



Psychiatric News

Newspaper of the AMERICAN PSYCHIATRIC ASSOCIATION

© 1979 by the American Psychiatric Association

Volume XVI No. 15

Washington, D. C.

August 3, 1979



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.

See "FDA," page 11

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

See "Testimony," page 4

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.

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 commis-

sioners (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

See "JCAH," page 6

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

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 under-represented 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 electroencephalography (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 ça change, plus c'est la même 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

Psychiatric News

Newspaper of the American
Psychiatric Association
An Equal Opportunity Employer

(ISSN 0033-2704)

Published on the first and third Fridays of each month under the auspices of the APA Division of Public Affairs, Robert L. Robinson, Director.

Officers of the Association

Alan A. Stone, M.D., President
Donald G. Langsley, M.D.,
President-Elect
Lewis Robbins, M.D.,
Vice-President
Peter Martin, M.D.,
Vice-President
H. Keith H. Brodie, M.D., Secretary
Charles Wilkinson, M.D., Treasurer
Robert Pasnau, M.D., Speaker,
Assembly of District Branches
Melvin Sabshin, M.D., Medical Director

Staff for PSYCHIATRIC NEWS

Herbert M. Gant, Editor
B. Alma Herndon, Margaret McDonald,
B. S. Herrington, Assistant Editors
Ardell Harper, Editorial Secretary
Donald W. Hammersley, M.D., Professional
Consultant
Raymond M. Glasscote, Consulting Editor
Evelyn S. Myers, Contributing Editor
Ron McMillen, Contributor
John Wykert, Correspondent, New York
Dorothy Trainor, Correspondent, Canada
Clarissa K. Wittenberg, Correspondent
Washington, D.C.
Nancy Frey, Advertising, Promotion, Production
Joanne Harap, Advertising Production
Coordinator
Marcia Livingston, Classified Advertising
Nancy Burton, Circulation Coordinator
Subscriptions: \$6 per year; foreign \$11;
single issues: U.S.—\$1.75; Canada
and foreign—\$1.25

Communications regarding dues, membership status, or changes of address from APA members should be directed to Division of Membership Services and Studies. Communications from nonmember subscribers should be directed to Circulation Department, American Psychiatric Association, 1700 Eighteenth Street, N.W., Washington, D.C. 20009. Four to six weeks advance notice is required for changes of address.

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

Advertising Representatives: Steven K. Herlitz, Inc. New York—850 Third Ave., Tel. (212) 421-6900; Northfield, Illinois—550 Frontage Rd., Tel. (312) 441-5960; San Francisco—703 Market St.; Tel. (415) 777-2050.

The collective views of the Editors and staff of this newspaper are expressed only in editorials on this page. Opinions expressed in by-lined articles, columns, letters, and cartoons are those of the writers and artists and do not necessarily represent the opinions of *Psychiatric News*.

The acceptance of advertising by this newspaper does not in any way constitute endorsement or approval by *Psychiatric News* or APA of any advertised service or product.

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." Solomon and Nathan found "that although all of the hospitals' staff held low opinion

See "Letters," page 8

MOVING?

PLEASE NOTIFY US
6 WEEKS IN ADVANCE

MEMBERS: This notification will change your address (and/or name) for the AMERICAN JOURNAL OF PSYCHIATRY, PSYCHIATRIC NEWS, and all member-wide APA mailings.

SUBSCRIBERS: Please notify each publication separately.

FORMER ADDRESS:

PASTE LABEL HERE

NEW ADDRESS and/or NAME:

NAME

CITY STATE ZIP
APA MEMBERS MAIL TO:

APA Division of Membership
Services and Studies
AMERICAN PSYCHIATRIC
ASSOCIATION
1700 Eighteenth Street, N.W.
Washington, D.C. 20009

SUBSCRIBERS MAIL TO:

APA Circulation Department
AMERICAN PSYCHIATRIC
ASSOCIATION
1700 Eighteenth Street, N.W.
Washington, D.C. 20009

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 heyday 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 op-

posite 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 See "Gaylin," page 24

NOW AVAILABLE... 1980 Appointment Books

The "week-at-a-glance" Appointment Book, published by the American Psychiatric Association, has been specifically developed to satisfy the needs of psychiatrists. It contains a comprehensive list of addresses and annual meeting dates of all major organizations and agencies of interest to psychiatrists. Members who have not tried this book in the past are urged to do so. It is returnable within 30 days for a full refund if not acceptable. (Returned copies must be received in saleable condition.)

The Pocket Size Appointment Book is also available and may be ordered in combination with the Desk Appointment Book.

Copies are now available. Your order will be processed immediately upon receipt of coupon and payment.

DESK: \$12.00
POCKET: \$6.00
BOTH: \$15.00

10% Discount for 10-99 copies
15% Discount for 100 copies or more

Send coupon to:

Publication Sales Department
American Psychiatric Association
1700 18th St., N.W., Washington, D.C. 20009

Please send me: ____ copies of **Desk Appointment Book** order #141 @ \$12.00 ea.
____ copies of **Pocket Appointment Book** order #141-1 @ \$6.00 ea.
____ copies of **Appointment Book Set** order #141-2 @ \$15.00 ea.
____ To expedite my order, I am enclosing an additional \$3.00 (U.S. only)

ENCLOSED IS MY TOTAL PAYMENT OF \$ _____

(All domestic orders amounting to \$35.00 or less must be accompanied by payment; all foreign orders, regardless of dollar amount, must be accompanied by payment.)

Name _____

Address _____

City _____ State _____ Zip _____

PN



HIGHLAND HOSPITAL

A Division of Duke University
presents a conference

PHYSICIAN STRESS: CAREER—MARRIAGE—FAMILY

Treatment and Prevention of Dysfunction
in Doctors and Their Families

September 27-30, 1979

Great Smokies Hilton
Asheville, North Carolina

Among Topics to be covered:

The Law and the Impaired Physician
Psychotherapy with Physicians and Emerging Physicians
Midlife Issues for Physicians
Treating Physicians' Children
Substance Abuse by Physicians
Physicians Facing Aging and Retirement
Treatment of Physicians' Spouses
Physician Health, Exercise, Diet, Leisure
Conjoint Evaluation and Family Systems Analysis of Physicians' Families

Setting:

Highland Hospital is nestled between the Blue Ridge and Great Smoky Mountains. Conference is scheduled at beginning of colorful foliage season.

Continuing Education Credit Available

Registration and Fees:	For information write
\$185.00 for physician	Physician Conference, Highland Hospital
\$ 30.00 for spouse	Asheville, NC 28802
\$ 30.00 for student	or call (704) 254-3201 Ext. 233



Current Psychiatric Therapies

VOLUME 18

Edited by
JULES H. MASSERMAN, M.D.

This is the latest volume in a series which has achieved world-wide commendation and circulation for its clarity, objectivity and therapeutic helpfulness. *Volume 18* presents the latest authoritative developments in the genetic, pharmacologic, environmental, esthetic, individual, familial, group and social modalities of various psychiatric therapies, in specific detail for clinical application.

1979, 336 pp., \$34.50 ISBN: 0-8089-1151-1

Future volumes in CURRENT PSYCHIATRIC THERAPIES are now available on a Continuation Order basis. Your Continuation Order authorizes us to ship and bill each future volume in the series automatically, immediately upon publication. This order will remain in effect until cancelled.

Send payment with order and save postage and handling charge.

Prices are subject to change without notice.

Grune & Stratton

A Subsidiary of Harcourt Brace Jovanovich, Publishers
111 FIFTH AVENUE, NEW YORK, N.Y. 10003
24-28 OVAL ROAD, LONDON NW1 7DX

Testimony

Continued from page 1

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 maintenance 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

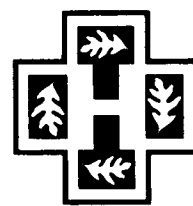
American Family Study

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.



The Harding Hospital
Worthington, Ohio

Fall Symposium

BORDERLINE PERSONALITY DISORDER

OTTO KERNBERG, M.D.

PAULINA KERNBERG, M.D.

JOHN G. GUNDERSON, M.D.

and a distinguished panel of discussants

September 17, 1979

7 hours CME credit

THE GEORGE T. HARDING, III, SEMI-ANNUAL
SYMPOSIA ON CURRENT ISSUES IN
PSYCHOTHERAPY AND HUMAN BEHAVIOR

For information, contact:

Symposia Registrar

Harding Hospital

445 East Granville Road

Worthington, Ohio 43085

(614) 885-5381, ext. 326

Registration: \$30

Closing date: September 3, 1979

The University of Chicago—Department of Psychiatry and
The Institute of Social and Behavioral Pathology



Announces:

The Psychiatrist and the Law: A Workshop

October 12-13, 1979

Course Director: Lawrence Zelic Freedman, M.D.

Foundations' Fund Research Professor of Psychiatry
University of Chicago, and

Chairman, Institute of Social and Behavioral Pathology

National authorities in the fields of psychiatry, law, policy and political science will explore significant problems in psychiatry and law through lectures, seminars, workshops, and audio-visual demonstrations. A moot court presided over by a distinguished jurist will focus on psychiatric issues and offer an opportunity for both instruction and registrant participation. Principles evolved from the historical development of psychiatry and the law will be discussed, as will the rapidly emerging problems arising from changing philosophical, social, and medical perspectives. Registrants will learn about the preparation of testimony, the role of expert witness, and prosecution and defense procedures.

Among the distinguished faculty:

Norval Morris

Former Dean, University of
Chicago Law School and,
Julius Kreeger Professor of
Law

Jacques Quen, M.D.

Clinical Professor of Psychiatry
and, Assistant Director,
Section of the History of
Psychiatry, Cornell University
Medical School

Participants will be guests at the **Harold Dwight Lasswell Memorial Lecture**, to be given on October, 12, 1979 by **Alan Stone, M.D.**, Professor of Psychiatry and Law, Harvard Law School and Medical School, and President of the American Psychiatric Association.

For more information, contact: University of Chicago, Office of Continuing Medical Education, Mary Ann Dillon, Course Coordinator, Box 139, 950 East 59th Street, Chicago, Illinois 60637, or (312) 947-5646.

This program meets the criteria for 15 CME credit hours.

JCAH

Continued from page 1

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

See "JCAH," page 14

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.



THE MENNINGER FOUNDATION

Continuing Education Workshops

Size and Shape in Mental Health: A historic conference designed and chaired by Gregory Bateson. September 7-9, 1979.

Infant Psychiatry: October 4-5, 1979.

Moral Development and Its Failures: October 18-19, 1979.

Group Psychotherapy: October 24-27, 1979; March 19-22, 1980 (Advanced); May 14-17, 1980; and July 23-27, 1980 (Aspen, Colorado).

Family Therapy: October 29-November 1, 1979; May 19-22, 1980; June 16-19, 1980; and July 28-August 1, 1980 (Aspen, Colorado).

Hospital Treatment: Psychodynamic Principles and Practices: November 14-16, 1979.

CME Credit Available.

All workshops will be in Topeka, Kansas. For registration information contact June Housholder, Division of Continuing Education, The Menninger Foundation, Box 829, Topeka, Kansas 66601. 913/234-9566, ext. 3685.

NEW YORK UNIVERSITY POST-GRADUATE MEDICAL SCHOOL

offers

TRAINING PROGRAM IN GROUP PSYCHOTHERAPY II

Course Directors: Edward Pinney, M.D. and Samuel Slipp, M.D.

Fridays, 9:00 A.M. to Noon

September 7, 1979 to January 25, 1980

This course is a continuation of *Training Program In Group Psychotherapy I* and is open to those who have completed that program or had had training and experience in group psychotherapy. The curriculum is designed to enhance the skills of the group therapist, to present advanced strategies of therapy and to review knowledge of current developments in the field. Modeled on the guidelines established by the American Group Psychotherapy Association, the course is open to psychiatrists, primary and family physicians, clinical psychologists, psychiatric social workers, psychiatric nurses, pastoral counselors, guidance counselors and professionals in related mental health fields. Each weekly session is composed of didactic, experiential and supervisory seminars.

* LECTURES IN GROUP
PSYCHOTHERAPY

* CONTINUOUS GROUP
CASE SEMINAR

* CLINICAL GROUP
EXPERIENCE

* LITERATURE SEMINAR

GUEST FACULTY

Thomas Aiello, M.D.
Ian Alger, M.D.
Helen DeRosis, M.D.
Helen Durkin, Ph.D.
Nina Fieldsteel, Ph.D.
Edrita Fried, Ph.D.

Walter Gadlin, Ph.D.
Henry Greenbaum, M.D.
Morton Kissin, Ph.D.
Jerome Kosseff, Ph.D.
Mark Novick, M.D.
L. Gerald Laufer, M.D.

Jean Munzer, M.D., Ph.D.
Edward Pinney, M.D.
Robert Prince, M.D.
Samuel Slipp, M.D.
Saul Tuttmann, M.D., Ph.D.
Sidney Yudin, Ph.D.

Fee: \$450 Accreditation: 60 hours AMA Category I

For course brochure or information, write or phone:

**N.Y.U. Post-Graduate Medical School
550 First Avenue, New York, N.Y. 10016
(212) 679-8745 (24 hour telephone)**

ANNOUNCING PUBLICATION OF THE CHRONIC MENTAL PATIENT

Report of a Conference held in January 1978

Edited by
John A. Talbott, M.D.

with contributions by James T. Barter, M.D., Paul R. Friedman, J.D., Raymond Glasscote, M.A., Trevor D. Glenn, M.D., Norman V. Lourie, M.S.W., W. Walter Menninger, M.D., Arthur T. Meyerson, M.D., Kenneth Minkoff, M.D., Samuel Muszynski, M.S.W., Lucy D. Ozarin, M.D., Gordon L. Paul, Ph.D., Ronald Peterson, Steven S. Sharfstein, M.D., Judith Clark Turner, Jane Bloom Yohalem, J.D.

This 277-page Report of the Conference, sponsored by APA and President Carter's Commission on Mental Health, identifies the chronic mental patient population, spells out where they are and what their needs and rights are. It specifies what programs work and what programs do not work in meeting the needs of these patients. It elaborates on the obstacles to implementing effective programs and the economic issues involved. It delineates the pros and cons of case management and specifies responsibility for coordinating, implementing, and monitoring services to chronic mental patients.

Finally, it proposes a *Call to Action* which opens with this statement: "There is no more urgent concern than the needs of the chronic mentally ill who suffer from severe, persistent, or recurrent mental illnesses with residual social and vocational disabilities. As a result of the deinstitutionalization programs of the past decade and the continuing growth of high risk populations that generate chronically ill, the problems associated with the care of these patients constitute a national crisis."

Since the Conference, the APA Assembly and the Board of Trustees have both approved the "Call to Action" which calls upon the APA to take the lead in undertaking programs to elevate the prestige and value of work with chronic mentally ill patients.

It follows that all APA members should be thoroughly versed in the current problems of this chronic patient population. This is best accomplished by reading this Conference Report now available from APA Publication Sales at \$11.00 a copy.

Send coupon to: American Psychiatric Association
Publication Sales
1700 18th St., N.W.
Washington, D.C. 20009

Please send me _____ copy(ies) of *The Chronic Mental Patient*
order #242, @ \$11.00 ea.

ENCLOSED IS TOTAL PAYMENT OF \$ _____
(All domestic orders amounting to \$35.00 or less must be accompanied by payment. All foreign orders, regardless of dollar amount, must be accompanied by payment.)

Name _____
Address _____
City _____ State _____ Zip _____

PN

THE
UNIVERSITY
OF
CHICAGO



DEPARTMENT OF NEUROLOGY ANNOUNCES NEUROLOGIC UPDATE 1979

September 14-16, 1979

This three day course will review recent advances in pathophysiology, diagnosis and therapy in clinical neurology. Lectures, panel discussions and videotapes will be used in the course. Special emphasis this year will be placed on cerebrovascular disease. The course will be directed to a level of interest to neurologists, internists, psychiatrists and other practitioners who provide care to patients with diseases of the nervous system.

The program faculty is drawn from The University of Chicago Departments of Neurology, Radiology, Psychiatry, and Surgery, as well as Michael Reese and Rush Presbyterian St. Luke's Medical Centers.

Approved for 21 hours of credit in
Category I, for the Physicians Recognition
Award of the American Medical
Association and the LCCME.

To be held at the Center for Continuing Education

For further information contact:
Barry G. W. Arnason, M.D.
Professor and Chairman
Department of Neurology
The University of Chicago
950 East 59th Street
Chicago, Illinois 60637
(312) 947-6069

TEN WEEK REVIEW COURSE

Sept. 17–Nov. 21, 1979 FEE: \$850.
IN

PSYCHIATRY & NEUROLOGY

sponsored by

COLLEGE OF PHYSICIANS AND
SURGEONS OF COLUMBIA UNIVERSITY

and

THE NEW YORK STATE PSYCHIATRIC INSTITUTE

at the

COLUMBIA-PRESBYTERIAN MEDICAL CENTER

New York City

A ten week course, 9 am to 5 pm,
Monday through Friday
Suitable for preparation
for National Board
examination

Psychopathology
Psychoanalysis
Medical Genetics
Biochemistry of Mental Illness
Neurology
Neurochemistry
Psychopharmacology

Community Psychiatry
History of Psychiatry
Legal Psychiatry

CLIP THIS COUPON

For information
mail this coupon to:
JAMES H. RYAN, M.D.
N.Y.S. Psychiatric Institute
722 West 168th Street
New York, N.Y. 10032

MAILING LABEL

Dr. _____
Street _____
City _____
State _____ Zip _____

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 atmo-

sphere 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 behavior is "tax exempt" from his intervention; the same principle applies to the child's caretakers. He added that besides permit-

ting 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-

See "Child," page 18

Letters

Continued from page 2

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 Solomon 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.
Brooklyn, N.Y.

