Volume 45
Number 4
February 19, 2010

PSYCHIATRIC NEWS

Newspaper of the
American
Psychiatric
Association

APA's 163rd ANNUAL MEETING, NEW ORLEANS, MAY 22-26, 2010

In many ways New Orleans is a far different city from the one that hosted APA's 2001 annual meeting. Yet the culture, music, food, and ambience that have made it the country's most original city are thriving and still a magnet for visitors. Added to those features, it now boasts a resilience and pride that make it even more welcoming than ever, as psychiatrists and others will see at this year's annual meeting.

When the city's charms accompany a scientific program in which cutting-edge research, the latest clinical advances, and well-known speakers will shine brightly, it can only make for a spectacular and can't-miss meeting experience.

This issue contains the preliminary scientific program, information on New Orleans, and ideas to fill your leisure time.

For registration information, see page 4.

Credit: Jose Fuste Raga / photolibrary

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Newspaper of the American Psychiatric Association PSYCHIATRIC NEWS

Psychiatric News, ISSN 0033-2704, is published bi-weekly on the first and third Monday of each month by the American Psychiatric Association, 1000 Wilson Boulevard, Arlington, Va. 22209-3901. Periodicals postage paid at Arlington, Va., and additional mailing offices. Postmaster: send address changes to Psychiatric News, APA, Suite 1825, 1000 Wilson Boulevard, Arlington, Va. 22209-3901. Online version: ISSN 1559-1255.

Subscriptions
U.S.: individual, $105. International: APA member, $142; nonmember, $158. Single issues: U.S., $21; Canada and international, $35. Institutional subscriptions are tier priced. For site licensing and pricing information, call (800) 368-5777 or e-mail institutions@psych.org.

Editorial Offices
Telephone: (703) 907-7868; E-mail: PNews@psych.org; Web site: pn.psychiatryonline.org

Advertising Sales
Pharmaceutical Print Advertising: Frank Cox, Kathleen Harrison, Valentin Torres, Pharmaceutical Media, Inc., 30 East 33rd Street, New York, N.Y. 10016; (212) 685-5010; Fax: (212) 685-6126; vtorres@pminy.com
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Credit: Sara Krulwich/The New York Times

Carrie Fisher performs on Broadway in her autobiographical show, "Wishful Drinking." Behind Fisher is a photo of her in the role for which she is best known—Princess Leia in "Star Wars."

Actress Makes Most of Honors For 'Being Mentally Ill'

The actress who most recently starred in her one-woman show 'Wishful Drinking' was always a one-woman show. And now she's a leading mental health advocate.

BY MARK MORAN

If Carrie Fisher's lecture at APA's Convocation of Fellows at APA's 2010 annual meeting is anything like the life she has led, it is bound to be . . . colorful.

To put it mildly. The issue of a tabloid Hollywood marriage (between Debbie Reynolds and Eddie Fisher), the actress-turned-novelist-turned-mental-health advocate grew up destined for show business and began appearing in Las Vegas with her mother before she was a teenager. She has played in scores of movies, most notably "Star Wars," for which she gained international notoriety—and cult-icon status—playing Princess Leia at the age of 19.

Fisher has wrestled with bipolar disorder, drug addiction, and alcoholism. Married and divorced from singer-songwriter Paul Simon, she has written about her triumphs and travails in the autobiographical and semi-autobiographical best-selling novels *Postcards From the Edge*, *Surrender the Pink*, *Wishful Drinking*, and *The Best Awful There Is.*

Fisher will speak at the APA Convocation on Monday, May 24, from 5:30 p.m. to 6:30 p.m. in Hall A at the Morial Convention Center in New Orleans.

