach. Excel. para-professional support staff. Sal. $35,100 to $46,600, dep. upon quals. Excel. bnft. pckg., incldg. 40 hr. work week, malprac. protection, retirement, and tax sheltered income prgm. Beautiful, friendly sun-belt loc. City of 30,000 with good schls. and excel. housing. Contact: Grace R. Ferguson, M.D., Superintendent, Big Spring State Hospital, P.O. Box 231, Big Spring, TX 79720 (915) 267-8216. An EO/AAE.

UTAH

THE DEPT. OF PSYCHIATRY, UNIV. OF UTAH has 3 posns. for FACULTY PSYCHIATRISTS. These full-time posns. are in Consul./Liaison and Substance Abuse and Inpt. psychiatry at the Salt Lake VA Medical Ctr. Applicants should have an interest in developing an acad. career and possess demonstrated interest in tchng., research and pt. care. Send CV and 3 professional refs. to Bernard I. Grosser, M.D. Chairman, Dept. of Psychiatry, 50 North Medical Dr., Salt Lake City, UT 84132. The Univ. of Utah and VA Medical Ctr. are EO/AAEs.

FACULTY POSN., Dept. of Psychiatry, Univ. of Utah College of Medicine, Director, Forensic Psychiatry Svc. at Utah State Hosp. Inpt. work with primary location at Utah State Hosp., one-hr. drive from Univ. Twenty percent time free for research. Sal. to start: $45,468 bd. elig.; $48,731 bd. cert., plus approx. $2,200/yr. deposited in retirement fund. Plus large bnft. pckg. Spectacular mtn. country with yr.-round recreation, within one hr. of four major ski resorts. Near two major universities. Apply to: David Tomb, M.D., Univ. of Utah College of Medicine, Salt Lake City, UT 84132.

VIRGINIA

DIRECTOR OF VIRGINIA TRTMT. CTR. FOR CHILDREN FACULTY APPT. THE MEDICAL COLLEGE OF VIRGINIA/VIRGINIA COMMONWEALTH UNIV. and the VIRGINIA DEPT. OF MH & MR are seeking a qualified professional for the posn. of Director of the Va. Trtmt. Ctr. for Chldrn./Chairman of the Div. of Child Psychiatry, MCV. Respon. for the dvlpmnt. and implementation of pt. care, trng., and research prgms. The Ctr. is loc. on the MCV campus and includes 40 inpt. beds, and outpt. clinic, and an active consul./liaison svc. Stimulating professional and acad. environment. Excel. bnfts., sal. nego. based on trng. and exper. Send CV to: PERSONNEL OFFICE, DMH&MR, P.O. Box 1797, Richmond, VA 23214. An EOE.

Large single specialty professional corp. has opening for PSYCHIATRIST with special interest in trtmt. of alcoholism to direct twenty-two bed inpt. alcoholism unit and to coordinate and develop alcoholism aftercare prgm. Excel. professional and corporate advantages. Sal. nego., dep. upon exper. Parity in professional corp. poss. after three yrs. Send complete resume with refs. to Robert F. Scott, M.D., Suite 212, 844 Kempsville Rd., Norfolk, VA 23502.

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.

Danville—Southern Va. MH Institute: PSYCHIATRIST or FAMILY PRACTICE PHYSICIAN with Psychiatric Trng. or interest and considerable knowledge of dvlpmt. and standard techniques in the diagnosis and trtmt. of mental disease and disorders for Southern Va. MH Institute, a new 96 bed intensive trtmt. ctr. loc. in south-central Va.; we offer the oppty. to participate in a compre. prgm. for acute and intermediate inpt. care and crises intervention in a multidisciplinary team setting, prgm. dvlpmt. in trng., a broad base of commty. interrelationships, and organizing new approaches to svc. delivery, prvt. prac. allowed; sal. nego. Send CV to Personnel Office, Southern Virginia Mental Health, 382 Taylor Dr., Danville, VA 24541 or phone (804) 799-6220. An EOE.