8A-7

Recruitment

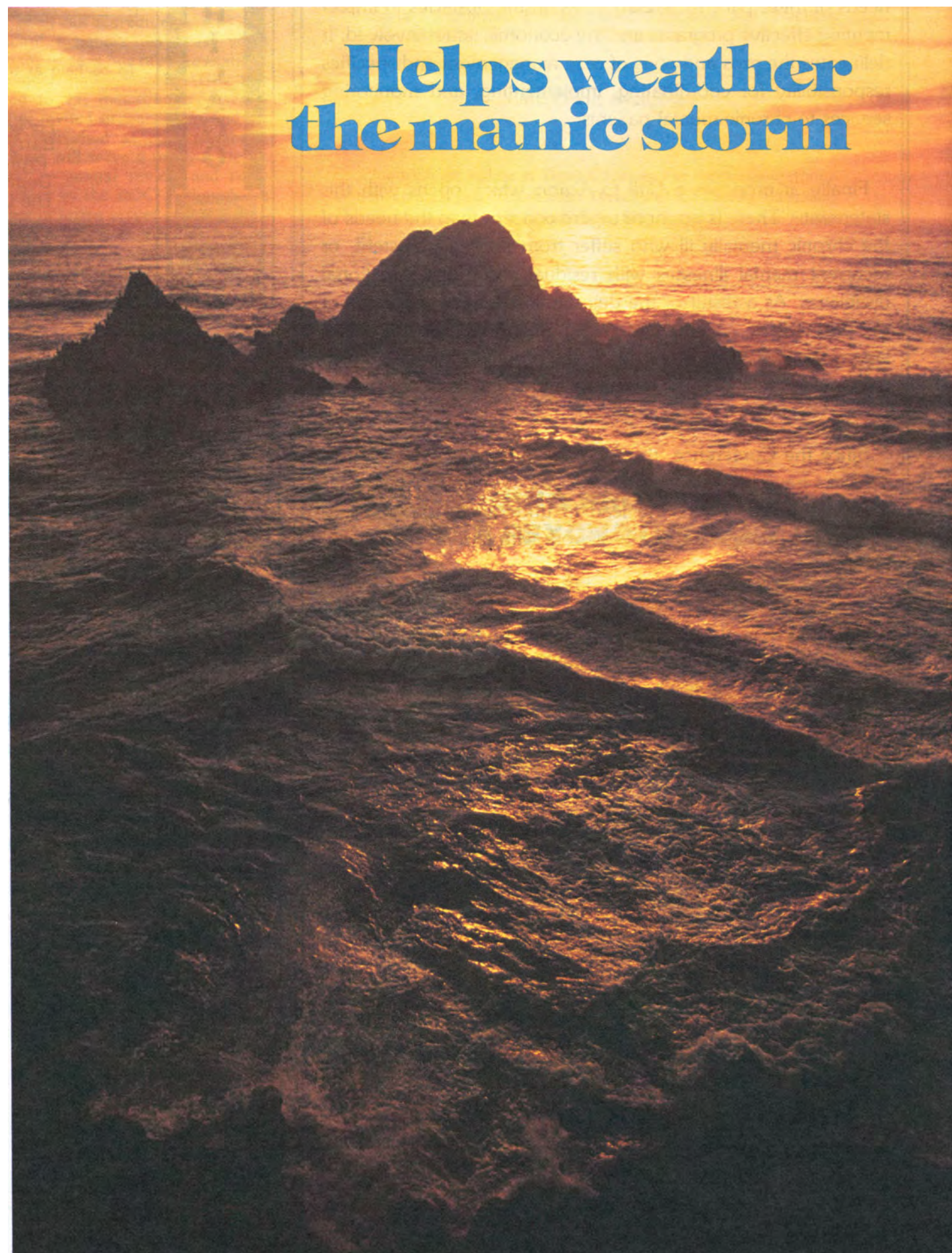
This letter is in response to an article in *Psychiatric News* of June 15, 1979, entitled "Decline of Psychiatric Residents Subject of Probe." During the past 27 years I have been closely allied to the psychiatric market as superintendent and chief medical director of the Madison State Hospital, Madison, 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.
Madison, Ind.

8A-9



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 respect 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

maintenance therapy with Eskalith® 300 mg capsules and 300 mg scored tablets brand of lithium carbonate

In manic-depressive patients with a history of mania, 'Eskalith'

- prevents or diminishes the intensity of future episodes
- can increase the intervals between episodes
- helps patients function within normal limits

Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

WARNING

Lithium toxicity is closely related to serum lithium levels, and can occur at doses close to therapeutic levels. Facilities for prompt and accurate serum lithium determinations should be available before initiating therapy.

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

WARNINGS: Lithium should generally not be given to patients with significant renal or cardiovascular disease, severe debilitation or dehydration, sodium depletion, or to patients receiving diuretics. Lithium may prolong the effects of neuromuscular blocking agents. Such agents should be given with caution to patients receiving lithium. Lithium therapy has been reported in some cases to be associated with morphologic changes in the kidneys.

Caution patient and family to watch for diarrhea, vomiting, tremor, mild ataxia, drowsiness, or muscular weakness as signs of lithium toxicity, and to discontinue therapy and contact a physician should they occur. Patients receiving combined therapy with lithium and an antipsychotic should be monitored closely for early evidence of neurologic toxicity and treatment discontinued promptly if such signs appear. Caution patients about activities requiring alertness (e.g., operating vehicles or machinery).

Lithium should not be used in pregnancy, especially during the first trimester, unless potential benefits outweigh possible hazards.

In general, nursing should not be undertaken while a patient is on lithium therapy, since lithium is excreted in human milk.

Not recommended for children under 12.

PRECAUTIONS: Lithium tolerance is greater during the acute manic phase and decreases when manic symptoms subside.

Lithium therapy may lead to sodium depletion. Normal diet (including salt) and adequate fluid intake (2500-3000 ml.) must be maintained, at least during initial stabilization period. Prolonged sweating or diarrhea can decrease tolerance; in such cases, administer supplemental fluid and salt.

Sweating, diarrhea, and concomitant infection with elevated temperatures may require temporary reduction or cessation of dosage.

ADVERSE REACTIONS: Mild to moderate toxic reactions may occur at serum lithium levels from 1.5 to 2.5 mEq./l., and moderate to severe reactions at levels from 2.0 to 2.5 mEq./l. Fine hand tremor, polyuria, and mild thirst may occur during initial therapy and persist. Transient and mild nausea and general discomfort may also appear during initial therapy. These effects usually subside with continued treatment or temporary reduction or cessation of dosage. If persistent, discontinue dosage. Diarrhea, vomiting, drowsiness, muscular weakness, and lack of coordination may be early signs of toxicity and may occur at levels below 2.0 mEq./l. At higher levels, ataxia, giddiness, tinnitus, blurred vision, and a large output of dilute urine may be seen. Serum levels above 3.0 mEq./l. may

produce a complex clinical picture, involving multiple organs and systems. Serum levels should not exceed 2.0 mEq./l. during acute phase.

The following reactions appear to be related to serum lithium levels, including levels within the therapeutic range: **Neuromuscular**—tremor, muscle hyperirritability (fasciculations, twitching, clonic movements of whole limbs), ataxia, choreo-athetotic movements, hyperactive deep tendon reflex; **Central Nervous System**—blackout spells, epileptiform seizures, slurred speech, dizziness, vertigo, incontinence of urine or feces, somnolence, psychomotor retardation, restlessness, confusion, stupor, coma; **Cardiovascular**—cardiac arrhythmia, hypotension, peripheral circulatory collapse; **Gastrointestinal**—anorexia, nausea, vomiting, diarrhea; **Genitourinary**—albuminuria, oliguria, polyuria, glycosuria; **Dermatologic**—drying and thinning of hair, alopecia, anesthesia of skin, chronic folliculitis, exacerbation of psoriasis, xerosis cutis; **Autonomic**—blurred vision, dry mouth; **Thyroid Abnormalities**—euthyroid goiter and/or hypothyroidism (including myxedema) with lower T₃ and T₄, I¹³¹ uptake may be elevated; rare cases of hyperthyroidism; **EKG Changes**—diffuse slowing, widening of the frequency spectrum, potentiation and disorganization of background rhythm; **EKG Changes**—reversible flattening, isoelectricity or inversion of T-waves; **Miscellaneous**—fatigue, lethargy, transient scotomata, dehydration, weight loss, tendency to sleep.

Reactions unrelated to dosage include: transient EEG and EKG changes, leukocytosis, headache, diffuse nontoxic goiter with or without hypothyroidism, transient hyperglycemia, generalized pruritus with or without rash, cutaneous ulcers, albuminuria, worsening of organic brain syndromes, excessive weight gain, edematous swelling of ankles or wrists, thirst or polyuria, sometimes resembling diabetes insipidus, and metallic taste. A single case of a syndrome resembling Raynaud's has been reported.

HOW SUPPLIED: 300 mg. capsules in bottles of 100, 300 mg. scored tablets in bottles of 100.

Smith Kline & French Laboratories
Philadelphia, PA



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

How to tell ATIVAN from other benzodiazepines.

Ativan is an effective, well-tolerated antianxiety agent. So are other benzodiazepines. But here are three ways Ativan stands out pharmacokinetically.*

1. Uncomplicated metabolic profile.

In contrast to most other benzodiazepines, the metabolic pathway of Ativan is straightforward. Ativan is active as given. Just one step from an active compound to an inactive one.

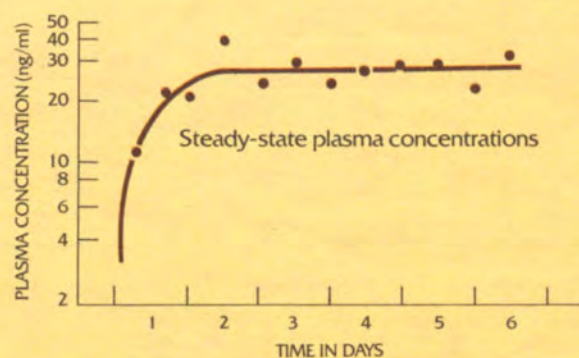
2. Steady-state levels achieved rapidly.

Most benzodiazepines take at least 7 to 10 days to reach steady-state serum levels. With Ativan, that equilibrium is reached in 2 to 3 days. A factor that can be important when you modify dosage schedules to meet individual needs.

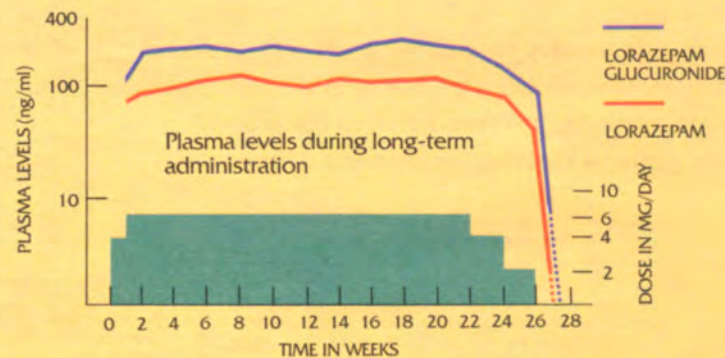
3. No accumulation of multiple metabolites.

Because Ativan has no active metabolites to be eliminated at varying rates, steady-state levels are achieved predictably and smoothly. Six-month studies show no evidence of drug-accumulation above steady-state levels even at maximum daily dosages.

*The pharmacokinetic profile of a drug cannot, at present, be directly related to its therapeutic effectiveness.



Concentrations of lorazepam on repeated-dose regimen (single 1-mg. tablets given at 9 a.m., 3 p.m. and 9 p.m. daily for 6 days). A steady state is achieved after the second day, and is maintained thereafter.



Lorazepam and lorazepam glucuronide plasma levels in ng/ml during chronic oral administration of the drug over a period of six months. Each point represents the mean of 8 subjects. The daily maintenance dose in milligrams per subject is given at weekly intervals.

ATIVAN® (LORAZEPAM)®

The uncomplicated benzodiazepine

Prescribing Information

Contraindications: Ativan is contraindicated in patients with known sensitivity to the benzodiazepines or with acute narrow-angle glaucoma.

Warnings: Ativan is not recommended for use in patients with a primary depressive disorder or psychosis. As with all patients on CNS-acting drugs, patients receiving lorazepam should be warned not to operate dangerous machinery or motor vehicles and that their tolerance for alcohol and other CNS depressants will be diminished.

Physical and Psychological Dependence: Withdrawal symptoms similar in character to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepine drugs. These symptoms include convulsions, tremor, abdominal and muscle cramps, vomiting and sweating. Addiction-prone individuals, such as drug addicts and alcoholics, should be under careful surveillance when receiving benzodiazepines because of the predisposition of such patients to habituation and dependence.

Precautions: In patients with depression accompanying anxiety a possibility for suicide should be borne in mind.

For elderly or debilitated patients, the initial daily dosage should not exceed 2 mg in order to avoid oversedation.

Ativan dosage should be terminated gradually since abrupt withdrawal of any antianxiety agent may result in

symptoms similar to those for which patients are being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions.

The usual precautions for treating patients with impaired renal or hepatic function should be observed.

In patients where gastrointestinal or cardiovascular disorders coexist with anxiety, it should be noted that lorazepam has not been shown to be of significant benefit in treating the gastrointestinal or cardiovascular component.

Esophageal dilation occurred in rats treated with lorazepam for more than one year at 6 mg/kg/day. The no-effect dose was 1.25 mg/kg/day (approximately 6 times the maximum human therapeutic dose of 10 mg per day). The effect was reversible only when the treatment was withdrawn within two months of first observation of the phenomenon. The clinical significance of this is unknown. However, use of lorazepam for prolonged periods and in geriatric patients requires caution, and there should be frequent monitoring for symptoms of upper G.I. disease.

Safety and effectiveness of Ativan in children of less than 12 years have not been established.

Essential Laboratory Tests: Some patients on Ativan have developed leukopenia and some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended for patients on long-term therapy.

Clinically Significant Drug Interactions: The benzodia-

zepines including Ativan produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

Carcinogenesis and Mutagenesis: No evidence of carcinogenic potential emerged in rats during an 18-month study with Ativan. No studies regarding mutagenesis have been performed.

Pregnancy: Reproductive studies in animals were performed in mice, rats, and two strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all of these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At doses of 40 mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses.

The clinical significance of the above findings is not known. However, an increased risk of congenital malformations associated with the use of minor tranquilizers (chloridazepoxide, diazepam and meprobamate) during the first trimester of pregnancy has been suggested in several studies. Because the use of these drugs is rarely a matter of urgency, the use of lorazepam during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant

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.

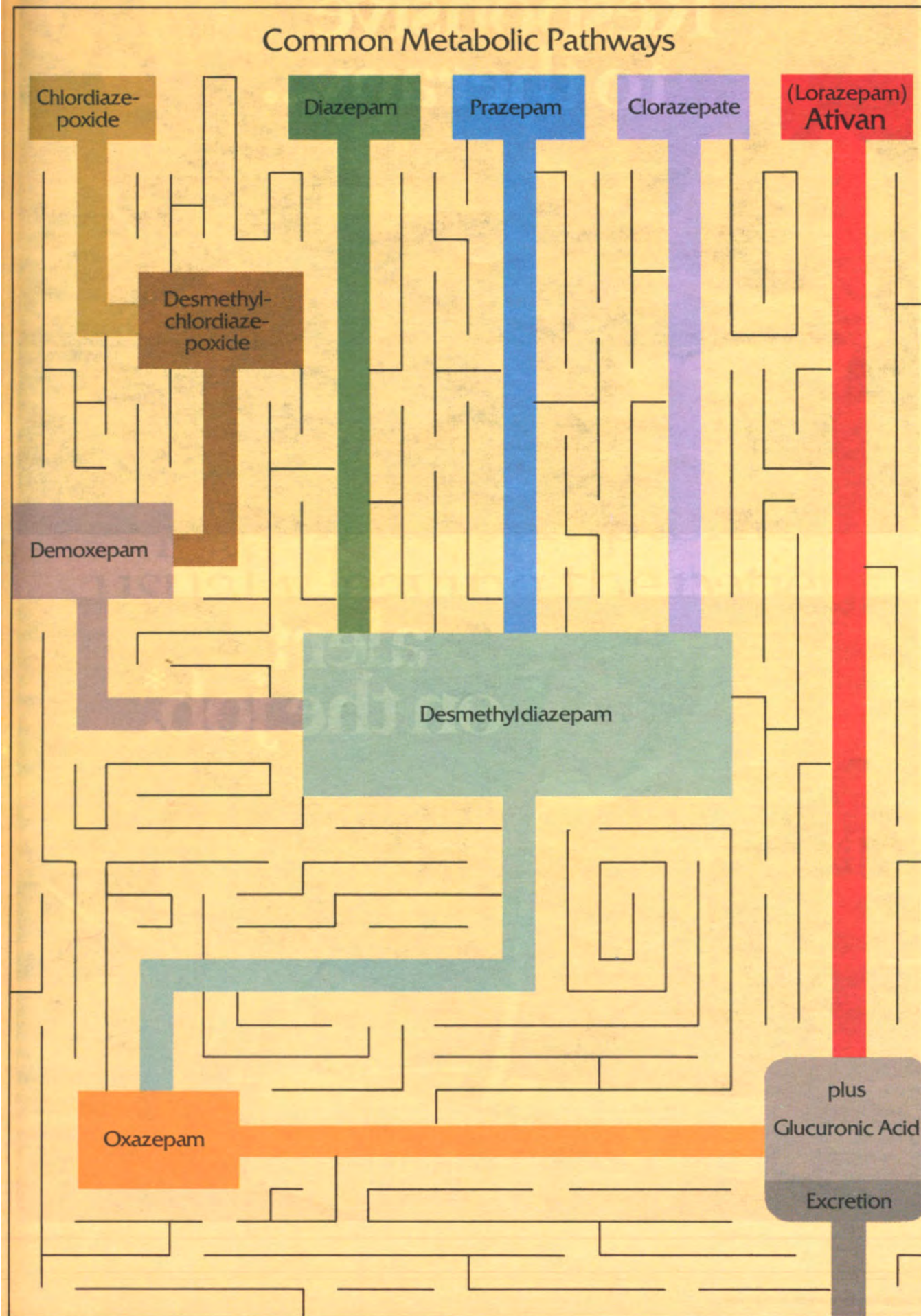
Its wide appraisal found that while in 1973 only about half the population favors more information to supplement physicians' instructions about the drugs they take, more recent evidence suggests that at least two thirds now want to be better informed. Studies have pointed out that patients are not exposed 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



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.

Copyright © 1978, Wyeth Laboratories Div. of AHPC, N.Y. N.Y. All rights reserved.

**A highly effective,
low-dose,
non-accumulating
anxiety agent.**

**(LORAZEPAM)®
ATIVAN®**

Wyeth Laboratories Philadelphia, Pa. 19101

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



A dosage form for every therapeutic need

-  **5 tablet strengths** for convenience in individualizing dosage: 1/2 mg, 1 mg, 2 mg, 5 mg and 10 mg.
-  **A tasteless, odorless, colorless liquid concentrate** for better patient compliance: 2 mg per ml.
-  **A rapid-acting injection** for psychiatric emergencies: 5 mg per ml, with 1.8 mg methylparaben and 0.2 mg propylparaben per ml, and lactic acid for pH adjustment to 3.4 ± 0.2.

Summary of Prescribing Information

Contraindications: Severe depression, coma, CNS depression due to centrally-acting depressants, Parkinson's disease, hypersensitivity to the drug.

Warnings: Usage in Pregnancy: Safe use in pregnancy or in women likely to become pregnant has not been established; use only if benefit clearly justifies potential hazards. Infants should not be nursed during drug treatment.

Usage in Children: Safety and effectiveness not established; not recommended in pediatric age group.

Combined Use With Lithium: Patients receiving lithium plus haloperidol should be monitored closely for early evidence of neurological toxicity.