Fisher was born in Beverly Hills in 1956. When she was 2, her parents divorced and her father married Elizabeth Taylor. She traveled and performed with her mother as

please see ***Fisher*** *on page 18*

Star Quarterback Took Years to Notch Victory Over Depression

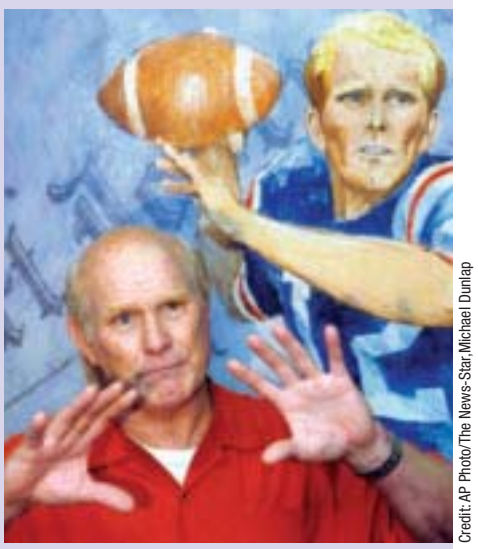
He's reinvented himself more than once, but sports fans among the APA membership will know him as one of professional football's greatest quarterbacks.

Hall of Famer and four-time Super Bowl champion quarterback Terry Bradshaw will be the "Conversations" guest at APA's annual meeting in New Orleans. He will be speaking about his own experience with depression.

"Conversations" is sponsored by the American Psychiatric Foundation, APA's charitable arm. It will be held Tuesday, May 25, from 5:30 p.m. to 6:30 p.m. in Hall A of the Morial Convention Center.

The only NFL player with a star on the Hollywood Walk of Fame, Bradshaw continues to defy an easy pigeonhole. He has been an award-winning broadcaster on "Fox NFL Sunday," a television and movie actor, gospel/

please see ***Bradshaw*** *on page 19*



Credit: AP Photo/The News-Star,Michael Dunlap

Terry Bradshaw tells audiences about his treatment for depression, "I'm experiencing life as it should be."

Meeting Highlights a Field With Much to Celebrate

BY ALAN F. SCHATZBERG, M.D.

APA's 2010 annual meeting will be a superb blend of science, clinical pearls, and entertaining sessions in a city where the lively nightlife, cultural diversity, and good food are the stuff of legend. The Scientific Program Committee has done a great job under the leadership of the co-chairs, Julio Licinio, M.D., and Donald Hilty, M.D.

I selected "Pride and Promise: Toward a New Psychiatry" as the meeting's theme. I think you'll find the program stronger than ever this year, reflecting a combination of information and fun. In a departure from previous years, we will have a greater blend of invited and member-generated sessions; to that end, we were fortunate to have been able to call on our academic leaders to help us screen and propose programs as we developed a comprehensive and balanced program. As a result, we have invited the best psychiatrist-scientists from around the world to teach us about their work in special lectures and scientific symposia.

One key point to note is that in response to many of you, we will start the meeting on Saturday morning, May 22, and end on Wednesday afternoon, May 26. So please plan to arrive so you can take advantage of the full program. Also, the official Opening Session and Convocation will be held in the early evening on Sunday and Monday, respectively (see box below).

We are delighted to be partnering once again with the National Institute on Drug Abuse (NIDA) to show how cutting-edge science on substance use disorders is informing clinical practice (see page 6). Lectures by its director, Nora Volkow, M.D., and A. Thomas McLellan, Ph.D., deputy director of the White House Office of National Drug Control Policy, are headlining the NIDA track.

Senior scholars such as Daniel Weinberger, M.D., Florian Holsboer, M.D., Ph.D., Eve Johnstone, M.D., Mario Maj, M.D., Ph.D., Raquel Gur, M.D., Ph.D., and Francene Benes, M.D., Ph.D., will address us on their exciting work in depression and schizophrenia. We will also have some of the top young M.D./Ph.D.s from around the country—such as Karl Deisseroth, Kerry Ressler, Vikaas Sohol, Amit Etkin, and others—show us where the field is heading.