Southeastern Va.—STAFF PSYCHIATRIST—Hosp. affiliated CMHC seeks gen. psychiatrist. Exper. in behavioral therapy preferred but not essential. Excel. location in Virginia's tidewater resort area. Ocean & Chesapeake Bay mins. away. Modern $2.4 million facility has 54 inpt. beds, 2,000 outpts., Partial Hospitalization, Emerg. Svc. and C&E Prgms. Competitive sal. and bnfts. Forward resume with refs. to Director, Maryview CMHC, 3636 High St., Portsmouth, VA 23704.

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 F. Scott, M.D., Suite 212, 844 Kempsville Rd., Norfolk, VA 23502.

Virginia Beach—Large single specialty professional corp. has opening for PSYCHIATRIST, bd. cert. or bd. elig. in child psychiatry. Posn. includes outpt. trtmt. of chldrn. and adols. and inpt. trtmt. of adols. in a prvt. psychiatric hosp. Excel. professional and corporate advantages. Sal. nego. dep. upon exper. Parity in professional corp. poss. after three yrs. Send complete resume with refs. to Robert F. Scott, M.D., Suite 212, 844 Kempsville Rd., Norfolk, VA 23502.

WASHINGTON

Chelan—Bd. Cert. or Elig. PSYCHIATRIST to direct a new 7-9 bed inpt. and outpt. psychiatric prgm. Loc. in a rural setting at Lake Chelan Commty. Hosp. on beautiful Lake Chelan. Provide direct consulting to nearby CMHCs. Competitive sal. and bnfts. based on quals. and exper. Flexible sal. and fee-for-svc. arrangements. New office space constructed to individual taste. 55 mile long Lake Chelan offers a wide variety of summer and winter recreat. sports incldg. sailing, boating, backpacking, winter skiing, 18 hole golf course, bird and deer hunting, and trout fishing. Contact James W. Frymier, Administrator, Lake Chelan Community Hospital, P.O. Box 908, Chelan, WA 98816, or phone (509) 682-2531.

Richland—PSYCHIATRIST, prefer commty. orientation; broad background, with poss. emphasis on child or family, to join Mid-Columbia MHC staff. Large part of respon. is working with other professionals and para-professionals to provide svcs. to a broad range of clientele. Dynamic, growing commty. with easy access to outdoor recreation. Sal. $42,000-$55,000. Write or call: William Sherman, M.D., Medical Director at (509) 943-9104, 1175 Gribble, Richland, WA 99352.

Seattle—OFFICE SUITE TO SHARE with 2 psychiatrists in full-time prvt. prac. Modern downtown medical bldg. All amenities. Excel. view of Sound and mtns. Contact: H. Orenstein, M.D., 901 Boren, Seattle, WA 98104. (206) 623-7444.

Spokane—Need full-time PSYCHIATRIST to direct a large day trtmt. prgm. in compre. CMHC. Join 5 psychiatrists and 100 professional staff. 300,000 people in beaut. NW setting, superb place to live. $41-45,000 dep. on exper. Call, write Mary Higgins, Executive Director, Community Mental Health Center, S. 107 Division, Spokane, WA 99202 (509) 838-4651. EOE.

Tacoma—Western State Hosp. has openings for bd. elig. or bd. cert. STAFF PSYCHIATRISTS in adult psychiatry, geriatrics, mentally ill offender, and involuntary trtmt. prgms. This hosp. is loc. only a few miles from Puget Sound and its beaches and fishing. We are 75 miles from Mt. Rainier and its skiing opptys. We offer CME trng. as well as opptys. to pick up credits through the nearby Univ. of Washington med. prgms. Sal. ranges from $38,871 to $45,000 per yr. (dep. on exper.), plus time off and reimbursement for O.D. tour. There are many lib. bnfts. Washington state lic. or eligibility req'd. Contact Giulio di Furia, M.D., Superintendent, Western State Hospital, Tacoma, WA 98494. (206) 756-9525.

WISCONSIN

PSYCHIATRIST: Bd. Elig. or Cert. to join a growing practice of 2 psychiatrists working in a very attractive, modern clinic with highly qualified multi-discpl. team members. Loc. close to beautiful recreat. area in northeastern Wis. Fishing, sailing. Excel. frng. bnfts. Send vitae to Box P-946, *Psychiatric News*.