General: Bronchopneumonia, sometimes fatal, has followed use of major haloperidol present as the lactate.

tranquilizers, including haloperidol. Prompt remedial therapy should be instituted if dehydration, hemoconcentration or reduced pulmonary ventilation occurs, especially in the elderly. Decreased serum cholesterol and/or cutaneous and ocular changes have been reported with chemically-related drugs, although not with haloperidol. Mental and/or physical abilities required for hazardous tasks or driving may be impaired. Alcohol should be avoided due to possible additive effects and hypotension.

Precautions: Administer cautiously to patients: (1) with severe cardiovascular disorders, due to the possibility of transient hypotension and/or precipitation of anginal pain (if a vasopressor is required, epinephrine should not be used since HALDOL haloperidol may block its vasopressor activity and paradoxical further lowering of blood pressure may occur); (2) receiving anticonvulsant medication since HALDOL haloperidol may lower the convulsive threshold; (3) with known allergies or a history of allergic reactions to drugs; (4) receiving anticoagulants. Concomitant antiparkinson medication, if required, may have to be continued after HALDOL haloperidol is discontinued because of different excretion rates; if both are discontinued simultaneously, extrapyramidal symptoms may occur. Intraocular pressure may increase when anticholinergic drugs, including antiparkinson drugs, are administered concomitantly with HALDOL haloperidol. When HALDOL haloperidol is used for mania in cyclic disorders, there may be a rapid mood swing to depression. Severe neurotoxicity may occur in patients with thyrotoxicosis receiving antipsychotic medication, including HALDOL haloperidol.

Adverse Reactions: CNS Effects: Extrapyramidal Reactions: Neuromuscular (extrapyramidal) reactions have been reported frequently, often during the

Haldol[®]

(haloperidol)
tablets/concentrate/injection

Promptly controls psychotic symptoms... usually leaving the patient alert and productive

Highly effective in a wide range of both acute and chronic psychotic disorders,^{1,7} such as hallucinations, delusions, suspiciousness, hostility, mania.

Permits aggressive titration to effective dosage levels for optimal response.^{1,4}

Facilitates prompt initiation of other therapeutic efforts... and often helps avoid hospitalization.^{1,3}

Minimal risk of hypotension, oversedation, or troublesome anticholinergic effects.^{2,4,6,8,9}

Transient hypotension occurs rarely; severe orthostatic hypotension has not been reported. Although some instances of drowsiness have been reported, marked sedation is rare.

Common side effects easily controlled.^{1,2,4,7}

Although extrapyramidal symptoms (EPS) have been reported frequently, they are usually dose-related and readily controlled with dose adjustment or antiparkinson drugs. EPS often diminish spontaneously with continued use of HALDOL haloperidol.

References: 1. Man, P.L.: Dis. Nerv. Syst. 34:113 (Feb.) 1973. 2. Ayd, F.J., Jr.: Med. Sci. 18:55 (Oct.) 1967. 3. Rapp, M.S.: Can. Psychiatr. Assoc. J. 15:73 (Feb.) 1970. 4. Howard, J.S.: Dis. Nerv. Syst. 35:458 (Oct.) 1974. 5. Gerle, B.: Clin. Trials J. 3:380 (Feb.) 1966. 6. Abuzahab, E.S., Sr.: Psychosomatics 11:188 (May-June) 1970. 7. Darling, H.F.: Dis. Nerv. Syst. 34:364 (Oct.-Nov.) 1973. 8. Snyder, S.H., et al: Science 184:1243 (June 21) 1974. 9. Stimmel, C.L.: Dis. Nerv. Syst. 34:219 (Apr.) 1976.

*Not an actual case history, this situation illustrates the action of HALDOL haloperidol as reported in various clinical studies (available on request).

first few days of treatment. Generally they involved Parkinson-like symptoms which were usually mild to moderately severe and usually reversible. Other types of neuromuscular reactions (motor restlessness, dystonia, akathisia, hyperreflexia, opisthotonos, oculogyric crises) have been reported far less frequently, but were often more severe. Severe extrapyramidal reactions have been reported at relatively low doses. Generally, extrapyramidal symptoms are dose-related since they occur at relatively high doses and disappear or become less severe when the dose is reduced. Antiparkinson drugs may be required. Persistent extrapyramidal reactions have been reported and the drug may have to be discontinued in such cases.

Withdrawal Emergent Neurological Signs: Abrupt discontinuation of short-term antipsychotic therapy is generally uneventful. However, some patients on maintenance treatment experience transient dyskinetic signs after abrupt withdrawal. In certain cases these are indistinguishable from "Persistent Tardive Dyskinesia" except for duration. It is unknown whether gradual withdrawal will reduce the occurrence of these signs, but until further evidence is available haloperidol should be gradually withdrawn.

Persistent Tardive Dyskinesia: Although rarely reported with HALDOL haloperidol, tardive dyskinesia may appear during or after long-term therapy. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and sometimes appear irreversible; there is no known effective treatment and all antipsychotic agents should be discontinued. The syndrome may be masked by reinstitution of drug, increasing dosage, or switching to a different antipsychotic agent.

Other CNS Effects: Insomnia, restlessness, anxiety, euphoria, agitation,

drowsiness, depression, lethargy, headache, confusion, vertigo, grand mal seizures, and exacerbation of psychotic symptoms.

Cardiovascular Effects: Tachycardia and hypotension. **Hematologic Effects:** Reports of mild, usually transient leukopenia and leukocytosis, minimal decreases in red blood cell counts, anemia, or a tendency toward lymphomonocytosis; agranulocytosis rarely reported and only in association with other medication. **Liver Effects:** Impaired liver function and/or jaundice reported. **Dermatologic Reactions:** Maculopapular and acneiform reactions, isolated cases of photosensitivity, loss of hair. **Endocrine Disorders:** Lactation, breast engorgement, mastalgia, menstrual irregularities, gynecomastia, impotence, increased libido, hyperglycemia and hypoglycemia. **Gastrointestinal Effects:** Anorexia, constipation, diarrhea, hypersalivation, dyspepsia, nausea and vomiting. **Autonomic Reactions:** Dry mouth, blurred vision, urinary retention and diaphoresis. **Respiratory Effects:** Laryngospasm, bronchospasm and increased depth of respiration.

The injectable form is intended only for acutely agitated psychotic patients with moderately severe to very severe symptoms.

Caution: Federal law prohibits dispensing without prescription.

Full directions for use should be read before HALDOL haloperidol is administered or prescribed.

HALDOL tablets are manufactured by McNeil Laboratories Co., Dorado, Puerto Rico 00646.

McNEIL

McNeil Laboratories, McNEILAB, Inc.,
Fort Washington, PA 19034

5/77

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 Col-dewey, 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.

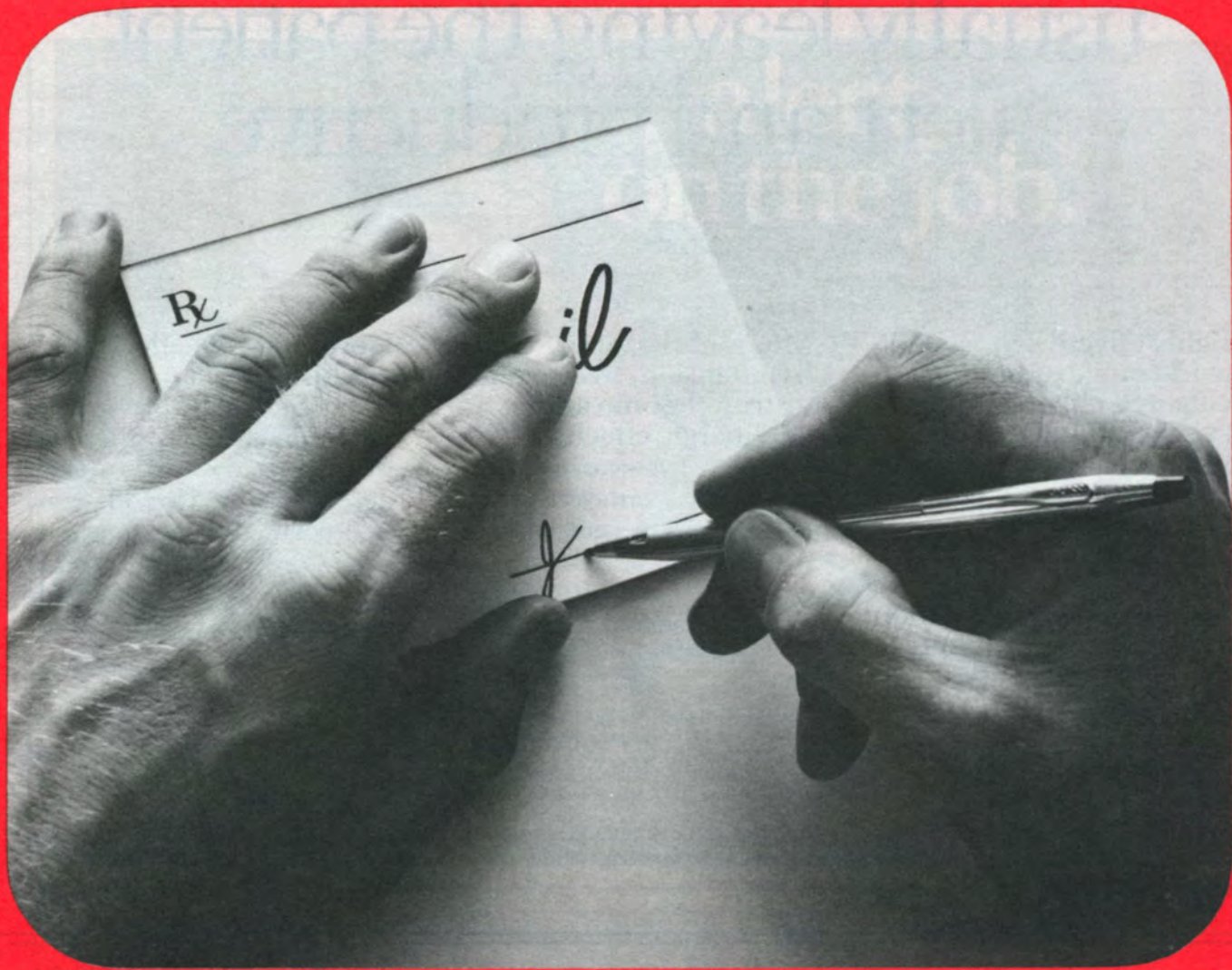
* * *

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.

There is no substitute



yours...

Contraindications: Known hypersensitivity. Should not be given concomitantly with a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred. When used to replace a monoamine oxidase inhibitor, allow a minimum of 14 days to elapse before initiating therapy with amitriptyline HCl. Initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction.

Warnings: May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or a history of urinary retention, or with angle-closure glaucoma or increased intraocular pressure; in patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. In patients who use alcohol excessively, potentiation may increase the danger inherent in any suicide attempt or overdose. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child. Not recommended for patients under 12 years of age.

Precautions: Schizophrenic patients may develop increased symptoms of psychosis; patients with paranoid symptomatology may have an exaggeration of such symptoms; manic depressive patients may experience a shift to the manic phase. In these circum-

stances, the dose of amitriptyline HCl may be reduced or a major tranquilizer, such as perphenazine, may be administered concurrently.

When given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required; paralytic ileus may occur in patients taking tricyclic antidepressants in combination with anticholinergic-type drugs. Use cautiously in patients receiving large doses of ethchlorvynol, since transient delirium has been reported on concurrent administration. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains until significant remission occurs. Potentially suicidal patients should not have access to large quantities of this drug. Prescriptions should be written for the smallest amount feasible. Concurrent electroshock therapy may increase the hazards associated with such therapy; such treatment should be limited to patients for whom it is essential.

When possible, discontinue the drug several days before elective surgery. Both elevation and lowering of blood sugar levels have been reported. Use with caution in patients with impaired liver function.

Adverse Reactions: Note: Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered. **Cardiovascular:** Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. **CNS and Neuromuscular:** Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappro-

Copyright © 1979 by Merck & Co., Inc.

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.

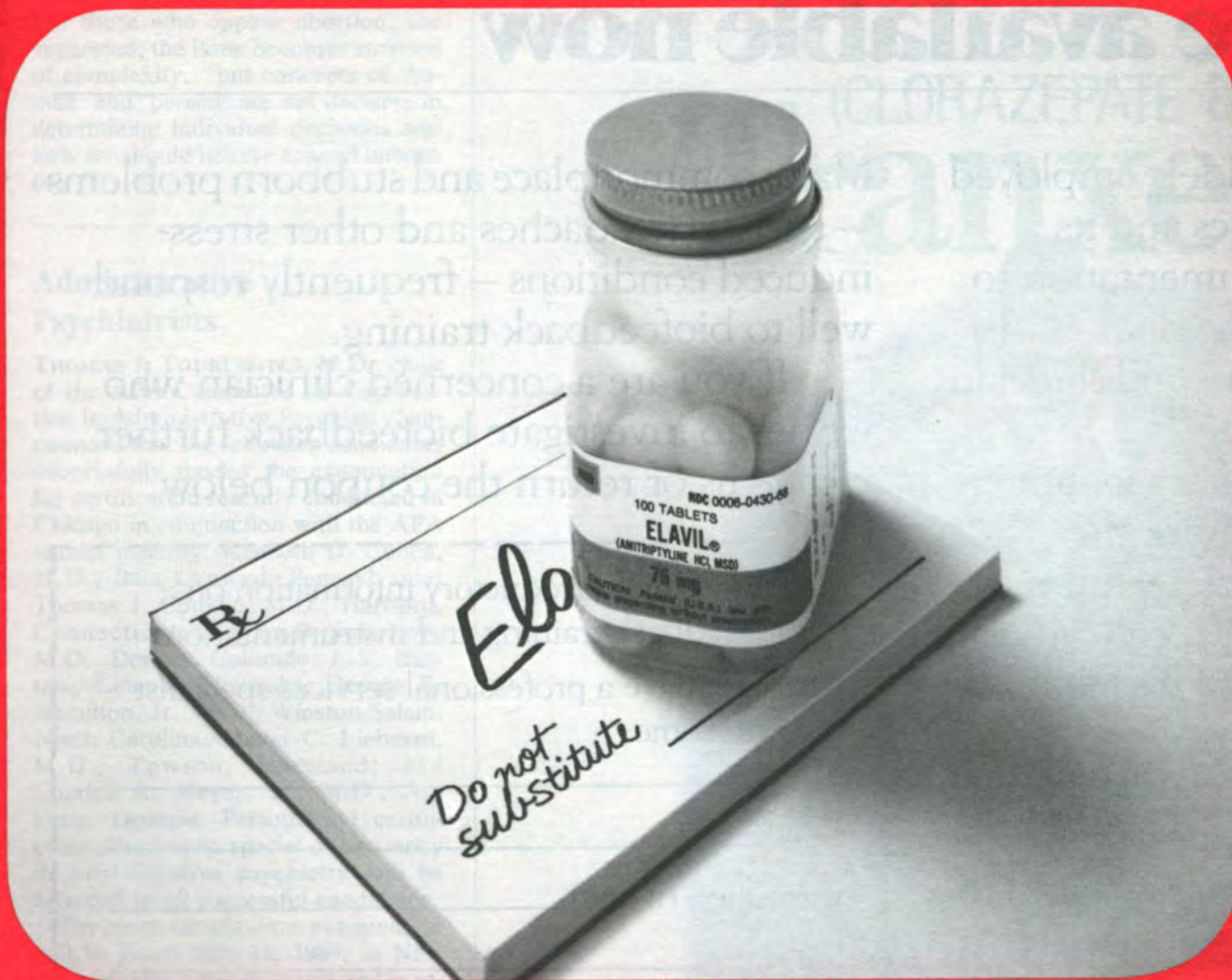
Three female psychiatrists, Christine Bienick, Gail M. Barton, and Elissa Benedek (M.D.s), have been doing research interviews with female therapists, seeking to assess whether there are indeed training gaps and how these may be compensated. Bienick presented preliminary observations from interview data 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

for experience—



or ours.

priate ADH (antidiuretic hormone) secretion. **Anticholinergic:** Dry mouth, blurred vision, disturbance of accommodation, increased intraocular pressure, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. **Allergic:** Skin rash, urticaria, photosensitization, edema of face and tongue. **Hematologic:** Bone marrow depression including agranulocytosis, leukopenia, eosinophilia, purpura, thrombocytopenia. **Gastrointestinal:** Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling, black tongue, rarely hepatitis (including altered liver function and jaundice). **Endocrine:** Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido, elevation and lowering of blood sugar levels. **Other:** Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, alopecia. **Withdrawal Symptoms:** Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction. **Overdosage:** Hospitalize as soon as possible all patients suspected of having taken an overdose. Treatment is symptomatic and supportive. In addition, the intravenous administration of 1 to 3 mg physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage should be repeated as required, particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. **How Supplied:** Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; tablets containing 75 mg and 100 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100; tablets containing 150 mg amitriptyline HCl, in single-unit packages of 100 and bottles

of 30 and 100, for intramuscular use, in 10-ml vials containing per ml: 10 mg amitriptyline HCl, 44 mg dextrose, 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives, and water for injection q.s. 1 ml. For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486 J9EL29(116)

MSD
MERCK
SHARP
DOHME

In clinically significant depression

TABLETS: 10 mg, 25 mg, 50 mg, 75 mg, 100 mg, and 150 mg
INJECTION: 10 mg per ml

Elavil®
(AMITRIPTYLINE HCl | MSD)

Clinical Biofeedback

The professional skills are easily acquired and the benefits to your patients are available now

Biofeedback is now a widely employed clinical technique. Autogenics and its affiliate have supplied instrumentation to over 600 hospitals, 500 universities, and thousands of other institutions and clinicians in private practice.

Large numbers of private practitioners have found it simple to acquire the skills to integrate biofeedback techniques with traditional therapeutic procedures. As the largest manufacturer of biofeedback instruments, Autogenics assists clinicians by guiding them to authoritative biofeedback handbooks, to one-day and two-day professional seminars, and to reference materials regarding efficacy, applications, patient selection and clinical protocols.

Biofeedback therapy is particularly useful in treating psychosomatic, psychological and neuromuscular disorders.

Many commonplace and stubborn problems — such as headaches and other stress-induced conditions — frequently respond well to biofeedback training.

If you are a concerned clinician who wishes to investigate biofeedback further, phone us or return the coupon below.

☐ Please send introductory information on biofeedback training and instrumentation.

☐ Please have a professional services specialist contact me.

Name_____

Specialty_____

Institution (if any)_____

Position_____

Address_____

_____ Zip_____

Mail to Autogenic Systems, Inc., Dept. P, 809 Allston Way, Berkeley, CA 94710. Phone (415) 548-6056.

AutogenicsTM

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."

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.

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 re-

placement. 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

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

Anxiety symptoms dispelled, yet not drowsy by day.

(CLORAZEPATE DIPOTASSIUM)
Tranxene® 

3.75, 7.5, and 15 mg capsules
11.25 and 22.5 mg
single-dose tablets



Lets you calm most patients without oversedating them.