The tragedy in Haiti calls to mind the devastation that Hurricane Katrina wrought on our host city nearly five years ago. Five sessions (symposia and workshops) will focus on lessons learned from the Gulf Coast response and advances in disaster psychiatry. But be prepared to discover that New Orleans has rebuilt itself and rebounded to reclaim its position among world-class conference locations (see page 4). Attendees at other national conferences held there have proclaimed that the Big Easy is back in business for those attending professional meetings.

The popular FocusLive series—interactive learning at its best—returns with three sessions focusing on sleep and sexual disorders, psychotherapy, and genetics and genomics. Also, the successful Advances In series, which is in partnership with American Psychiatric Publishing Inc., will be reprised with sessions chaired by leading researchers and authors. Topics include forensics (chaired by Robert Simon, M.D.), psychotherapeutic treatments (Glen Gabbard, M.D.), substance abuse treatment (Marc Galanter, M.D., and Herbert

please see ***From the President*** *on page 20*

New Schedule for the Annual Meeting!

In response to attendees' feedback, APA has made important changes to the 2010 annual meeting schedule that will save them time and money.

- The meeting will be held over five days instead of the usual six—**ending on Wednesday** (May 26) instead of Thursday.
- The full range of meeting formats (such as symposia, workshops, seminars, and master courses) **will begin on Saturday** (May 22) and run through the end of Wednesday. In the past, only CME courses and industry-supported symposia were held before the official start of the meeting on Sunday.
- To better accommodate attendees' evening plans, the **Opening Session** will begin earlier this year. It will still be held on its usual day—Sunday—but it will begin at 4:30 p.m. instead of 5 p.m.
- Sessions are being scheduled in topical tracks so that members can focus on their professional areas of interest.

Attendees will be able to spend less time away from the office and their patients, as well as save money on hotel and related expenses.

To take full advantage of the new program at this year's annual meeting, attendees should arrive in New Orleans by Friday evening, May 21.

Hope Edges Out Despair As Recovery Moves Forward

New Orleans' recovery from Hurricane Katrina remains an ongoing, and highly variable, project nearly five years after the storm threatened the city's very existence. But signs of renewal are evident throughout the city.

BY AARON LEVIN

"No one walking down St. Charles Street after Katrina could imagine how much the city has come back," said New Orleans novelist Tom Piazza. "Today the restaurants and clubs are rockin' and rollin', and the Saints did wonders for the city's morale [by making it to the Superbowl], but it's also shocking to see how little has changed."

Recovery Varies

In fact, New Orleans' recovery from Hurricane Katrina varies with geography and the resources of the inhabitants, said Piazza, who has written on post-Katrina New Orleans in a novel, *City of Refuge*, and an extended essay, "Why New Orleans Matters."

"Even to speak of 'the city' is misleading," said Piazza, in an interview with *Psychiatric News*. "Different social and economic groups give you different answers."

Statistics only hint at how the city has changed. Orleans Parish's population fell from 461,600 on July 1, 2005, two months before the storm, to 210,768 a year later. The U.S. Census Bureau estimated that the population had risen back to 336,644 by 2008, the latest available data.

The vast physical and human disruption caused by the storm and the failure of the levees only heightened the city's sense of precariousness.

"There's an abnormally high level of tension between extraordinary affirmations of hope and possibility and extraordinary levels of greed, venality, and crime," said Piazza. "It's hard to live with opposing levels of hope and despair simultaneously."

A ride around town offers alternate vistas of that hope and despair. The less-damaged and better-insured sections are doing well. The low-income neighborhoods, out of sight of most visitors, are still struggling.

For instance, in the downtown area around the Morial Convention Center, where many APA annual meeting sessions will be held, things are even better than before Katrina, said New Orleans psychiatrist Edward Foulks, M.D., Ph.D. "Anything around there that was messed up was fixed up."