PSYCHIATRIST (bd. elig.), staff, 20 hrs. per week in rural Wis. CMHC. JCAH accred. facility, with 17 inpt. psychiatric beds. One hr. drive from Milwaukee. Trtmt./staff supervisory duties in inpt./outpt./day svcs. depts. Compensation at $35.00 per hr. plus on-call pay. Contact Catherine Dean, Lakeland Counseling Ctr., Box 1005, Elkhorn, WI 53121. (414) 723-5400. EOE.

Cumberland—Another full-time PSYCHIATRIST needed to join 55 assorted staff at CMHC in beautiful northwestern Wis. Enjoy full range of summer and winter sports, excel. hunting and fishing, near where you'll live and work. No traffic jams, smog, or noise pollution. Average 40 hr. work-week, 4 weeks paid vac. and many other substantial frngs. Income potential in excess of $60,000 ann. ($51,000 guaranteed). Contact J. M. Rathbun, M.D., Box 518, Cumberland, WI 54829. Include vitae.

Madison—Mendota MH Institute-CHILD PSYCHIATRIST for 10 bed forensic unit for emotionally disturbed adols., PSYCHIATRIST CHIEF for 20 bed tertiary care geriatric unit, PSYCHIATRIST CHIEF for 35 bed adult tertiary care unit, STAFF PSYCHIATRIST for expanding forensic psychiatry prgm. Mendota MH Institute is a JCAH approved 225 bed institute loc. in Madison which has been named one of the top two communities in the U.S. in which to live, contains the main campus of the Univ. of Wis. and is the State Capital. MMHI is a unique regional care facil. with close affil. with many Univ. depts. and trng. prgms. Research poss. Wis. license is req'd. Starting sal. to $50,235 dep. upon quals. Lib. frng. bnfts. Malpractice covered. EOE. Contact: Lee Ecklund, M.D., Director (608-244-2411), Mendota Mental Health Institute, 301 Troy Dr., Madison, WI 53704.

Marshfield—Marshfield Clinic, a multispecialty grp. prac. of 170 physicians, is seeking a bd. cert. or bd. elig. PSYCHIATRIST to lead a well integrated, intelligent, and creative trtmt. team. The posn. involves trtmt. directorship of Norwood Health Ctr. which includes a 19-bed, JCAH accred. inpt. psychiatric unit, a day svcs. prgm., and psychiatric consul. for long-term mentally ill and developmentally disabled pts. This posn. also includes outpt. psychiatric consul. and trtmt. at Marshfield Clinic, as well as consul. and liaison with St. Joseph's Hosp., a new 500-bed gen. hosp. All inquiries treated confidentially. Call or write Warren Garitano, M.D., Chairman, Dept. of Psychiatry, Marshfield Clinic, Marshfield, WI 54449.

Milwaukee—ADULT & CHILD PSYCHIATRISTS for well estab. prvt. psychiatric grp. practice. Eclectic and quality care, both outpt. and inpt. Base sal., incentive bonus. Excel. frng. bnfts. Send resume to: Basil Jackson, M.D., Ph.D., 2130 North Mayfair Rd., Milwaukee, WI 53226 or call (414) 258-9222.

Milwaukee—ADULT & CHILD PSYCHIATRY posns. avail. as Associates in Dept. of Psychiatry of multidiscipline, prvt. practice clinic. Oppty. exists to develop rewarding prvt. practice with pre-existing referral sources. Med. College affil. poss. Eclectic approach incldg. psychoanalytic, grp., hypnosis, biological and biofeedback clinics utilized. Bd. elig. or cert. req'd. Reply to David L. Sovine, M.D., 1200 East Capitol Dr., Milwaukee, WI 53211, (414) 332-0171.

Superior—GENERAL OR COMMUNITY PSYCHIATRIST to join outpt. and day svc. ctr. serving 45,000 pop. in N.W. WI. Eclectic staff of 23. Sal. $47,000 min. with full frngs. Loc. in Superior, pop. 35,000 and next to Duluth, pop. 100,000. Good recreat. area; sailing, skiing; canoeing, camping, etc. Univ. area. WI lic. req. For more info. call Greg Kruse, collect at (715) 392-8216, or send resume to Human Resource Center, 1914 Susquehanna Ave., Superior WI 54880.