As with all benzodiazepines, patients should be cautioned against hazardous tasks requiring mental alertness. See overleaf for brief summary.

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, chlor-diazepoxide, clonazepam, dextro-amphetamine, diazepam, disulfiram, ethchlorvynol, flurazepam, glutethimide, levodopa/carbidopa, meprobamate, methylphenidate, and oxazepam.

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

Anxiety symptoms dispelled, yet not drowsy by day.

Tranxene®

(CLORAZEPATE DIPOTASSIUM) 4306CB CAPSULES, 3.75, 7.5, and 15 mg TRANXENE-SD SINGLE DOSE TABLETS, 11.25 and 22.5 mg

Brief Summary

INDICATIONS — TRANXENE is indicated for the symptomatic relief of anxiety associated with anxiety neurosis, in other psychoneuroses in which anxiety symptoms are prominent features, and as an adjunct in disease states in which anxiety is manifested.

TRANXENE is indicated for the symptomatic relief of acute alcohol withdrawal.

The effectiveness of TRANXENE in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should reassess periodically the usefulness of the drug for the individual patient.

CONTRAINDICATIONS — TRANXENE is contraindicated in patients with a known hypersensitivity to the drug, and in those with acute narrow angle glaucoma.

WARNINGS — TRANXENE is not recommended for use in depressive neuroses or in psychotic reactions.

Patients on TRANXENE should be cautioned against engaging in hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles.

Since TRANXENE has a central nervous system depressant effect, patients should be advised against the simultaneous use of other CNS-depressant drugs, and cautioned that the effects of alcohol may be increased.

Because of the lack of sufficient clinical experience, TRANXENE is not recommended for use in patients less than 18 years of age.

Physical and Psychological Dependence: Withdrawal symptoms (similar in character to those noted with barbiturates and alcohol) have occurred following abrupt discontinuance of clorazepate. Symptoms of nervousness, insomnia, irritability, diarrhea, muscle aches and memory impairment have followed abrupt withdrawal after long-term use of high dosage.

Caution should be observed in patients who are considered to have a psychological potential for drug dependence.

Evidence of drug dependence has been observed in dogs and rabbits which was characterized by convulsive seizures when the drug was abruptly withdrawn or the dose was reduced; the syndrome in dogs could be abolished by administration of clorazepate.

Usage in Pregnancy: An increased risk of congenital malformations associated with the use of minor tranquilizers (chlor-diazepoxide, diazepam, and meprobamate) during the first trimester of pregnancy has been suggested in several studies. TRANXENE, a benzodiazepine derivative, has not been studied adequately to determine whether it, too, may be associated with an increased

risk of fetal abnormality. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of childbearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physician about the desirability of discontinuing the drug.

Usage during Lactation:

TRANXENE should not be given to nursing mothers since it has been reported that nordiazepam is excreted in human breast milk.

PRECAUTIONS — In those patients in which a degree of depression accompanies the anxiety, suicidal tendencies may be present and protective measures may be required. The least amount of drug that is feasible should be available to the patient.

Patients on TRANXENE for prolonged periods should have blood counts and liver function tests periodically. The usual precautions in treating patients with impaired renal or hepatic function should also be observed.

In elderly or debilitated patients, the initial dose should be small, and increments should be made gradually, in accordance with the response of the patient, to preclude ataxia or excessive sedation.

ADVERSE REACTIONS — The side effect most frequently reported was drowsiness. Less commonly reported (in descending order of occurrence) were: dizziness, various gastrointestinal complaints, nervousness, blurred vision, dry mouth, headache, and mental confusion. Other side effects included insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression and slurred speech.

There have been reports of abnormal liver and kidney function tests and of decrease in hematocrit. Decrease in systolic blood pressure has been observed.

DOSEAGE AND ADMINISTRATION

For the symptomatic relief of anxiety:

TRANXENE is administered orally. The capsules may be given in divided doses. The usual daily dose is 30 mg. The dose should be adjusted gradually within the range of 15 to 60 mg daily in accordance with the response of the patient. In elderly or debilitated patients it is advisable to initiate treatment at a daily dose of 7.5 to 15 mg.

TRANXENE capsules may also be administered as a single dose daily at bedtime; the recommended initial dose is 15 mg. After the initial dose, the response of the patient may require adjustment of subsequent dosage. Lower doses may be indicated in the elderly patient. Drowsiness may occur at the initiation of treatment and with dosage increment.

TRANXENE-SD tablets (22.5 mg) may be administered as a single dose every 24 hours. This tablet is intended as an alternate dosage form for the convenience of patients stabilized on a dose of 7.5 mg capsules three times a day. TRANXENE-SD tablets

should not be used to initiate therapy.

TRANXENE-SD HALF STRENGTH tablets (11.25 mg) may be administered as a single dose every 24 hours.

For the symptomatic relief of acute alcohol withdrawal:

Recommended schedule: 1st 24 hours, 30 mg TRANXENE initially, followed by 30 to 60 mg in divided doses; 2nd 24 hours, 45 to 90 mg in divided doses; 3rd 24 hours, 22.5 to 45 mg in divided doses; 4th day, 15 to 30 mg in divided doses. Thereafter gradually reduce to 7.5 to 15 mg daily, and discontinue as soon as condition is stable. Maximum daily dose is 90 mg. Avoid excessive reductions in total drug on successive days.

DRUG INTERACTIONS — If TRANXENE is to be combined with other drugs acting on the central nervous system, careful consideration should be given to the pharmacology of the agents to be employed. Animal experience indicates that TRANXENE prolongs the sleeping time after hexobarbital or after ethyl alcohol, increases the inhibitory effects of chlorpromazine, but does not exhibit monoamine oxidase inhibition. Clinical studies have shown increased sedation with concurrent hypnotic medications. The actions of the benzodiazepines may be potentiated by barbiturates, narcotics, phenothiazines, monoamine oxidase inhibitors or other antidepressants.

If TRANXENE is used to treat anxiety associated with somatic disease states, careful attention must be paid to possible drug interaction with concomitant medication.

MANAGEMENT OF OVERDOSAGE — Overdosage is usually manifested by varying degrees of CNS depression ranging from slight sedation to coma. As in the management of overdosage with any drug, it should be borne in mind that multiple agents may have been taken.

There are no specific antidotes for the benzodiazepines. The treatment of overdosage should consist of the general measures employed in the management of overdosage of any CNS depressant. Gastric evacuation either by the induction of emesis, lavage, or both, should be performed immediately. General supportive care, including frequent monitoring of the vital signs and close observation of the patient, is indicated. Hypotension, though rarely reported, may occur with large overdoses. In such cases the use of agents such as Levophed® Bitartrate (levarterenol bitartrate injection, USP) or Aramine® Injection (metaraminol bitartrate injection, USP) should be considered.

While reports indicate that individuals have survived overdoses of TRANXENE (clorazepate dipotassium) as high as 450 to 675 mg, these doses are not necessarily an accurate indication of the amount of drug absorbed since the time interval between ingestion and the institution of treatment was not always known. Sedation in varying degrees was the most common physiological manifestation of TRANXENE overdosage. Deep coma when it occurred was usually associated with the ingestion of other drugs in addition to TRANXENE.



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

Psychiatric News, August 3, 1979

Do lithium dosage schedules keep your patients going around in circles?

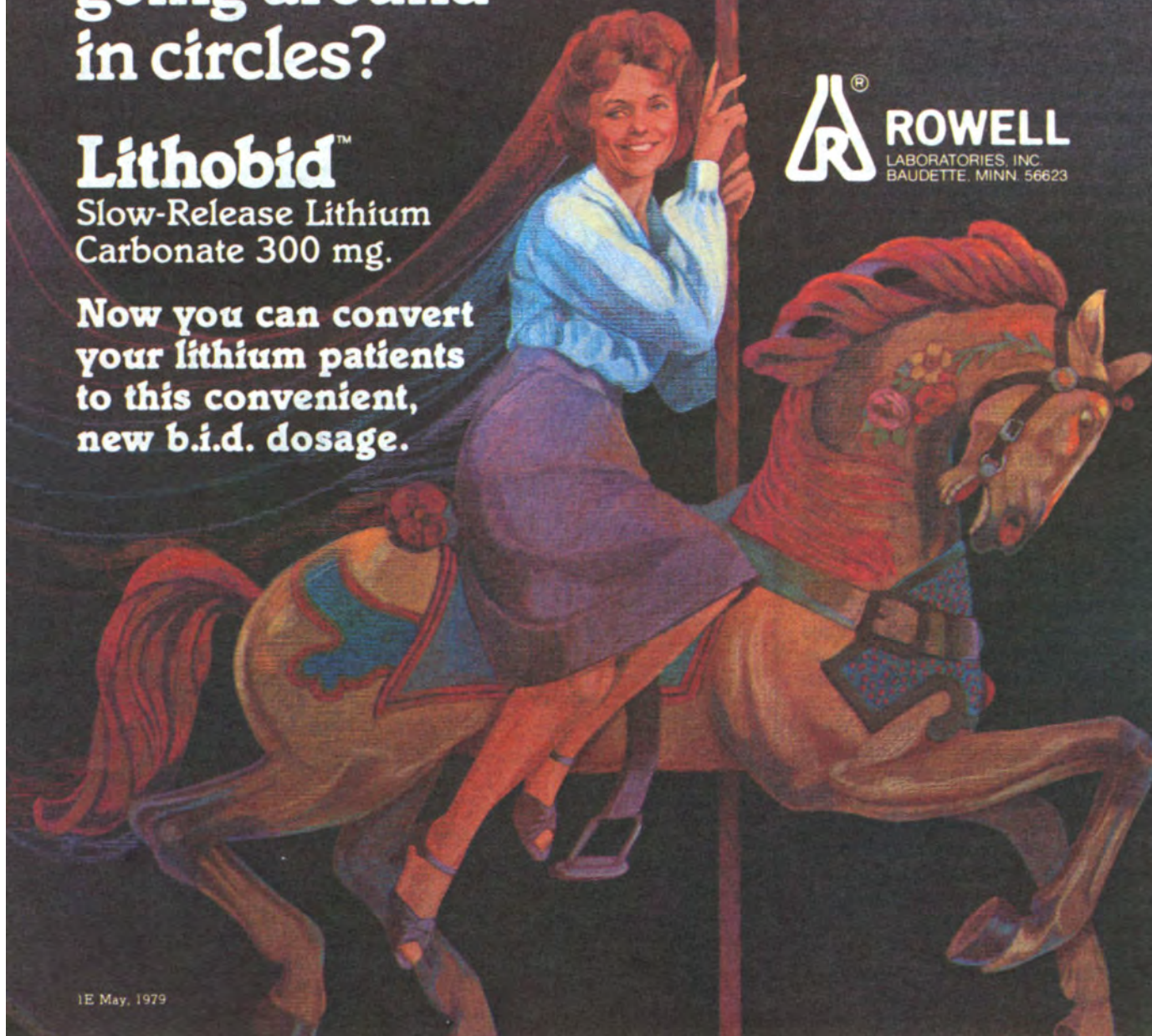
Lithobid™ Slow-Release Lithium Carbonate 300 mg.

Now you can convert your lithium patients to this convenient, new b.i.d. dosage.

Slow-Release Lithobid enables twice-a-day dosing as a practical route to better patient compliance. Patients on conventional lithium dosage forms can be converted to new Lithobid at the same daily dose, divided b.i.d. All patients on long-term lithium maintenance therapy will appreciate the convenience of this reduced dosage frequency.

Conventional tablets or capsules cause serum lithium spikes. New Lithobid blunts these peaks and keeps post-absorption serum levels within bounds.

ROWELL
LABORATORIES, INC.
BAUDETTE, MINN. 56623



Lithobid™ Slow-Release Lithium Carbonate 300 mg.

Before prescribing, see complete prescribing information in Rowell literature. The following is a brief summary.

WARNING

Lithium toxicity is closely related to serum lithium levels, and can occur at doses close to therapeutic levels. Facilities for prompt and accurate serum lithium determinations should be available before initiating therapy.

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

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

Lithium therapy has been reported in some cases to be associated with morphologic changes in the kidneys.

Caution patient and family to watch for diarrhea, vomiting, tremor, mild ataxia, drowsiness, or muscular weakness as signs of lithium toxicity, and to discontinue therapy and contact a physician should they occur. Patients receiving combined therapy with lithium and an antipsychotic should be monitored closely for early evidence of neurologic toxicity and treatment discontinued promptly if such signs appear. Caution patients about activities requiring alertness (e.g., operating vehicles or machinery).

Lithium should not be used in pregnancy, especially during the first trimester, unless potential benefits outweigh possible hazards.

Not recommended for children under 12.

Precautions: Lithium tolerance is greater during the acute manic phase and decreases when manic symptoms subside.

Lithium therapy may lead to sodium depletion. Normal diet (including salt) and adequate fluid intake (2500-3000 ml) must be maintained, at least during initial stabilization period. Protracted sweating or diarrhea can decrease tolerance; in such cases, administer supplemental fluid and salt.

Each tablet contains 40 mg of sodium chloride, equivalent to 15.7 mg of sodium. Sweating, diarrhea, and concomitant infection with elevated temperatures may require temporary reduction or cessation of dosage.

Adverse Reactions: Mild to moderate toxic reactions may occur at serum lithium levels from 1.5 to 2.5 mEq/L, and moderate to severe reactions at levels from 2.0 to 2.5 mEq/L. Fine hand tremor, polyuria, and mild thirst may occur during initial therapy and persist. Transient and mild nausea and general discomfort also appear during initial therapy. These effects usually subside with continued treatment or temporary reduction or cessation of dosage. If persistent, discontinue dosage.

Diarrhea, vomiting, drowsiness, muscular weakness, and lack of coordination may be early signs of toxicity and may occur at levels below 2.0 mEq/L. At higher levels, ataxia, giddiness, tinnitus, blurred vision, and a large output of dilute urine may be seen. Serum levels above 3.0 mEq/L may produce a complex clinical picture, involving multiple organs and systems. Serum levels should not exceed 2.0 mEq/L during acute phase.

The following reactions appear to be related to serum lithium levels, including levels within the therapeutic range: Neuromuscular—tremor, muscle hyperirritability (fasciculations, twitching, clonic movements of whole limbs), ataxia, choreo-athetotic movements, hyperactive deep tendon reflex; Central Nervous System—blackout spells, epileptiform seizures, slurred speech, dizziness, vertigo, incontinence of urine or feces, somnolence, psychomotor retardation, restlessness, confusion, stupor, coma; Cardiovascular—cardiac arrhythmia, hypotension, peripheral circulatory collapse; Gastrointestinal—anorexia, nausea, vomiting, diarrhea; Genitourinary—albuminuria, oliguria, polyuria, glycosuria; Dermatologic—drying and thinning of hair, alopecia, anesthesia of skin, chronic folliculitis, exacerbation of psoriasis, xerosis cutis; Autonomic—blurred vision, dry mouth; Thyroid Abnormalities—euthyroid goiter and/or hypothyroidism (including myxedema) with lower T₃ and T₄.¹³¹ uptake may be elevated; EEG Changes—diffuse slowing, widening of the frequency spectrum, potentiation and disorganization of background rhythm; EKG Changes—reversible flattening, isoelectricity or inversion of T-waves; Miscellaneous—fatigue, lethargy, transient scotomata, dehydration, weight loss, tendency to sleep.

Reactions unrelated to dosage include: transient EEG and EKG changes, leukocytosis, headache, diffuse nontoxic goiter with or without hypothyroidism, transient hyperglycemia, generalized pruritus with or without rash, cutaneous ulcers, albuminuria, worsening of organic brain syndromes, excessive weight gain, edematous swelling of ankles or wrists, thirst or polyuria, sometimes resembling diabetes insipidus, and metallic taste. A single case of a syndrome resembling Raynaud's has been reported.

Dosage and Administration: *Acute Mania*—900 mg b.i.d. or 600 mg t.i.d. (1800 mg per day) usually will provide serum lithium levels ranging between 1.0 and 1.5 mEq/L. Serum levels should be determined twice per week until serum level and clinical condition have been stabilized.

Long-Term Control—900 mg to 1200 mg per day in two or three divided doses usually will maintain serum lithium levels at 0.6 to 1.2 mEq/L. Serum lithium levels should be monitored at least every two months.

How Supplied: 300 mg peach-colored tablets, imprinted "ROWELL 7514" in red, are supplied in bottles of 100 and 1000.

ROWELL LABORATORIES, INC.
BAUDETTE, MINN. 56623

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

ANXIETY

SIMPLE SYMPTOM...OR SYNDROME?



Some psychiatrists consider anxiety a simple symptom complex¹

Some psychiatrists maintain that anxiety is a self-limiting symptomatic reaction to stressful circumstances that occurs when the magnitude of the stress surpasses the patient's ability to cope.

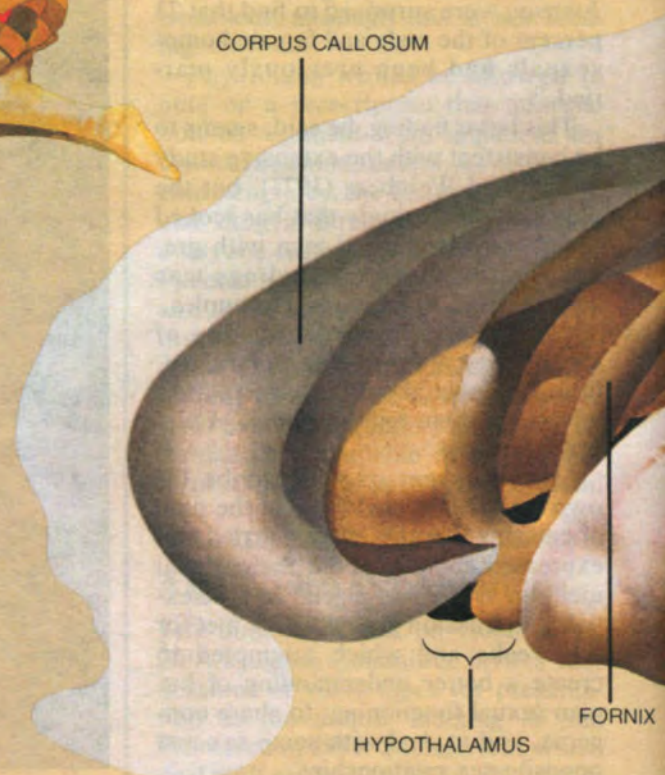
1. *Stress Without Distress*. Hans Selye, interviewed by McCrie R: *Pract Psychol for Physicians* 3:52-56, Aug 1976

2. Fisher S: Anxiety: What causes it and how to treat it, a panel discussion reprinted in *Medical Opinion* 6:5-25, July 1977

3. Brazier MAB, Crandall PH, Walsh GO: *Exp Neurol* 51:241-258, Apr 1976

Others suggest it is a syndrome, a true disorder²

Psychiatrists who view anxiety as a syndrome theorize that its etiology and/or maintenance is primarily dependent on events within the central nervous system. They point out that certain individuals appear to be inherently more anxiety-prone than others—seem not only to perceive a wider range of situations as threaten-



The limbic system, thought to be the seat of the emotions. Changes in limbic system function could lead to peripheral overarousal—interpreted by the patient as anxiety. Studies in animals and a limited study in human beings³ support the premise



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

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months,

has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency

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 as 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 given

See “Children,” page 30

ROCHE

ing but to respond to these situations with more pronounced levels of CNS arousal and subjective anxiety.