In the newer-and-better category is the National World War II Museum on Magazine Street, which Foulks described as "spectacular."

Credit: Alexei Levedev/Momenta

Actor Brad Pitt commissioned 13 prominent architectural firms to design attractive housing for residents of the devastated Lower Ninth Ward. So far, 15 have been built—on stilts to keep them above any future flood waters—and many sport bright colors not often seen on conventional houses.

French Quarter Rebounded Quickly

Not far away, the French Quarter, the city's original home, is built largely above flood lines and has steadily returned to life as a choice residential, dining, and entertainment district.

The French Quarter anchors a great swath of the east bank of the Mississippi River—the part that actually looks like it's north of the river on the map.

Flood damage there was minimal because the ground is surprisingly higher closer to the river. However, many buildings in those areas suffered wind damage or were struck by falling trees during the hurricane.

Life in those areas, roughly paralleling the historic St. Charles Avenue

please see ***Recovery*** *on page 33*

Quiet Beauty, Raucus Fun Coexist in French Quarter

The French Quarter—New Orleans' historic heart—has survived the Civil War, yellow fever, and the horrendous hurricane of 2005 to emerge once again as the most cherished part of the city.

BY JOAN AREHART-TREICHEL

Mysteriously shadowed courtyards, lush, magenta bougainvillea draping wrought-iron balconies, jazz notes sallying forth from a saxophone into the sultry night air.

Welcome to New Orleans, a city hugging America's mightiest river, the Mississippi. And welcome specifically to New Orleans' historic heart—the French Quarter—which stretches along the Mississippi for several blocks.

New Orleans was founded in 1718 by Frenchman Jean-Baptiste Le Moyne de Bienville and was centered on the Vieux Carré, or old square. The Vieux Carré eventually became known as the French Quarter and is New Orleans' oldest neighborhood.

Three years later, the city-to-be was far from fetching. As one visitor described it, it was "a hundred wretched hovels in a malarious wet thicket of willows and dwarf palmettos, infested by serpents and alligators." And during the next few years, it came to be settled by a volatile mix of officers, merchants, shopkeepers, smugglers, quasi-pirates, trappers, gold hunters, and riffraff.

In 1763 the Spanish gained control of New Orleans. After two massive fires, the wooden buildings constructed by the French were replaced with more fire-resistant ones made of brick or stucco and built adjacent to each other and close to the curb to create a firewall. The new buildings also had Spanish-style balconies or galleries made of

Credit: Joan Arehart-Treichel

Many of the charming old structures of the French Quarter still stand, like that at 1140 Royal Street. Note the gallery constructed of hand-wrought or cast iron, a signature of French Quarter architecture.

Credit: Joan Arehart-Treichel

As in years gone by, lush bougainvillea and cast-iron gates, balconies, and galleries are hallmarks of the French Quarter.

elaborate wrought iron or cast iron, as well as Spanish-style courtyards in the back, containing flagstone paths, fountains, and magnolia and banana trees. One can easily imagine how pleasant it must have been to recline in one of those courtyards while a languorous breeze drifted in from the river.

In 1800, Spain gave Louisiana back to France. In 1803, the United States purchased it. Most new faces in New Orleans were now American—brawny boatmen and Yankee traders whom the French and Spanish residents disdained.

During the next few years, the city grew rapidly. There were influxes not just of Americans, but of Creole French (people of French descent born in the Americas), and even people from France. One of

please see ***French Quarter*** *on page 37*

REGISTER NOW FOR THE MEETING!

There are three easy ways to register for APA's 2010 annual meeting and courses, and you can save on fees by registering before **April 16.** Forms to register by mail or fax can be accessed at APA's Web site at <www.psych.org/MainMenu/EducationCareerDevelopment/Meetings/AnnualMeeting.aspx> under "Meeting Registration."