Tomah—STAFF PSYCHIATRISTS needed—800-bed VA Medical Ctr. (medical and psychiatric pts.). Excel. working conditions and bnfts. Sal. range $44,000 and up dep. upon quals.-bds. desired but not necessary. EEO employer. Contact Chief of Staff, VA Medical Center, Tomah, WI 54660. (608) 372-3971, Ext. 213.

CANADA

Montreal, Quebec—McGILL UNIV.—FACULTY OF MEDICINE, DEPT. OF PSYCHIATRY. The Dept. of Psychiatry of McGill Univ., in conjunction with the Philippe Pinel Institute, is looking for a full time professor of psychiatry, for research and supervision of research, in the field of violence and aggression. Applicant must be experienced, in addition, in the use of primates for psychosociological and neurophysiological research. Sal. will depend on quals. and exper. Effective date of appt.: Nov. 1, 1979. Closing date for application: Sept. 1, 1979. Reply, with a copy of CV, to: M. Dongier, M.D., Chairman, Dept. of Psychiatry, Allan Memorial Institute, 1033 Pine Ave. West, Montreal, Quebec, Canada H3A 1A1.

POSITIONS WANTED

ADOL. & ADULT PSYCHIATRIST with 10 yrs. postgrad. exper. and sub-specialty in geriatrics interested in relocating in Santa Barbara area & associating with estab. clinic or prvt. practitioner. Resume on request. Reply Box P-928, *Psychiatric News*.

PSYCHIATRIST, U.S. trained, presently Medical Director of large CMHC, seeks full or part time employment oppty. in North/Central N.J. Eccl. trained, experienced in commty. psychiatry; CMHC operations and prvt. prac. Trained in relaxation and hypnotherapy techniques. Board certified. Reply Box P-947, *Psychiatric News*.

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LARGEST & MOST LUCRATIVE PRIVATE PRACTICE in the Midwest's medical, cultural and recreational ctr. Very low overhead in large, beautiful offices. Uniquely transferable. Reply Box P-945, *Psychiatric News*.

OUTPATIENT PSYCHIATRIC PRACTICE for sale. Beautiful Finger Lakes region of N.Y., easy access to Universities and major metro. areas. Six figure gross. Will introduce professionally. Inpatient work avail. if desired. Reply Box P-938, *Psychiatric News*.

PSYCHIATRIC PRACTICE AND LIFE STYLE FOR SALE: I am making the next step and moving aboard a boat. Practice as little as 3 days a wk. or more as desired. Income accordingly. Beach house, sailboat, etc. also possibly avail. Contact Bob Baringer, M.D., Rt. 1, Box 84L, St. Augustine, FL 32084, (904) 824-8666.

PSYCHIATRIC PRACTICE AND OFFICE FOR SALE: N.J. seashore area with close proximity to both Phila. and N.Y. City. Many recreat. facils. Increasing pt. pop. with relative shortage of psychiatrists in rapidly growing commty. Six figure gross. Office located adjacent to large hosp. Will introduce professionally. Reply Box P-922, *Psychiatric News*.

PSYCHIATRIC PRACTICE FOR SALE—For one or two medically oriented psychiatrists, in and out patient. Excel. oppty., terms nego. Southeast, U.S., warm climate, safe, mid-size commty. Send name, address and phone number to Box P-936, *Psychiatric News*.

COURSES & WORKSHOPS

American Association for Marriage and Family Therapy—37TH ANNUAL CONFERENCE—**Washington D.C.—Oct. 4-7, 1979.** Featured Speaker: Ronald D. Laing, M.D. All-day Pre-Conference Institutes, incldg. intensive two-day exper. given by A. K. Rice Institute. For info. contact AAMFT, 924 W. Ninth St., Upland, CA 91786, 714/981-0888.

AMERICAN INSTITUTE FOR PSYCHOANALYSIS of the Karen Horney Psychoanalytic Institute and Ctr., 329 East 62nd St., New York, N.Y. 10021, announces its 1979-80 trng. prgm. in psychoanalysis leading to certification for psychiatrists and Ph.D. clin. psychologists. For info. contact Harry Gershman, M.D., Dean at the above address. (212) 838-8044.