Symptom or syndrome, anxiety responds to Valium (diazepam)

When a patient’s coping mechanisms are insufficient to deal with his level of anxiety, Valium can promptly and effectively relieve the anxiety and its somatic symptoms. Initial calming often occurs in hours. After several

days of Valium (diazepam) therapy, anxiety relief is pronounced and sustained. And as the anxiety is reduced, accompanying tension, insomnia-like symptoms and somatic symptoms are also relieved.

Available in three scored tablet strengths, Valium allows you to set, adjust and readjust dosage as appropriate. For patients prone to anxiety at bedtime, you may want to add an *h.s.* dose to a *b.i.d.* or *t.i.d.* regimen.

Valium is usually well tolerated; side effects more severe than drowsiness, fatigue or ataxia are rare. As with all CNS-acting medications, patients should be cautioned against drinking alcohol or operating dangerous machinery while on Valium therapy.

Periodic reassessment of the necessity for Valium is recommended.

CINGULATE GYRUS

THALAMUS

HIPPOCAMPUS

LENTIFORM NUCLEUS

AMYGDALA

VALIUM[®] (diazepam)[®]

2-mg, 5-mg, 10-mg scored tablets

UNTIL THE PATIENT CAN COPE AGAIN

that Valium (diazepam) produces its calming effects by acting on parts of the limbic system, the thalamus and hypothalamus. However, further research will be necessary to establish the modes and sites of action of Valium in human beings.

and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss

therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin

rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Therapist

Continued from page 15

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 stereotyping 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

The therapeutic window helps you see the difference between Pamelor® (nortriptyline HCl) and other antidepressants.



Indications: For relief of depressive symptoms. Endogenous depressions are more likely to be alleviated than others.

Contraindications: Hypersensitivity. Should not be given concomitantly with MAO inhibitors or within 2 weeks of the use of this drug since hyperpyretic crises, severe convulsions, and fatalities have occurred when similar tricyclic antidepressants were used in such combinations. Cross-sensitivity with other dibenzazepines is a possibility. Contraindicated during acute recovery period after myocardial infarction.

Warnings: Use with caution in patients with cardiovascular disease because of tendency to produce sinus tachycardia and prolong conduction time. Myocardial infarction, arrhythmia, and strokes have occurred. May block antihypertensive action of guanethidine and similar agents. Because of anticholinergic activity, use cautiously in patients with glaucoma or a history of urinary retention. Patients with a history of seizures should be followed closely because the drug is known to lower the convulsive threshold.

Great care is required for hyperthyroid patients and those taking thyroid medication because of possible development of cardiac arrhythmia. Caution patients about possibility of impaired mental and/or physical ability to operate a motor vehicle or dangerous machinery. Response to alcoholic beverages may be exaggerated and may lead to suicidal attempts. Safe use during pregnancy, lactation, and women of childbearing potential has not been established and the drug should not be given unless clinical situation warrants potential risk. Not recommended for use in children.

Precautions: Psychotic symptoms may be exacerbated in schizophrenic patients. Increased anxiety and agitation may occur in overactive or agitated patients. Manic-depressive patients may experience shift to manic phase. Hostility may be aroused. Concomitant administration of reserpine may produce a "stimulating" effect. Watch for possible epileptiform seizures during treatment. Use cautiously with anticholinergic or sympathomimetic drugs. Concurrent

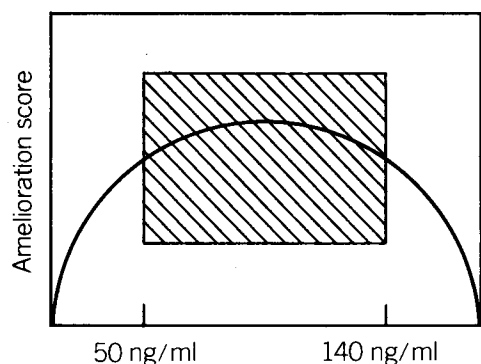
electroconvulsive therapy may increase hazards associated with nortriptyline HCl. When possible, discontinue drug several days prior to surgery. Potentially suicidal patients require supervision and protective measures during therapy. Prescriptions should be limited to the least possible quantity. Both elevation and lowering of blood sugar levels have been reported.

Adverse Reactions: Note: The pharmacologic similarities among the tricyclic antidepressant drugs require that each of the following reactions be considered when nortriptyline is administered.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Confusional states (especially in the elderly) with hallucinations, disorientation, delusions; anxiety, restlessness, agitation; insomnia, panic, nightmares; hypomania; exacerbation of psychosis.

Neurologic: Numbness, tingling, paresthesias of extremities; incoordination, ataxia, trem-



**The Pamelor
Therapeutic Window:
a well-defined range of
therapeutic blood levels.**

All tricyclics have a range of steady-state plasma levels that produce maximal antidepressant effects and minimal toxic effects.¹ When this range is well-defined it is called the "therapeutic window." To date, conclusive evidence for a therapeutic window has been obtained for only one tricyclic—nortriptyline.²

Highly predictable determination of optimal dosage

The more accurately the limits of the therapeutic window are defined, the more predictably individual dosage requirements for a tricyclic agent can be determined.² That's why an initial starting dose of 75 mg Pamelor daily can achieve optimal plasma levels for 70% of depressed patients.³ A single dosage adjustment to 100 mg Pamelor daily will achieve therapeutic blood levels for most patients who have not responded to 75 mg.

Minimal titration

With other tricyclic agents, the therapeutic dose is usually determined by increasing the daily dose from 25 mg upward to 300 mg. This time-consuming and often random process of titration is virtually eliminated with Pamelor. Because the initial dose is usually a therapeutic dose, you can spend less time on dosage adjustment and more time on psychotherapy.

Minimal significant side effects

Pamelor therapy is well tolerated. Daytime drowsiness is rarely a problem. As with all antidepressants, however, patients should be cautioned against driving or operating hazardous machinery. Anticholinergic side effects are also minimal, although some patients may experience dry mouth.

Pamelor therapy is clinically effective

Improvement of symptoms of depression can often begin to be seen in some patients within a week. These include relief of depressed mood, sleep disturbances, and fatigue. Global improvement is usually observed by the second week. Maximum improvement with Pamelor, as with other antidepressants, may require longer therapy particularly in severe depressive illnesses.



Pamelor® (nortriptyline HCl) NF 25mg. Capsules

**Helps make the therapeutic dosage
easy to determine.**

ors; peripheral neuropathy; extrapyramidal symptoms; seizures, alteration in EEG patterns; tinnitus.

Anticholinergic: Dry mouth and rarely, associated sublingual adenitis; blurred vision, disturbance of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilation of the urinary tract.

Allergic: Skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight); edema (general or of face and tongue), drug fever, cross-sensitivity with other tricyclic drugs.

Hematologic: Bone-marrow depression, including agranulocytosis; eosinophilia; purpura; thrombocytopenia.

Gastrointestinal: Nausea and vomiting, anorexia, epigastric distress, diarrhea, peculiar taste, stomatitis, abdominal cramps, black-tongue.

Endocrine: Gynecomastia in the male, breast enlargement and galactorrhea in the female; increased or decreased libido, impotence,

testicular swelling; elevation or depression of blood sugar levels.

Other: Jaundice (simulating obstructive); altered liver function; weight gain or loss; perspiration; flushing; urinary frequency, nocturia; drowsiness, dizziness, weakness, fatigue; headache; parotid swelling; alopecia.

Withdrawal Symptoms: Though these are not indicative of addiction, abrupt cessation of treatment after prolonged therapy may produce nausea, headache, and malaise.

Dosage and Administration: Usual adult dose—25 mg. three or four times daily; dosage should begin at a low level and increase as required. As an alternate regimen, the total daily dosage may be given once-a-day. Elderly and Adolescent—30 to 50 mg. per day, in divided doses, or the total dosage may be given once-a-day. Doses above 100 mg. per day and use in children are not recommended. If a patient develops minor side effects, the dosage should be reduced. The drug should be discontinued promptly if

adverse effects of a serious nature or allergic manifestations occur.

How Supplied: Capsules 10 mg. and 25 mg.; solution 10 mg./5 cc.

For more detailed information see full prescribing information.

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, Idström 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.

© 1979 Sandoz, Inc.
SDZ-9-15



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 didactic 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. Raffky, 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.

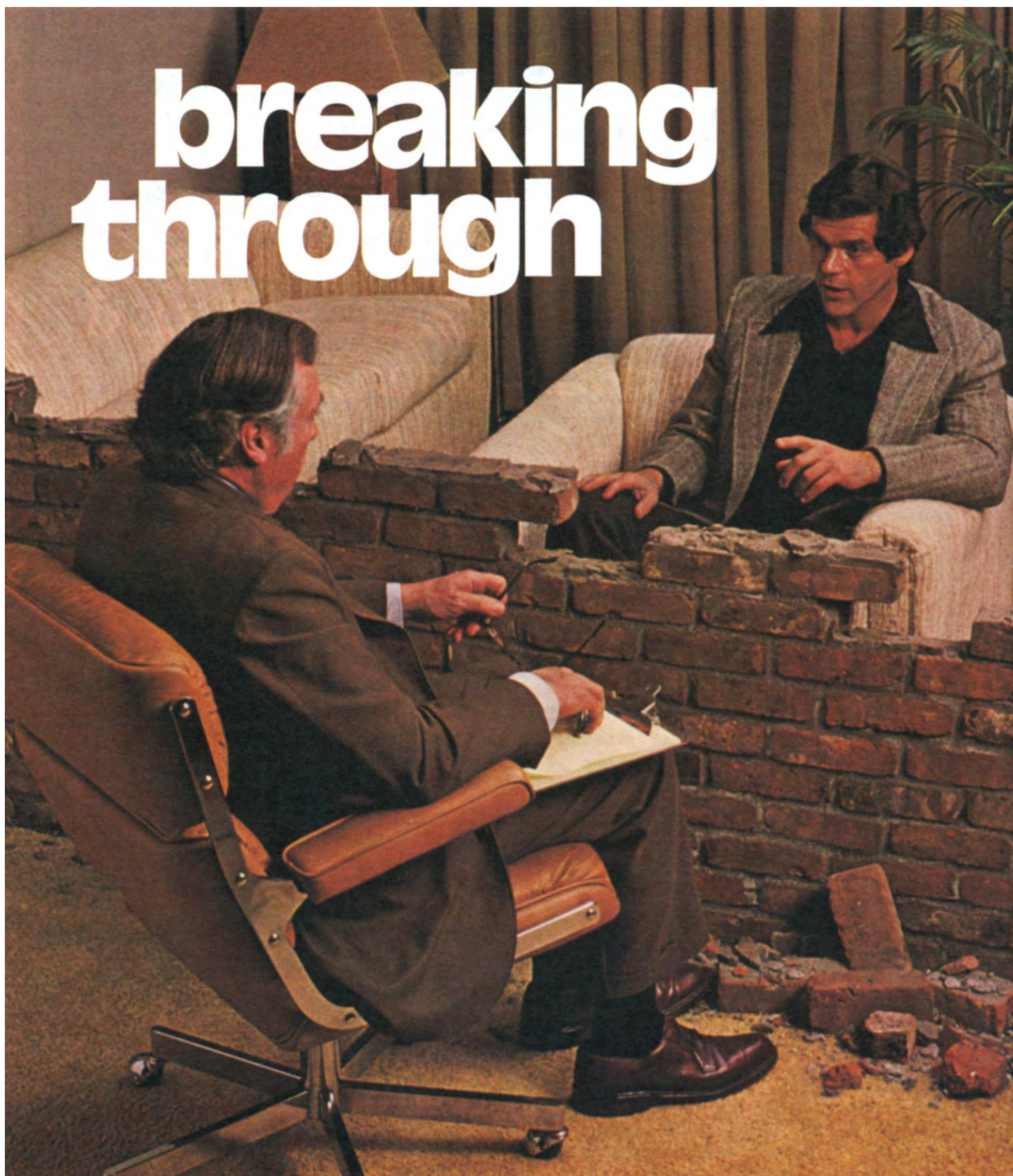
Psychiatric News: Frank implies bluntness?

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.

See "Gaylin," facing page



Available:

TRIAVIL® 2-25: Each tablet contains 2 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL® 2-10: Each tablet contains 2 mg perphenazine and 10 mg amitriptyline HCl.
TRIAVIL® 4-50: Each tablet contains 4 mg perphenazine and 50 mg amitriptyline HCl.
TRIAVIL® 4-25: Each tablet contains 4 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL® 4-10: Each tablet contains 4 mg perphenazine and 10 mg amitriptyline HCl.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); evidence of bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Should not be given concomitantly with a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. When used to replace a monoamine oxidase inhibitor, allow a minimum of 14 days to elapse before initiating therapy with TRIAVIL. Therapy should then be initiated cautiously with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given concomitantly with guanethidine or similarly acting compounds since TRIAVIL may block the antihypertensive action of such compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. Dosage of anticonvulsive agents may have to be increased. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time, particularly in high doses. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. In patients who use alcohol excessively, potentiation may increase the danger inherent in any suicide attempt or overdose. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of some untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides. There is sufficient experimental evidence to conclude that chronic administration of antipsychotic drugs which increase prolactin secretion has the potential to induce mammary neoplasms in rodents under the appropriate conditions. There are recognized differences in the physiological role of prolactin between rodents and humans. Since there are, at present, no adequate epidemiological studies, the relevance to human mammary cancer risk from prolonged exposure to perphenazine and other antipsychotic drugs is not known.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Paralytic ileus may occur in patients taking tricyclic antidepressants in combination with anticholinergic-type drugs.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported. Use with caution in patients with impaired liver function.

In marked agitation with depression symptomatic relief may make the patient more accessible and responsive.

Rapid relief of marked agitation in many patients

The tranquilizer component alleviates symptoms of agitation and anxiety within a few days, without apparent dulling of mental acuity. Hypnotic effects from the tranquilizer component appear to be minimal, particularly in patients permitted to remain active. However, TRIAVIL may impair mental and/or physical abilities required for performance of hazardous tasks.

Highly effective antidepressant action

The antidepressant component relieves symptoms of depression such as poor concentration and feelings of hopelessness as well as early morning awakening; adequate relief of symptoms may take a few weeks or even longer.

Helps break barriers to psychotherapy

As symptoms are relieved, many patients often communicate more effectively, become more cooperative, and are able to return to normal daily activities.

More prescribing convenience

There are now five tablet strengths of TRIAVIL for ease of dosage adjustment. For many patients with agitation and depression, you can now initiate therapy with one TRIAVIL[®] 4-50, containing 4 mg perphenazine and 50 mg amitriptyline HCl, b.i.d. The regimen is simple, economical, and may well enhance patient compliance.

Treatment with TRIAVIL—a balanced view:

TRIAVIL is contraindicated in CNS depression from drugs, in the presence of evidence of bone marrow depression, and in patients hypersensitive to phenothiazines or amitriptyline. It should not be used during the acute recovery phase following myocardial infarction or in patients who have received an MAOI within two weeks. Patients with cardiovascular disorders should be watched closely. Not recommended in children or during pregnancy. TRIAVIL may impair mental and/or physical abilities required for performance of hazardous tasks and may enhance the response to alcohol. Antiemetic effect may obscure toxicity due to overdosage of other drugs or mask other disorders. The possibility of suicide in depressed patients remains until significant remission occurs. Such patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

For marked
agitation with depression
Triavil[®]
dual-action
containing perphenazine and amitriptyline HCl



Copyright © 1979 by Merck & Co., Inc.

ADVERSE REACTIONS:

Similar to those reported with either constituent alone. **Perphenazine:** Extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) have been reported and can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

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

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

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

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

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

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

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

J8TR32 (DC6613215)

For more detailed information, consult your MSD Representative or see full Prescribing Information, Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486.

MSD
MERCK
SHARP
DOHME

Gaylin

Continued from facing page

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

See "Gaylin," page 35

Bisexuals

Continued from page 19

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-

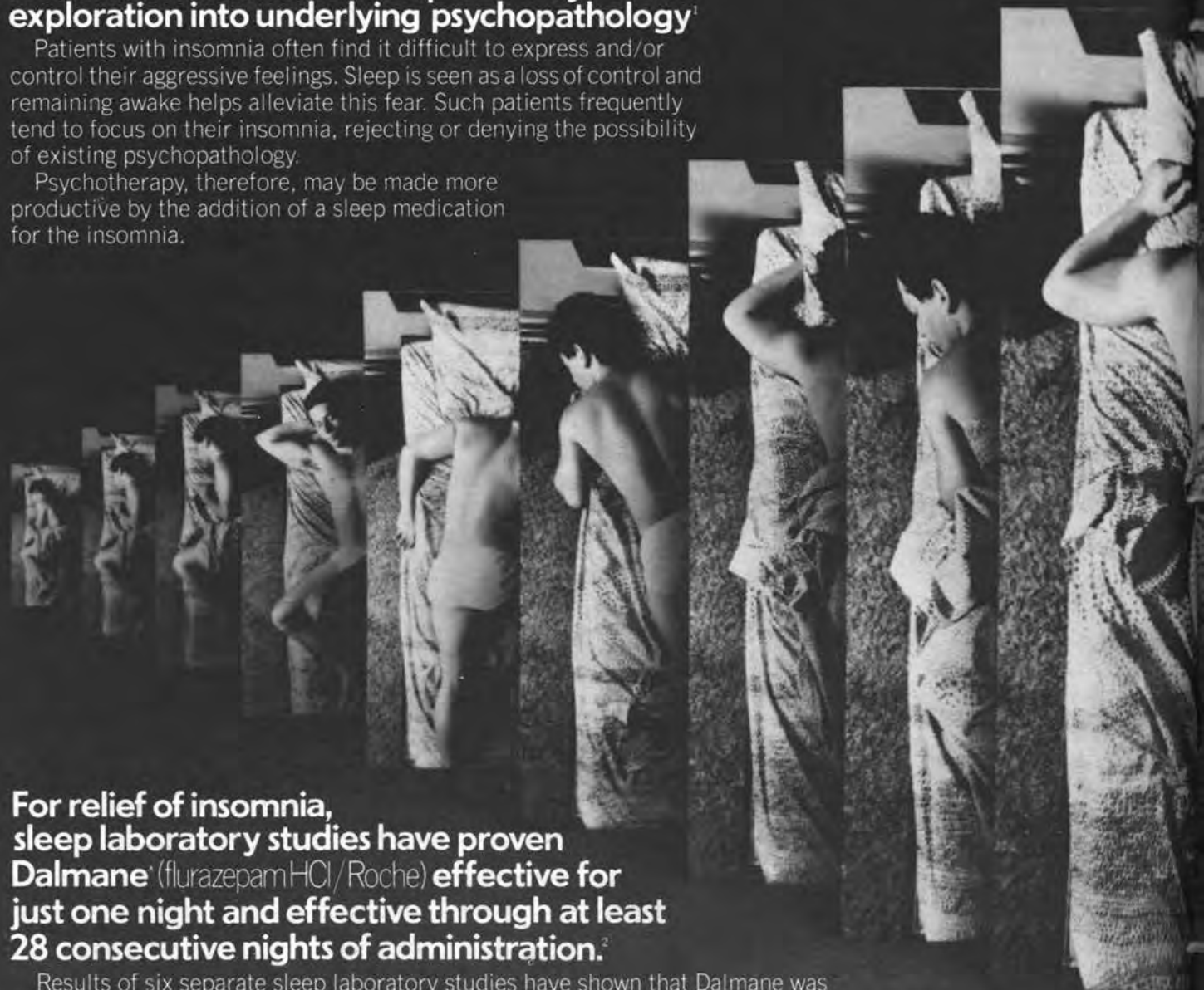
See "Bisexuals," facing page

INSOMNIA OFTEN DOES NOT BUT IT ALMOST ALWAYS STANDS

A focus on this somatic complaint may hinder exploration into underlying psychopathology¹

Patients with insomnia often find it difficult to express and/or control their aggressive feelings. Sleep is seen as a loss of control and remaining awake helps alleviate this fear. Such patients frequently tend to focus on their insomnia, rejecting or denying the possibility of existing psychopathology.