REGISTER ONLINE

Click on the 2010 annual meeting logo on APA's homepage at <www.psych.org> or go directly to <www.psych.org/MainMenu/EducationCareerDevelopment/Meetings/AnnualMeeting.aspx> and then look for "Meeting Registration." "Housing Reservations" can also be found here.

FAX REGISTRATION FORM

Fax your completed registration form with credit card information to (703) 907-1097.

MAIL REGISTRATION FORM

Mail your completed registration form and payment by credit card or check made payable to APA to Registration, APA, Suite 1825, Arlington, Va. 22209-3901.

After April 16, you may register online only (on-site fees apply), not by mail or fax.

What Will You Discover? Just Follow Your Feet

At the center of the famous French Quarter is Jackson Square, home to the magnificent St. Louis Cathedral, originally built as a church in 1718 and the oldest continually operating cathedral in the United States.

BY MARK MORAN

Credit: everystockphoto.com / Mary Witzig

After finishing your walking tour of the French Quarter, relax in Woldenberg Park and watch the Mississippi River traffic.

Put on your walking shoes and get ready for a leisurely stroll when you come to New Orleans, because the city's famed French Quarter is made for seeing at a slow pace.

There are a number of vendors offering guided walking tours. And there is so much history in the Quarter—architectural, religious, musical, and literary—that visitors are liable to stumble across something interesting on their own; it would be all but impossible to encompass every site in the neighborhood.

But here is a sample itinerary, doable by everyone with some energy and a pair of comfortable shoes (and maybe a water bottle and a sunhat).

Walking north on Canal Street you'll pass the Shops at Canal Street, offering high-end fashion and jewelry shopping. Turn right at Decatur Street, and you will find a number of New Orleans' renowned music venues, including House of Blues and the Louisiana Music Factory. Between Conti and St. Louis streets, you will also come across the Visitors Center for the Jean Lafitte National Historical Park and Preserve.

The Visitors Center shares the history and traditions of the city and the delta through exhibits and film, and the national park encompasses five other landmarks of architectural, historical, or natural importance throughout southern Louisiana.

Next on the itinerary is a left turn on St. Louis Street followed by a three-block walk

Begin on Canal Street down by the Mississippi River at the Canal Street Ferry. Also known as the Algiers Ferry, it carries automobiles and pedestrians across the river from the west bank at Canal Street to the historic Algiers Point neighborhood on the east bank of the river.

to Bourbon Street. A walk up and down Bourbon is a unique only-in-the Big-Easy experience—jazz and blues joints, bars that spill out onto the street, street performers, shopping (mostly of the low-end variety), and lots of people watching. In either direction on Bourbon are any number of music venues—the Famous Door, Fat Catz Music Club, the Cajun Cabin, Cat's Meow, and Fritzel's European Jazz Club.

Walking east on Bourbon (to the right after you've turned off of St. Louis), go two blocks to St. Peter Street and turn right. At 726 St. Peter is Preservation Hall, home to the world-renowned Preservation Hall Jazz Band and other elite acts dedicated to preserving the heritage of New Orleans jazz music.

Follow St. Peter Street to Jackson Square. Also known as Place des Armes, the square served as the center of early New Orleans and was renamed for Andrew Jackson following the Battle of New Orleans in 1814. There, Jackson commanded American troops and defeated the invading British, who were intent on capturing New Orleans and the enormous territory of the Louisiana Purchase.

Jackson Square is also home to the magnificent St. Louis Cathedral. First built in 1789 (it was rebuilt several times since then), the Basilica of St. Louis, King of France, is the oldest continually operating cathedral in the United States.

Travel around Jackson Square by turning left (east) on Royal Street, then right again on St. Ann as you walk along the eastern edge of the square. Turn left at Chartres Street and follow Chartres three blocks to Ursuline Street.

At Ursuline and Chartres, you will encounter the Old Ursuline Convent. A striking architectural landmark in its own right, it was built in 1752 and is believed to be the only surviving structure from the French Colonial period in America. Today it serves as an archive for the Archdiocese of New Orleans.