Nationwide Workshops & Study Vacations in CLINICAL HYPNOSIS. The American Association of Trainers in Clinical Hypnosis, 26 Cedar St., Syosset, NY 11791.

NEW ORLEANS PSYCHIATRIC SYMPOSIUM, Dec. 6-9, 1979, Hyatt Regency Hotel. Meet, learn with Shervert Frazier, Mardi Horowitz, Solomon Snyder and Gary Tucker. 22 Class I credits. CME, Inc., 2030 E. 4th St., #113, Santa Ana, CA 92705. (714) 547-5186.

STRUCTURED INTERVIEWING FOR PSYCHOLOGICAL AND PSYCHIATRIC EVALUATION. **Aug. 27 through Aug. 31, 1979.** A full five day workshop in the technique of the Structured Clin. Interview (Burdock & Hardesty) intended for the continuing education of the professional as well as the advanced grad. student, will be held at Bellevue Psychiatric Hosp. under the auspices of NY Univ. Post-Graduate Med. Schl. The SCI is a technique for screening of behavioral problems and for evaluating psychological maladjustment in normals as well as in psychiatric pts. It provides psychodiagnostic info. and measurement of change after therapeutic intervention. Though the vehicle for trng. will be the SCI, the trng. in eval. interviewing will provide a wide spectrum of clin. material of value in its own right. The participant's skill in interviewing and proficiency in judging verbal and non-verbal behavior will be enhanced through critical exam. of clin. profiles. Each participant will have the oppty. to develop the appropriate repertoire of behaviors for administering, scoring and interpreting material. Research findings will be presented to illustrate empirically derived patterns of psychopathology. Prerequisite: Ph.D., M.A. or M.D. Limited enrollment. 30 AMA cat. 1 hrs.; and APA Continuing Education Certificate. For application write to: Dr. Anne S. Hardesty, c/o Office of the Recorder, Room 4-44N LHB, New York Univ. Post-Graduate Medical School, 550 First Ave., New York, NY 10016.

MISCELLANEOUS

ANXIETY AND TENSION REDUCTION: Cassette tape introduces several major techniques for reducing autonomic arousal, gross muscle tension, and cognitive anxiety. Hosp. tested-moneyback trial. Free 96-pg. report on stress with purchase. Send $4.95 or your VISA/Master Charge number to: Stress Management Research Associates, P.O. Box 2232-PN, Houston, TX 77001.

FOR SALE—ORIGINAL DIEGO RIVERA DRAWINGS OF HUMAN EMOTIONS. Twenty-two full color-drawings (11 sets) by renowned Mexican painter, Diego Rivera, and his wife, artist Frida Kahlo. Each set portrays each artist's response to a different human emotion. Not only magnificent works of art, but use of drawing for study or therapy may qualify for tax bnfts. For further details and documentation or personal inspection, reply Box P-949, *Psychiatric News*.

"HOW TO ESTABLISH YOUR OWN PRIVATE PRACTICE" . . . by Dr. Donald Hendrickson, Mr. Stephen Janney and Mr. James Fraze, CPA. A complete 234 pg. looseleaf book. $24.95 plus $2.00 postage and handling (Foreign orders must be in U.S. dollars). PREPAID. Professional Consultants Associates, 406 White River Blvd., Muncie, IN 47303.

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TRAINING AIDS: "ASYLUM" (96 min. film) of R. D. Laing's ther. Commty.: ". . . an excruciating experience"—*Psychiatric News;* "APPROACHES" (45 Min. videotape); contrasting interviews of a patient by Drs. H. J. Searles and R. D. Laing; "CONVERSATIONS with R. D. LAING" (26 min. videotape); a seminar on pre-natal experience, psychosis & dying. Contact Peter Robinson, 176 W. 87, New York, NY 10024 (212) 799-1051.

WANTED: YOUR FAVORITE or UNFAVORITE PSYCHIATRIST JOKES. We have all heard them at cocktail parties and during sessions. I am collecting them to study representations of psychiatry as expressed in humor. Write: Elliott M. Stein, M.D., 1295 N.W. 14th St., Suite L, Miami, FL 33136.