Psychotherapy, therefore, may be made more productive by the addition of a sleep medication for the insomnia.



For relief of insomnia, sleep laboratory studies have proven Dalmane® (flurazepam HCl/Roche) effective for just one night and effective through at least 28 consecutive nights of administration.²

Results of six separate sleep laboratory studies have shown that Dalmane was significantly effective in improving sleep induction and maintenance during short, intermediate and longer-term use.² Although the prolonged administration of Dalmane is seldom necessary, prolonged use should be accompanied by the appropriate patient evaluations, such as periodic blood counts and liver and kidney function tests.

A double-blind study has proven Dalmane® (flurazepam HCl/Roche) effective for psychiatric patients with insomnia³

Forty-nine hospitalized male patients received either Dalmane or placebo. Compared to placebo, Dalmane reduced the time needed to fall asleep, reduced the number of awakenings and increased total sleep time.³

DALMANE® flurazepam HCl/Roche

One 30-mg capsule h.s.—usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule h.s.—recommended initial dosage for elderly or debilitated patients.

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

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Several studies of minor tranquilizers (chlordiazepoxide, diazepam, and meprobamate) suggest increased risk of congenital malformations during the first trimester of pregnancy. Dalmane (flurazepam HCl/Roche), a benzodiazepine, has not been studied adequately to determine whether it may be associated with such an increased risk. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

STAND ALONE, OUT.



WHEN YOU DECIDE A SLEEP
MEDICATION IS INDICATED

DALMANE[®] IV
flurazepam HCl/Roche
30-MG AND 15-MG CAPSULES

MORE PROVEN NIGHTS OF EFFICACY
THAN ANY OTHER MEDICATION TESTED
FOR INSOMNIA

A WIDER MARGIN OF SAFETY⁴

Dalmane offers a safety profile comparably higher than many other sleep medications. There have been no reports of physical or psychological dependence when taken at recommended dosages. In controlled studies involving 2115 patients, the majority of side effects reported were of the sedative-type generally expected with a sleep medication. As with all medications in its class, Dalmane should be administered with caution to patients who are addiction-prone. Patients should also be cautioned about possible combined effects with alcohol and other CNS depressants.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies, or with impaired renal or hepatic function. Periodic blood counts and liver and kidney function tests are advised during repeated therapy.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest

pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, paradoxical reactions, e.g., excitement, stimulation and hyperactivity, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase.

Dosage: Individualize for maximum beneficial effect.
Adults: 30 mg usual dosage; 15 mg may suffice in some patients. **Elderly or debilitated patients:** 15 mg recommended initially until response is determined.
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

REFERENCES: 1. Kales A, Kales JD, Humphry FJ II: Sleep and dreams, chap. 2.3, in *Comprehensive Textbook of Psychiatry*, ed. by Freedman AM, Kaplan HI, Sadock BJ, ed 2. Baltimore, The Williams & Wilkins Company, vol 1, 1976, pp. 114-128. 2. Kales A, et al: *Clin Pharmacol Ther* 19:576-583, May 1976. 3. Jacobson A, et al: *Psychophysiology* 7:345, Sep 1970. 4. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ



ROCHE PRODUCTS INC.
Manati, Puerto Rico 00701

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

See "Bipolar," page 28

Bisexuals

Continued from facing page

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.

7B-8

Bipolar

Continued from page 27

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,
See "Bipolar," facing page

Stop the crisis...



"This rapid onset of action [with the I.M. dosage form] makes mesoridazine valuable in the treatment of psychiatric emergencies* ... it provided excellent control of symptoms, yet allowed patients to be alert, accessible, and responsive to therapeutic and custodial procedures."

Hamid T A and Wertz W J: *Am J Psych*, 130: 689-692, 1973.

*Because of possible hypotensive effects, parenteral administration should be reserved for bedfast patients or for acute ambulatory cases. Patients should be kept lying down for at least one-half hour after injection. In prescribing Serentil® observe the same precautions as with other phenothiazines, including awareness of all adverse reactions observed with them.

Serentil® (mesoridazine) as the besylate



Injectable: 1 ml (25mg)



Concentrate: 25mg/ml



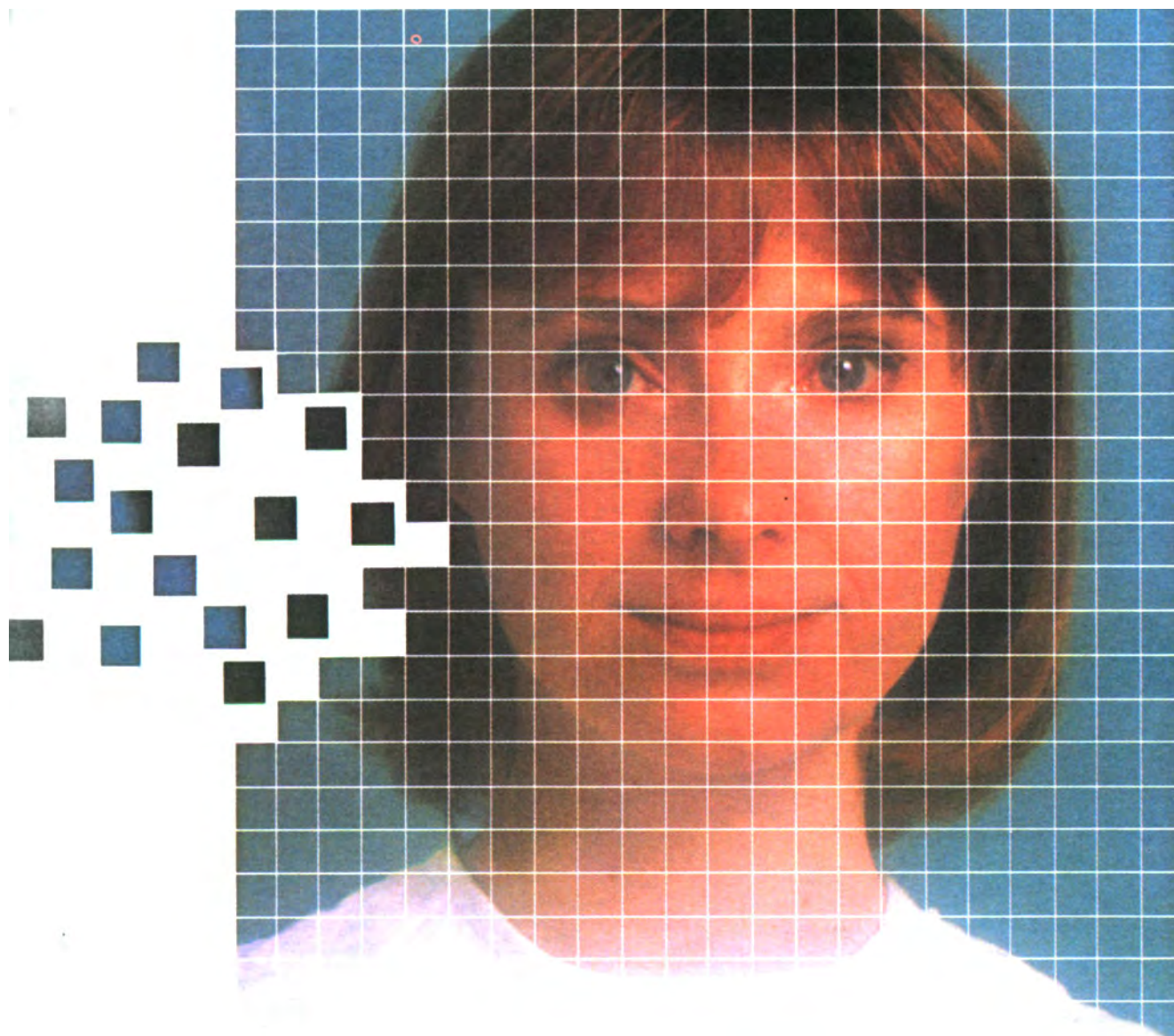
Tablets: 10, 25, 50 and 100 mg

... for long-term maintenance of the schizophrenic patient after the emergency

"... ensuing treatment with Serentil alone led to progressively greater improvements, not only in thinking disturbances, but also in psychomotor, [and] paranoid ... disturbances ..."

Aguilar S J: *Dis Nerv Sys*, 36: 484-489, 1975.

Start the therapy



"Symptoms which reflect the greatest improvement are conceptual disorganization, tension, suspiciousness, and hallucinations... Patients treated with mesoridazine showed significant improvement in paranoid ideation, thinking processes, and psychomotor disturbances."

Ritter R M and Tatum P A: J Clin Pharm, 12 : 349-355, 1972.

Bipolar

Continued from facing page

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.

See "Bipolar," page 30

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

Indication: Schizophrenia.

Contraindications: Severe central nervous system depression, comatose states and hypersensitivity to the drug.

Warnings: Administer cautiously and increase dosage gradually to patients participating in activities requiring complete mental alertness (e.g., driving). The safety of this drug in pregnancy has not been established; hence it should be given only when the anticipated benefits exceed the possible risk to mother and fetus. Not recommended for use in children under 12 years of age since safe conditions for this use have not been established. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides.

Precautions: Ocular changes have been seen with other phenothiazines but, to date, have not been related to mesoridazine. Because of possible hypotensive effects, reserve parenteral administration for bedfast patients or acute ambulatory cases, and keep patient lying down for at least one-half hour after injection. Leukopenia and/or agranulocytosis have been attributed to phenothiazine therapy. A single case of transient granulocytopenia has been associated with mesoridazine. Patients receiving anti-convulsant medication should be continued on that regimen while receiving mesoridazine to prevent possible convulsive seizures. As with most medications, the dosage of mesoridazine should be adjusted to the needs of the individual and the lowest effective dosage should always be used.

Adverse Reactions: Mesoridazine has demonstrated a remarkably low incidence of adverse reactions compared with other phenothiazine compounds.

Drowsiness, Parkinson's syndrome, dizziness, weakness, tremor, restlessness, ataxia, dystonia, rigidity, slurring, akathisia, motoric reactions (opisthotonos). Dry mouth, nausea and vomiting, fainting, stuffy nose, photophobia, constipation and blurred vision have occurred. Inhibition of ejaculation, impotence, enuresis, incontinence. Itching, rash, hypertrophic papillae of the tongue and angioneurotic edema. Hypotension, tachycardia, EKG changes. The following reactions have occurred with phenothiazines and should be considered: miosis, obstipation, anorexia, paralytic ileus. Erythema, exfoliative dermatitis, contact dermatitis. Agranulocytosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplastic anemia, pancytopenia. Fever, laryngeal edema, angioneurotic edema, asthma. Jaundice, biliary stasis. Changes in terminal portion of the EKG, including prolongation of the Q-T interval, lowering and inversion of the T wave and appearance of a wave tentatively identified as a bifid T or a U wave have been observed with phenothiazines, including mesoridazine. These appear to be reversible and due to altered repolarization, not myocardial damage. While there is no evidence that these changes are in any way precursors of any 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 would appear to be of questionable value as a predictive device. Hypotension, rarely resulting in cardiac arrest has also been noted. Akathisia, agitation, motor restlessness, dystonic reactions, trismus, torticollis, opisthotonos, oculogyric crises, tremor, muscular rigidity, akinesia. As with all antipsychotics, tardive dyskinesia may

appear on long-term therapy or after long-term therapy is discontinued. Risks seem to be greater in elderly patients on high dose therapy, especially females. Discontinue all antipsychotic agents if the symptoms of tardive dyskinesia syndrome appear. (See full prescribing information for description of the symptoms of the tardive dyskinesia syndrome). Menstrual irregularities, altered libido, gynecostasia, lactation, weight gain, edema, false positive pregnancy tests. Retention, incontinence. Hyperpyrexia, behavioral effects suggestive of a paradoxical reaction, including excitement, bizarre dreams, aggravation of psychoses and toxic confusional states. Following long-term therapy, a peculiar skin-eye syndrome marked by progressive pigmentation of areas of the 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. How Supplied: Tablets: 10 mg., 25 mg., 50 mg. and 100 mg. mesoridazine (as the besylate); bottles of 100.

Ampuls: 1 ml. [25 mg. mesoridazine (as the besylate)]. Inactive ingredients: disodium edetate, U.S.P., 0.5 mg.; sodium chloride, U.S.P., 7.2 mg.; carbon dioxide gas (bone dry) q.s.; water for injection, U.S.P., q.s. to 1 ml.; boxes of 20 and 100. Concentrate: 25 mg. mesoridazine (as the besylate) per ml. alcohol, U.S.P., 0.61% by volume. Immediate containers. Amber glass bottles of 4 fl. oz.

For complete details, please see the full prescribing information.



**Boehringer
Ingelheim**

Boehringer Ingelheim Ltd., Ridgefield, CT 06877

Children

Continued from page 21

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 an ob-gyn consultant, having left child psychiatry, she noted that she has become intolerant of some psychiatric constructs such as the "genetic" mother. She asked if anyone knew what it felt like to be called an "ulcer-genetic" 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

See "Children," page 32

Bipolar

Continued from page 29

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

CALM AND ALERT*

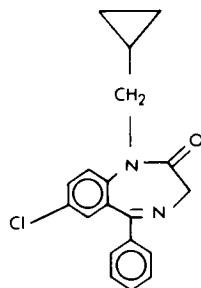
THE PATIENT ON

VERSTRAN®
(prazepam) 

VERSTRAN® (prazepam)

Caution: Federal law prohibits dispensing without prescription.

Description: Verstran (prazepam), a benzodiazepine derivative, is identified chemically as 7-chloro-1-(cyclopropylmethyl)-1,3-dihydro-5-phenyl-2H-1,4-benzodiazepin-2-one. The molecular weight is 324.8 and the structural formula is as follows:



Clinical Pharmacology: Studies in normal subjects have shown that Verstran (prazepam) has depressant effects on the central nervous system. Oral administration of single doses as high as 60 mg and divided doses up to 100 mg t.i.d. (300 mg total daily dose) were without toxic effects.

Single oral doses of Verstran in normal subjects produced peak blood levels at 6 hours postadministration, with significant amounts still present after 48 hours. Verstran was slowly absorbed over a prolonged period, rather than constant blood levels were maintained, and excretion was prolonged. The mean half-life of prazepam measured in subjects given 10 mg t.i.d. for one week was 63 (± 15 s.d.) hours before and 70 (± 10 s.d.) hours after multiple dosing — a nonsignificant difference. Human metabolism studies showed that prior to elimination from the body, prazepam is metabolized in large part to 3-hydroxyprazepam and oxazepam.

Indications: Verstran (prazepam) is indicated for the symptomatic relief of anxiety associated with anxiety neurosis, in other psychoneuroses in which anxiety symptoms are prominent features, and as an adjunct in disease states in which anxiety is manifested.

The effectiveness of Verstran (prazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should reassess periodically the usefulness of the drug for the individual patient.

Contraindications: Verstran (prazepam) is contraindicated in patients with a known sensitivity to the drug and in those with acute narrow angle glaucoma.

Warnings: Verstran (prazepam) is not recommended in psychotic states and in those psychiatric disorders in which anxiety is not a prominent feature.

Patients taking Verstran should be cautioned against engaging in hazardous occupations requiring mental alertness, such as operating dangerous ma-

chinery, including motor vehicles.

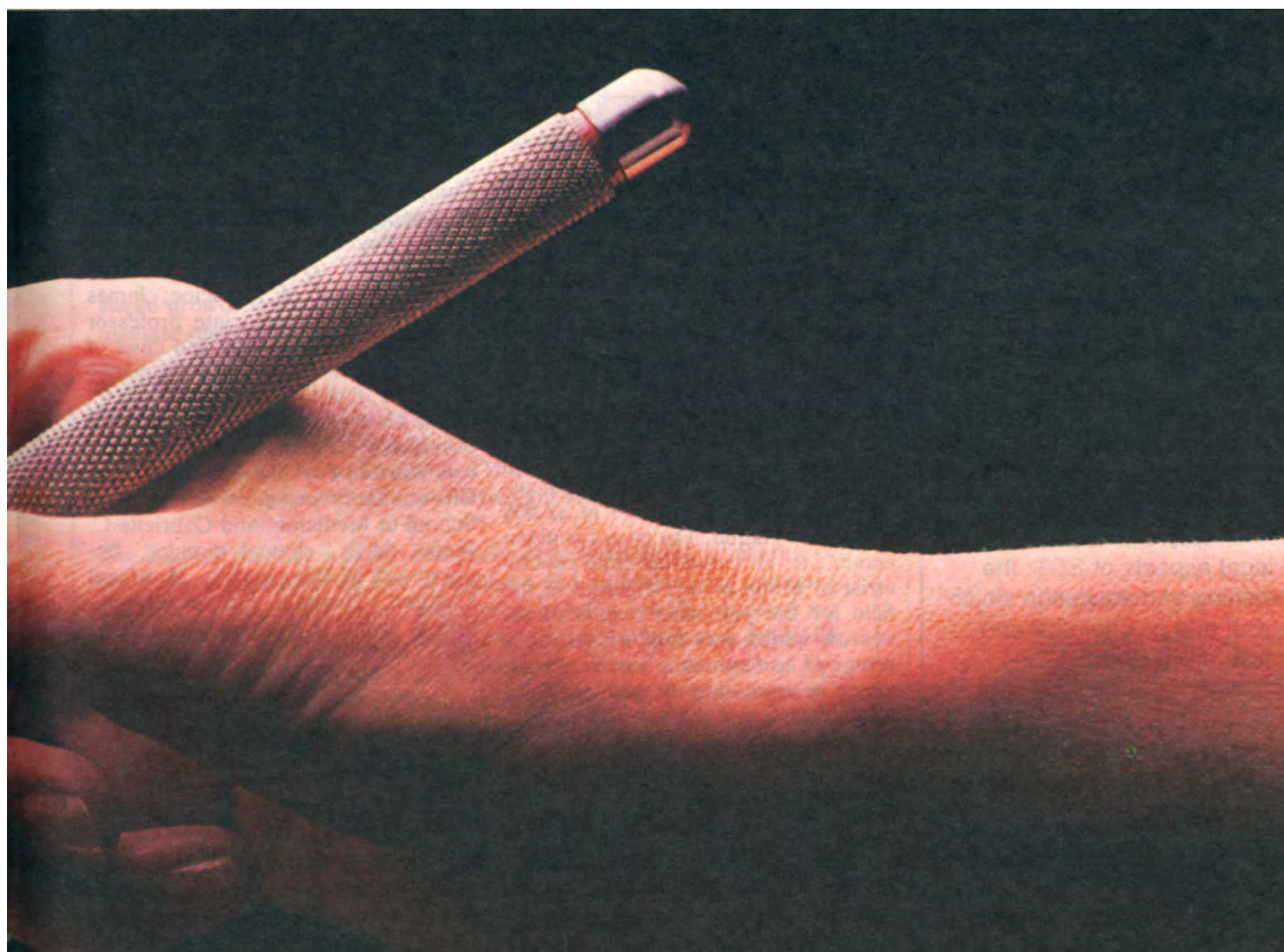
Because Verstran has a central nervous system depressant effect, patients should be advised against the simultaneous use of other CNS-depressant drugs, including phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants. The effects of alcohol may also be increased.

Physical and Psychological Dependence: Withdrawal symptoms similar in character to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepine drugs. These symptoms include convulsions, tremor, abdominal and muscle cramps, vomiting and sweating. Addiction-prone individuals, such as drug addicts and alcoholics, should be under careful surveillance when receiving benzodiazepines because of the predisposition of such patients to habituation and dependence.

Precautions:

Use in Pregnancy and Lactation:

An increased risk of congenital malformations associated with the use of minor tranquilizers (chloridiazepoxide, diazepam, and meprobamate) during the first trimester of pregnancy has been suggested in several studies. Verstran (prazepam) a benzodiazepine derivative, has not been studied adequately to determine whether it, too, may be associated with an increased risk of fetal abnormality. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of childbearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised



Smooth, consistent anxiolytic action is the reason.

PROVEN EFFICACY

- Effective symptomatic relief of anxiety
- Therapeutic response achieved with first dose
- Verstran—a suitable antianxiety alternative to diazepam

ESTABLISHED SAFETY

- Virtually no drowsiness* in most Verstran patients (less than 10%)
- Other side effects, if present, are minimal¹
- Verstran is appropriate concomitant therapy for anxiety associated with most somatic disorders²
- No accumulation after steady state is reached
- Psychomotor testing in normal volunteers suggested no statistically significant impairment of psychomotor performance at recommended doses (10 mg t.i.d. vs placebo)¹

References:

1. Data on file, Warner/Chilcott Medical Department.
2. See package insert.

*As with all CNS-acting agents, patients should be cautioned against driving, drinking, or engaging in hazardous activities.



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.

that if they become pregnant during therapy or intend to become pregnant they should communicate with their physician about the desirability of discontinuing the drug. In view of their molecular size, Verstran and its metabolites are probably excreted in human milk. Therefore, this drug should not be given to nursing mothers.

In those patients in whom a degree of depression accompanies the anxiety, suicidal tendencies may be present, and protective measures may be required. The least amount of drug that is feasible should be available to the patient at any one time.

Patients taking Verstran for prolonged periods should have blood counts and liver function tests periodically. The usual precautions in treating patients with impaired renal or hepatic function should also be observed. Hepatomegaly and cholestasis were observed in chronic toxicity studies in rats and dogs.

In elderly or debilitated patients, the initial dose should be small, and increments should be made gradually, in accordance with the response of the patient, to preclude ataxia or excessive sedation. Pediatric Use: Safety and effectiveness in patients below the age of 18 have not been established.

Adverse Reactions: The side effects most frequently reported during double-blind placebo-controlled trials employing a typical 30 mg divided total daily dose and the percent incidence in the Verstran (prazepam) group were: fatigue (11.6%), dizziness (8.7%), weakness (7.7%), drowsiness (6.8%), lightheadedness (6.8%), and ataxia (5.0%). Less frequently reported were: headache, confusion, tremor, vivid

dreams, slurred speech, palpitation, stimulation, dry mouth, diaphoresis, and various gastrointestinal complaints. Other side effects included: pruritus, transient skin rashes, swelling of feet, joint pains, various genitourinary complaints, blurred vision, and syncope. Single nightly dose, controlled trials of variable dosages showed a dose-related incidence of these same side effects. Transient and reversible aberrations of liver function tests have been reported, as have slight decreases in blood pressure and increases in body weight.

These findings are characteristic of benzodiazepine drugs.

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

If vomiting has not occurred spontaneously, it should be induced. Immediate gastric lavage is also recommended. General supportive care, including frequent monitoring of the vital signs and close observation of the patient, is indicated. Hypotension, though unlikely, may be controlled with Levophed® (levorotational bitartrate) or Aramine® (metaraminol bitartrate). Caffeine and Sodium Benzoate Injection, USP, may be used to counteract central nervous system depressant effects.

Dosage and Administration: Verstran (prazepam) is administered orally in divided doses. The usual daily dose is 30 mg. The dose should be adjusted gradually within the range of 20 to 60 mg daily in accordance with the response of the patient. In elderly or debilitated patients it is advisable to initiate treatment at a

divided daily dose of 10 mg to 15 mg. (See Precautions.)

Prazepam may also be administered as a single dose daily at bedtime. The recommended starting nightly dose is 20 mg. The response of the patient to several days' treatment will permit the physician to adjust the dose upward or, occasionally, downward to maximize antianxiety effect with a minimum of daytime drowsiness. The optimum dosage will usually range from 20 to 40 mg.

Drug Interactions: If Verstran (prazepam) is to be combined with other drugs acting on the central nervous system, careful consideration should be given to the pharmacology of the agents to be employed. The actions of the benzodiazepines may be potentiated by barbiturates, narcotics, phenothiazines, monoamine oxidase inhibitors or other antidepressants.

If Verstran is used to treat anxiety associated with somatic disease states, careful attention must be paid to possible drug interaction with concomitant medication.

How Supplied: Verstran (prazepam) 10 mg light blue, scored tablets in bottles of 100 (N 0047-0276-51) and 1000 (N 0047-0276-60).

STORE BETWEEN 59°-86° F (15°-30° C). VE-GP-91
U.S. Patents 3192199, 3192200



Warner/Chilcott
Division, Warner-Lambert Company
Morris Plains, N.J. 07950

Increase your professional library— order APA's three most recent Task Force Reports Now

Electroconvulsive Therapy, Task Force Report 14

Prepared by the APA Task Force on Electroconvulsive Therapy;
Fred Frankel M.D., Chairperson

This new report presents a comprehensive study of one of the most controversial issues in psychiatry today. The efficacy of ECT for affective disorders, schizophrenia, and for other mental illnesses is discussed, as are its adverse effects. Chapters included contain information on the social, ethical, and legal aspects of ECT; the methods of its administration and the training and education which the use of it requires; and its physiological and biochemical concomitants. Possible future research is also discussed.

The History of American Psychiatry: A Teaching and Research Guide, Task Force Report 15

Prepared by the APA Committee on History, Library, and
Museum; Daniel Blain, M.D. and Michael Barton, Ph.D.

This reports presents a compilation of reading and resource materials related to the history of the science of psychiatry and the learning and teaching of its historic development. Attention is given to the actions of citizens, professionals and government which have affected this historical development, and a chronology of psychiatry (primarily in the United States) is included.

Relating Environment to Mental Health and Illness: The Ecopsychiatric Base, Task Force Report 16

Prepared by the APA Task Force on the Ecopsychiatric Data
Base, Jay T. Shurley, M.D., Chairperson

This report details the work of the Task Force in giving a conceptual framework to the linkage of environment with mental health and illness. A comprehensive bibliography, sections of which are annotated, is given.

Send coupon to:

Publication Sales Department
American Psychiatric Association
1700 18th St. N.W., Washington, D.C. 20009

Please send me: _____ copies of **Task Force Report 14**,
order #228, @ \$7.50 ea.
_____ copies of **Task Force Report 15**,
order #146, @ \$4.00 ea.
_____ copies of **Task Force Report 16**,
order #147, @ \$4.00 ea.

ENCLOSED IS TOTAL PAYMENT OF \$ _____
(All domestic orders amounting to \$35.00 or less must be
accompanied by payment.
All foreign orders, regardless of dollar amount, must be
accompanied by payment.)

Name _____

Address _____

City _____ State _____ Zip _____

PN

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 non-profit 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

Continued from page 30

a father who hits you over the head."

John Steffek, 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. Steffek 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

Psychiatric News, August 3, 1979

NORTHWEST
Permanente
PC/PHYSICIANS & SURGEONS

OPPORTUNITIES IN THE PACIFIC NORTHWEST

Rapid growth in the Portland metropolitan area has created an immediate opening in the Department of Psychiatry.

Northwest Permanente, P.C. is a physician corporation which provides health care services to the 240,000 members of the Kaiser Foundation Health Plan of Oregon. Through its association with the Kaiser Foundation Health Plan, a federally qualified HMO, Northwest Permanente, P.C. operates nine outpatient clinics and two full service hospitals.

The medical practice is varied and professionally stimulating, offering the physician a pure practice free of business and administrative concerns. We offer a competitive salary and comprehensive benefits package including a sabbatical program, liberal vacation and educational leave, life, medical/dental and disability insurance, malpractice coverage and two excellent retirement programs. The physician is eligible to become a shareholder and a director of our corporation after two years of service.

Portland, Oregon, with a metropolitan population of one million, is a city with a moderate climate located in a stable, prosperous economic region of the beautiful Northwest. Cultural and educational opportunities are varied and outdoor recreational facilities are superb including excellent skiing, backpacking, fishing and boating opportunities. The Environmental Protection Agency, in a recent study, selected Portland as the "most livable city" in the United States.

Please send a curriculum vitae with your initial response to Marvin F. Goldberg, M.D., Regional Medical Director, Northwest Permanente, P.C., 1500 S. W. First Avenue, 11th Floor, Portland, Oregon 97201.

An Equal Opportunity Employer

**THE FEDERAL PRISON SYSTEM
WANTS YOU!**

\$40,000—\$47,500

Winston Churchill once remarked that the mood and temper of the public with regard to the treatment of crime and criminals is one of the most unfailing tests of the civilization of any nation.

The Federal Bureau of Prisons has within its 46 facilities throughout the country positions for qualified psychiatrists who have a concern for the social consequences of our revolving-door recidivism and a desire to play a major role in altering that cycle.

Within the confines of these institutions can be found a fascinating, clinical reservoir of patients exemplifying the whole spectrum of mental health problems, as well as clear evidences of the social and cultural stresses within our society. There are many opportunities for the energetic psychiatrist to practice community-oriented psychiatry. There is a vast potential for research, program development, staff training and direct service.

Positions immediately available include:

SPRINGFIELD, MISSOURI
ATLANTA, GEORGIA
ALDERSON, WEST VIRGINIA
LEXINGTON, KENTUCKY

Depending upon your level of qualifications, positions are available with a beginning salary of \$40,000 to \$47,500, plus U.S. Civil Service or Public Health Service Commissioned Corps fringe benefits and possible bonuses up to \$13,000.

When you realize what a great opportunity this is, call or write:

Robert L. Brutsché, M.D.
Assistant Surgeon General, USPHS
Medical Director, Bureau of Prisons
U.S. Department of Justice
320 First Street, N.W.
Washington, D.C. 20534 Telephone: (202) 724-3055

An Equal Opportunity Employer

Del Amo Hospital

3270 WEST LOMITA BLVD.
TORRANCE, CALIFORNIA 90505

Announces
**Commencement of Construction of a
56-Bed Addition
to Present Facilities**

Del Amo Hospital is presently a free-standing 110 bed JCAH accredited psychiatric hospital. The completed addition will provide a modern 166 bed hospital to include emotionally disturbed children and an expanded adolescent program. General psychiatric and alcohol and substance abuse services will continue to be emphasized. The hospital is a part of a planned major medical complex which includes Torrance Memorial Hospital Medical Center, a 247 bed general hospital which is also expanding.

Torrance is the largest of the Los Angeles South Bay "beach cities". Just south of Los Angeles International Airport, it is the hub of a rapidly growing financial, industrial and commercial area. The hospital is in the shadows of the beautiful Palos Verdes Peninsula hills and offers easy access to many choices of life-style—rural, beach, city. Delightful climate!

**Inquiries Invited: Kenneth D. Gaver, M.D., Medical Director
(213) 530-1151**

Darryl M. Diamond, M.D.,
Director of Staff Development
(213) 530-8343

Wm. H. Bennett, Jr., Administrator
(213) 530-1151

SOUTHERN CALIFORNIA

HMO Certification presents a unique opportunity to join a progressive Department of Psychiatry. Immediate openings for full-time child and adult Psychiatrists. California licence and ABP & N approved residency required.

Patients have pre-paid coverage.

Starting Salary \$45,000–47,000. Excellent benefits include vacation, health and dental coverage, retirement, insurance, malpractice. Planned working schedule. Partnership after two years. Active CME.

Cerritos is located in Los Angeles County, 10 minutes north of Long Beach and 35 minutes northwest of Newport Beach by freeway.

Write and send C.V. to:

**Philip Shulman, M.D.
Southern California Permanente Medical Group
1515 North Vermont Avenue, 2W
Los Angeles, California 90027
(213) 667-5515**

AN EQUAL OPPORTUNITY EMPLOYER



Open to both
men and women

 **Public Service Commission**
Canada **Fonction publique**
Canada

OPPORTUNITIES FOR PSYCHIATRISTS IN CANADA (529-172-077)

Salary: \$37,249 - \$46,200

Ref. No: 79-PSY-MD-2

Correctional Service of Canada
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.

The position of Clinical Director carries with it a university appointment in the Department of Psychiatry. Staff psychiatrists may also be awarded university appointments depending on suitability.

Qualifications

The necessary qualifications are acceptable accreditation as a trained psychiatrist in the applicant's country; ability to be licensed in Canada. Knowledge of English is essential.

Saskatoon is an attractive university city of 135,000 with many cultural and environmental opportunities (hunting, fishing, etc.).

"Additional job information is available by writing to the address below"; and

"Toute information relative à ce concours est disponible en français et peut être obtenue en écrivant à l'adresse suivante".

How to apply

Send your application form and/or résumé to:

Ms. J. Knox
Public Service Commission of Canada
National Capital Region Staffing Office
L'Esplanade Laurier, West Tower, 16th floor
Ottawa, Ontario K1A 0M7

Please quote the applicable reference number at all times.

PROVINCE OF NOVA SCOTIA CAREER OPPORTUNITIES

PSYCHIATRISTS NOVA SCOTIA

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.

QUALIFICATIONS:

Canadian Certification or Fellowship and a licence to practice in Nova Scotia (requires an L.M.C.C. or the N.B.M.E. (U.S.) and a current licence to practice in an American State.) A one year temporary licence (can be renewed) is available for those with the qualifications who are prepared to write for the L.M.C.C.

BENEFITS:

Excellent salary and other perquisites.

- Private practice within certain limitations is officially approved for all full-time salaried positions (with a full-licence).
- Up to \$3,000 in assistance is available for expenses involved in moving to Nova Scotia.
- In addition, a relocation grant of \$5,000 is provided if a commitment is made for one year's service on a salaried basis.

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.

Continuing Medical Education

SYLLABUS and SCIENTIFIC PROCEEDINGS

In Summary Form

**132nd APA Annual Meeting, Chicago, Illinois,
May 12-May 18, 1979**

This 428-page text provides a complete and individual summary of all the symposia, papers, special lectures, issue workshops, evening panels, films and videotape sessions presented at the 1979 Annual Meeting in Chicago. Each summary is followed by a statement of educational objectives, a list of references, and in most cases, by a series of self-assessment questions. Individual authors and their addresses are given for the reader's information and convenience.

The book incorporates all aspects of the *Scientific Proceedings in Summary Form* previously published each year and additional information required to be published as a syllabus for continuing medical education. It also includes the recording form to be used for Category I Credit as required by the American Psychiatric Association and the American Medical Association.

Please send me _____ copies of the *Continuing Medical Education Syllabus and Scientific Proceedings in Summary Form*, Order No. 153-9, @ \$10.00 ea.

ENCLOSED IS TOTAL PAYMENT OF \$ _____

(All domestic orders amounting to \$35.00 or less must be accompanied by payment. All foreign orders, regardless of dollar amount, must be accompanied by payment.)

Name _____
Address _____
City _____ State _____ Zip _____

Send coupon to: **Publication Sales**
American Psychiatric Association
1700 18th St., N.W., Washington, D.C. 20009

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 bore-

Psychiatric News, August 3, 1979

dom, 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.

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.

Classified Notices

RATES: \$3.50 per line; \$14.00 minimum; \$4.00 extra for *Psychiatric News* box number.

DEADLINE: Absolute deadline for all ad copy and cancellations and changes for issues is:

September 17 for October 19 issue
October 1 for November 2 issue
October 15 for November 16 issue
November 1 for December 7 issue
November 15 for December 21 issue
December 3 for January 4 issue

ADDRESS CORRESPONDENCE
TO: Marcia Livingston
Classified Advertising
Psychiatric News
1700 18th Street, N.W.
Washington, D.C. 20009

All advertisers in this section must employ without regard for race or sex, in accordance with law. Readers are urged to report any violations immediately to the Editor.

NATIONWIDE

OPPTYS. FOR PSYCHIATRIST—FORREST ASSOCIATES, retained by client organizations nationally, is seeking candidates on their behalf to fill openings at all exper. levels. Opptys. are avail. in Community Prgrms., Hospitals, and Academic Settings. Entry sals. range to \$60,000 per annum, dep. upon individual quals. and exper., plus generous frng. bnfts. Reply, with a current copy of the CV to: FORREST ASSOCIATES, P.O. Box 472, Murray, KY 42071.

ALABAMA

PSYCHIATRISTS for CMHC, Bd. cert. or bd. elig., licensed to practice medicine in Alabama. To supervise and provide med. svcs. in an assigned county office of a two-county MH system. Duties include: inpt. and trmt., supervision of clin. staff in emerg., and outreach svcs. Other staff include consulting psychiatrists, clin. psychols., nurses, social workers. Ctr. funding is stable. Catchment area of 100,000 in mtn. and lake recreation area with excel. med. commty., fine schls., and prgsv. business and industry. Sal. from \$42,000-\$60,000 dep. on exper., quals., and motivation. Time and expenses nego. in the total pkg. Send resume to Dr. John David Hall, Marshall-Jackson Mental Health Ctr., 2409 Magnolia St., Guntersville, AL 35976 (205) 582-3203. EEOE.

ALASKA

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. inclgd. 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.

ARIZONA

TIRED OF COLD WINTERS AND UPTIGHT LIFE-STYLES? 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.

ARKANSAS

Jonesboro—CMHC in college town near Memphis needs Bd. Elig./Cert. PSYCHIATRISTS to join staff of state operated ctr. AR licensure. Sal. approx. \$50,000, excel. frng. state paid malpractice ins. Excel. recreat. opptys. Contact: Robert M. Rankin, M.D., M.P.H., Com. Mental Health, 4313 West Markham St., Little Rock, AR 72201, ph. 501-664-4500.

Little Rock—Bd. Cert. PSYCHIATRIST for Medical Director, modern, 300-bed psychiatric hosp. with 24 bd. cert./bd. elig. psychiatrists. Closely integrated with Univ. of AR Schl. of Med. Sciences, loc. on same campus. Clinical appts. at Med. Ctr. Research encouraged. Approved 3-yr. rsdncy. in psychiatry. Referrals accepted from CMH centers throughout state. Sal. \$50,000, house provided, excel. frng., state-pd. malpractice ins. AR licensure. Recreat. opptys. unlimited. Contact: Robert M. Rankin, M.D., M.P.H., Com. Mental Health, 4313 West Markham St., Little Rock, AR 72201, ph. 501-664-4500.

Little Rock—Bd. Cert. PSYCHIATRIST with interest and trng. in trmt. of adols. to run a compre. network of Adolescent Treatment Services for the Arkansas State MH Div. Closely integrated with Univ. of Ark. Schl. of Med. Sciences, loc. on same campus. Clin. appts. at Med. Ctr. Sal. approx. \$50,000, excel. frng., state-pd. malpractice insur. Excel. recreat. and cult. opptys. Contact: Robert M. Rankin, M.D., M.P.H., Com. Mental Health Services, 4313 West Markham St., Little Rock, AR 72201, ph. 501-664-4500.

Little Rock—PSYCHIATRIST interested in working with post-hosp. pts. in new and innovative deinstitutionalization prgm. AR licensure. Sal. \$50,000, house, excel. frng. bnfts., state paid malpractice ins. Recreat. opptys. unlimited. Contact: Robert M. Rankin, M.D., M.P.H., Com. Mental Health, 4313 W. Markham St., Little Rock, AR 72201, ph. 501-664-4500.

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.

CLINICAL DIRECTOR for CMHC and psychiatric hosp. Job entails planning, directing and maintaining of clin. activities. Must demonstrate outstanding exper. of at least five (5) yrs. in clin. prac., and three (3) yrs. in clin. admin. and have demonstrated abilities in commty. and professional liaison, staff dvlpmnt., planning, and supervision. Limited caseload req'd. Must have current CA license in either psychiatry, clin. psychology or clin. social work. Sal. nego. reflecting prevailing compensation for clin. discipline, exper., duties, plus frng. bnfts. Send CV and refs. to Larry R. Yoder, Administrator, 3600 San Dimas St., Bakersfield, CA 93301, (805) 327-7621. APPLICATIONS MUST BE RECEIVED BY 9/01/79. SUCCESSFUL CANDIDATE EXPECTED TO START APPROX. 1/01/80.

PSYCHIATRIST—Oppty. for experienced staff psychiatrist with either inpt. or outpt. emphasis. Mixed urban-rural setting lends well to commty. psychiatry and crisis orientation. Full range of svcs. inclgd. new prgm. dvlpmnt.; budgeted at \$2,700,000 ann. Consulting and tchn. functions in conjunction with Univ. of Cal. family prac. rsdncy. prgm. Sal. effective 7-1-79 \$48,300 yr. (Bd. elig.) or \$49,800 (Bd. cert.); excel. bnfts. Contact Arthur Gatenby, M.D., Program Chief, 2750 Eureka Way, Redding, CA 96001. (916) 241-8340.

PSYCHIATRIST—Part-time posn. avail. in a crisis-resolution oriented adult outpt. svc. of a compre. commty.-oriented, hosp.-based, multidiscpl. MHC. Ca. lic. req'd. Send inquiries, resume and refs. to V. S. Stenberg, Personnel Director, Sutter Community Hospitals, 2820 L St., Sacramento, CA 95816, (916) 454-2222, ext. 1540.

PSYCHIATRISTS—Full-time Director for the Consultation Liaison Svc. in the Univ. of Ca., San Francisco, Schl. of Med., Dept. of Psychiatry. The primary respons. of this posn. will be administering consultative svcs. and trng. psychiatric rsdnts. Other duties include tchn. med. students, interns, and rsdnts. about emotional factors of illness, as well as providing postgrad. educ. for staff and commty. physicians. Will hold faculty title of Associate Professor of Psychiatry or Professor of Psychiatry. Need admin. skills in coordinating all existing relationships between psychiatry and other clin. svcs., establishing trng., svc. and research where such activities would be appropriate and do not exist. Qualified candidates representing minorities and women encouraged to apply. Application deadline: Aug. 31, 1979. Direct Inquiries to: Leonard S. Zegans, M.D., Director of Education, Langley Porter Neuropsychiatric Institute, 401 Parnassus Ave., San Francisco, CA 94143.

Bakersfield—CHILD PSYCHIATRIST to provide consul. and clin. supervision of a clin. and educational team in a highly innovative adol. day trmt. prgm. Addtl. involvement in all Ctr. prgms. for youth, inclgd.

some direct therapy. Also considerable consul. with juvenile probation dept. Prefer a psychodynamic orientation and familiarity with behavior modification techniques and an interest in lrng. disabls. Sal. range \$40,845-\$53,397 per annum dep. on exper. and quals. Lib. frng. bnfts. Malprac. insur. provided and prvt. prac. allowed. Contact Larry R. Yoder, Administrator, Kern View CMHC and Hospital, 3600 San Dimas, Bakersfield, CA 93301.

Central Calif.—BD. ELIG./CERT. PSYCHIATRIST—Sal. to \$43,032 ann. plus employer paid Social Security through 7/79 (12% increase effective 9/79). Growth oppty. in estab. Kern County MH Prgm. New facilities serving metro. area of 200,000 pop. Excel. bnfts. incldg. retirement, vac., sick leave, insur. Contact Kern County Personnel Dept., 1120 Golden State Ave., Bakersfield, CA 93301 or call Daniel Grabski, M.D., Director (805) 861-2261.

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.

Los Angeles/Newport Beach—Dynamic, academically-oriented prvt. grp. is accepting applications in ADULT PSYCHIATRY and CHILD PSYCHIATRY. Applicants must possess background in behavioral approaches and current Calif. lic., Bd. Cert. req'd. unless within three yrs. of rsdncy. Income potential excel. Send CV to Gene R. Moss, M.D., Behavioral Medical Group, Inc., 10950 College Pl., Cerritos, CA 90701.

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.

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

Pomona Valley MHC—PSYCHIATRIST, Bd. elig. or cert. for CMHC serving the cities of Pomona, Claremont and La Verne, CA. Sal. nego. Duties and respons. to include diagnostic and therapeutic coverage of clinic pts.; crisis eval.; supervision and tchnlg. of MH trainees. Direct all inquiries to Personnel, Pomona Valley MHC. 1149 North Garey Ave., Pomona, CA 91767.

San Diego—County MH openings in continuing care involving inpt. and outpt. assignments. Contact: David Seid, San Diego County Personnel Dept., 1375 Pacific Hwy., San Diego, CA 92101, (714) 236-4546.

San Gabriel Valley-L.A. area—PSYCHIATRIST. Our Private MHC needs a full-time, eclectic psychiatrist to enhance our energetic, autonomous but team-oriented multi-disc. staff. Inpt., Outpt., supervision & consultation with the freedom to grow. Exc. financial & emotional rewards. Deluxe offices. Write Mark Kosins, M.D., P.O. Box 519, Rosemead, CA 91770 or call (213) 285-2241.

Sausalito—ASSOCIATE WANTED for prvt. psychiatric practice in stress reduction. Elegantly decorated office in beautiful, prestigious area on San Francisco Bay. New business with tremendous growth possibilities. Financial investment req'd. Contact Robert Picker, M.D., The Stress Reduction Center of Marin, 3020 Bridgeway, Suite 105, Sausalito, CA 94965. (415) 848-4667.

Southern California area—PRIVATE PRACTICE POSITION with General Psychiatric Group. Growing Interdiscpl. Grp. Pract. Short term Inpt. exper. helpful. Multi-discpl. Team approach. Prgm. dvlpmt. encouraged. Gen. and Sub-specialization currently includes Family Therapy, Sleep Disorders, Encounter Groups, Alcoholism Trtmt. Prgm., Psychodrama, etc. Theoretical Orientation include Traditional, Integrative, Gestalt, Behavior Mod., Existentialism, Psychobiological etc. Full Bnfts. incldg. Pension Plan, Profit Sharing, Health Insur. Malprac. Insur. New Offices and Hosp. Cal. Lic. Req'd. Contact John Beck, M.D. or Ms. Christianson—Santa Monica Med. Plaza, 1260-15th St., Suite 1402, Santa Monica, CA 90404. 213-451-8828.

COLORADO

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

Boulder: CHILD PSYCHIATRIST OR GENERAL PSYCHIATRIST WHO TREATS ADOLS. AND FAMILIES TO REPLACE ACTIVE PARTICIPANT, (ENTERING SERVICE) OF SIX MEMBER PSYCHIATRIC ASSOCIATION. BOULDER, CO. 303-494-7860.

Denver—1/2 time PSYCHIATRIST sought, as consultant to Day Care and Outpt. Team. Bd. cert. or elig.

Sal. nego. Phone: Marnin Fischbach, M.D. at (303) 344-9260 after 11:15 A.M. or send resume to same, c/o Aurora MHC, 1646 Elmira St., Aurora, CO 80010.

Denver—PSYCHIATRISTS-Full-time and part-time posns. avail. Adult and Child Psychiatrist posns. avail. Gen. Hosp. with compre. CMHC incldg. outpt. units loc. in neighborhood health prgm. seeks commty.-oriented psychiatrists. Prgm. is involved in rsdncy. trng. and offers oppty. for variety of clin., administrative and tchnlg. career patterns. Prgm. includes gen. hosp., CMH prgm. and drug and alcoholism svcs. Sal. range: \$3,391-\$4,238 per month dep. on exper. Starting date: Immed. Reqs.: Approved Psychiatric rsdncy. with exper. in MHC and with inpt. exper. Colorado Lic. req'd. Contact: Edmund Casper, Director, Division of Psychiatric Services, Denver Dept. of Health and Hospitals, West 8th Ave. & Cherokee, Denver, CO 80204, Ph: (303) 893-7377.

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.

CONNECTICUT

CHILD/ADOLESCENT PSYCHIATRISTS—Bd. Cert. of Elig. Posns. avail. for CLINICAL DIRECTOR and for STAFF PSYCHIATRISTS in newly reorganized 50 bed adolescent hosp. JCAH accredited. Central Connecticut Valley Region. Possible affiliation Yale Child Study Center. Sal. competitive plus excel. fringe benefits. Contact Harold Davidson, M.D. Chief Psychiatrist, Department Children/Youth Services, 345 Main St., Hartford, CT 06115.

Hartford—PSYCHIATRIST—Mount Sinai Hosp., a 375-bed univ. affiliated Hosp. has a full-time posn. avail. for a Bd. cert. or elig. Staff Psychiatrist to provide Educational and Clin. Svcs. for a 17-bed, short term. Adult Inpt. multidisciplinary Unit. Limited prvt. prac. oppty. Starting sal. commensurate with exper. in addition to an excel. bnft. pkg. Contact: John J. Haksteen, M.D., Chief of Psychiatry, Mount Sinai Hosp., 500 Blue Hills Ave., Hartford, CT 06112, (203) 242-4431. An EOE.

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.

Newtown—CONNECTICUT PSYCHIATRIC RESIDENCIES. AMA approved psychiatric rsdncy. vacancies. Active varied trtmt. prgm. dynamically oriented and affil. with Yale Univ. Trng. in New Haven avail. to qualified rsdnts. Prgm. includes affil. at CMHCs for ambulatory psychiatry in a commty. setting. Three and four yr. prgms. avail. dep. on level of trng. Extensive didactic tchnlg. schedule incldg. basic and clin. neurology. Supervision provided for inpt. and outpt. exper. with adult and adols. Apts. avail. for married rsdnts. with no childrn. at no cost. Limited housing for married physicians with families. Sal. 1st yr. \$13,777. 2nd yr. \$14,693. 3rd yr. \$14,947, and 4th yr. \$16,348. Write to Robert B. Miller, M.D., Superintendent, Fairfield Hills Hosp., Newtown, CT 06470.

DISTRICT OF COLUMBIA

EXECUTIVE DIRECTOR—A United Way affiliated agency that provides svcs. to emotionally disturbed childrn. 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 childrn. 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. Krempfer, Ph.D., Director, PEACE RIVER CENTER FOR PERSONAL DEVELOPMENT, INC., 1745 Highway 17 South, Bartow, FL 33830 (813) 533-2738.

Maccleddy—CLINICAL DIRECTOR, Bd. Cert. Psychiatrist. Directs all MH prgms. in a progs. 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.

Maccleddy—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., Maccleddy, 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., 1 1/2 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 Chat-ham/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. consults., 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/AEE.

Ph.D. CLINICAL PSYCHOLOGIST to do clin. testing, participate in research on eval. of psychotherapy, teach behavioral science to med. students. Must have research, tchnlg. 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/AEE 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/AEE.

Des Moines—Bd. cert. or elig. PSYCHIATRIST for FT posn. on 54-bed acute care psychiatric unit. Primary respons. will involve supervision and tchnlg. 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 tchnlg. interests. Contact George Winokur, M.D., Head, Dept. of Psychiatry, Univ. of Iowa College of Medicine, Iowa City, IA 52242. EO/AEE.

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., inclgd. 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. inclgd. 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 tchnng. 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 tchnng. 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 Vitaeas 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 tchnng. med. students. Applicants must be Bd. Elig. or Bd. Cert. Exper. in outpt. psychiatry and tchnng. 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 dvlpmnt., commty. educ., trtmt. of indivls., fams., and/or grps., dvlpmnt. of child psychiat. svcs., and consult. to other prof. staff. We would be int. in applics. from indivls. 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.

Psychiatric News, August 3, 1979

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 prgm.; 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. tchnng. 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 inclgd. 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 Rodenhauer, M.D., Director of Professional Services, Brook Lane Psychiatric Center, P.O. Box 1945, Hagerstown, MD 21740.

Baltimore—OPENING FOR CHILD PSYCHIATRIST—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/AEE. Interested individuals should send letter of application and CV to: Richard M. Saries, 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 tchnng. 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 tchnng. and research; we are academically affiliated and participate in med. schl. tchnng. 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. tchnng. 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/AEE.

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. dvlpmnt. of new prgms., dir. trtmt., consul., tchnng. & 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 dvlpmnt. 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 tchnng. 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 multi-spec. 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 tchnng. 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 tchnng. hosp.; tchnng. 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 tchnng. consul./liaison psychiatry, dynamic psychotherapy, and milieu therapy. Contact: Charles K. Hoffing, 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. inclgd. 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 tchnng., 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/tchg. 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 tchg. 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 optpys. 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 accepted. 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. psychiat.; in psychiat. consul. to gen. hosp. & com. soc. agencies; & child psychiat. Courses in relevant basic sciences & clin. subjects are given in addition to tchg. thru indvd. supvn. & preceptorship; emphasis placed on tchg. 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; optpy. to learn and advance; good sal. and prvt. prac. privileges; tchg. 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 dvlpmt. of this unit into a first-class geriatric tchg. 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, consults., 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., tchg., 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. optpys. 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. optpys. 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 optpy. 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 eclectic. 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-discipl. 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 optpy. 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 dvlpmt. of a univ. inpt. tchg. 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 multidisciplinary 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 optpys. Expanding med. commty. in rural area with all specialties represented. Salaried and prvt. prac. optpys. 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 tchg. 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. pkg. 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 optpys. 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, sub-acute, 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. optpy. 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 tchg. 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 multidisciplinary staff in providing direct clin. svcs. to adults on Outpt. and Inpt. basis. Outpt. svcs. include work with crisis intervention and emerg. svcs. Optpy. to provide invsc. trng. and commty. educ. as well. Ties with tchg. 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-

Psychiatric News, August 3, 1979

DOES HIS TRANQUILIZER NEED A "TRANQUILIZER"?



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.

Mellaril (thioridazine) has the lowest incidence of extrapyramidal reactions of all major tranquilizers.¹ Seldom is it necessary to use concomitant antiparkinsonian drugs, which can cause side effects of their own and contribute to the problem

of noncompliance. Mellaril (thioridazine) is contraindicated in patients with hypertensive or hypotensive heart disease of extreme degree.

Your own observations have probably told you how well many patients get along on Mellaril therapy, how effectively it helps in the management of psychotic symptoms.

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 anti-

psychotic 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.

SANDOZ PHARMACEUTICALS, EAST HANOVER, NEW JERSEY 07936



Mellaril® (thioridazine)

TABLETS: 50 mg, 100 mg, 150 mg, and 200 mg thioridazine HCl, USP
MELLARIL-S™ (thioridazine) SUSPENSION, per 5 ml (teaspoon):
thioridazine base equivalent to 100 mg thioridazine HCl, USP

**kind to many patients with
psychotic symptoms**

© 1979 Sandoz, Inc.

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. Applies. 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. pkg., inclgd. 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. pkg. 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 after-care 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-discipl. 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 dvlpmnt. 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 multi-disciplinary team setting, prgm. dvlpmnt. 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 inclgd. sailing, boating, backpacking, winter skiing, 18 hole golf course, bird and deer hunting, and trout fishing. Contact James W. Frymire, 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-discipl. 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 assisted 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 inclgd. 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*.

PRACTICES FOR SALE

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. In-

creasing 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, inclgd. 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 Frazee, 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.

LOOKING FOR A PUBLISHER? Learn how you can have your book published, promoted, distributed. Send for Free Booklet PN-3, Vantage Press, 516 W. 34th St., New York, N.Y. 10001.

Tired of the cold weather? Want to practice where it's warm and the people are friendly? For the amount you'll gross the first year, buy yourself a six figure Gulf Coast area practice. Purchase or lease beautiful office bldg. optional. Even the neuroses here are easy going! All enquiries held confidential. Reply Box P-888, *Psychiatric News*.

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.

Psychiatric News, August 3, 1979