Continuing down Ursuline Street, turn right on Decatur Street again and head for the French Market. This open-air market has operated in one form or another since the late 1700s and today is a venue for shopping, entertainment, and regional cuisine. A little further down Decatur is Jimmy Buffett's Margaritaville, a lively venue for rock and R&B music.

To round out the tour, continue on Decatur past Jackson Square again and turn left at St. Peter Street, following it to the river.

To your left you'll see the Moon Walk, a scenic boardwalk along the Mississippi, built by former Mayor Moon Landrieu—a fine place to watch the steamboats and other river traffic.

Continuing along the bend in the river, you can end your walking tour at Woldenberg Park. A green and scenic venue, it's a great place to spread out a picnic blanket and rest up and contemplate the architectural and historic riches this one neighborhood offers. ■

Join APA and Save on Registration Fee

Not a member of APA? Join at APA's 2010 annual meeting in New Orleans to receive a rebate toward your APA membership.

The APA Annual Meeting Rebate Program invites nonmembers who have registered for the annual meeting and have paid the full-time nonmember registration fee ($905 in advance, $950 on site) to join APA while at the annual meeting to receive a rebate equal to the difference between the nonmember and member registration fees. The rebate for 2010 is $565. Prorated member dues will be paid from the rebate amount and the balance applied to future year's dues.

To qualify, you must be a psychiatrist residing in the United States or Canada and be eligible for APA general membership status. To apply, submit a general membership application on site at the annual meeting at one of the membership desks located in the registration area or in the Member Center located in Halls B-D at the Morial Convention Center. You will also need to submit proof of ACGME-, AOA- , or RCPS(C)-approved psychiatry residency training and valid medical licensure to APA no later than June 30.

More information is available from the APA Membership Department at (888) 357-7924.

HAPA to Meet

The Hellenic American Psychiatric Association (HAPA) will hold its 11th annual meeting in conjunction with APA's 2010 annual meeting in New Orleans. The meeting is scheduled for Tuesday, May 25, from 6 p.m. to 8 p.m. at the Hilton New Orleans Riverside.

There will be two featured speakers: Petros Levounis, M.D., M.A., and Ioannis Zervas, M.D. Levounis is director of the Addiction Institute of New York, chief of the Division of Addiction Psychiatry at St. Luke's and Roosevelt Hospital, and an associate clinical professor of psychiatry at Columbia University; he will speak on "Leadership, Motivation, and Change: Lessons From Addiction Medicine." Zervas is an assistant professor of psychiatry at Athens University School of Medicine in Greece; he will speak on "Women's Mental Health at the Athens University: A Person-Centered Approach." There will also be a brief business meeting.

Starting this year, the meeting will be followed by a prearranged Dutch-treat dinner to be held at a local restaurant beginning at 8:30 p.m.

Those interested in attending the meeting and/or dinner must preregister by sending an e-mail to maria@lymberis.com and submit their HAPA dues of $50. (This fee has not increased since HAPA's founding in 1999.)

Dues may be mailed to Arthur Papas, M.D., 5 Byron Road, Weston, Mass. 02493-2228. More information is available by contacting him at anpapas@comcast.net or (781) 431-7399. More information about HAPA and a membership application are posted at <www.hellenic-psych.org>. ■

Find Museums as Unique As the City Itself

One museum you shouldn't miss is the nation's official World War II Museum, which houses oral histories, images, and artifacts about the war from the battles in the Pacific to the D-Day invasion.

BY MARK MORAN

"Party town" is the conventional description of New Orleans, but away from the noise and bright lights is a quietly thriving museum culture in the Crescent City.

Art, history, architecture, religion, and racial and ethnic cultures—New Orleans has a lot to preserve and dozens of museums throughout the city devoted to celebration of regional identity and general culture. And it is also host to a number of fine museums designed for children and families.

Here is a small sample of New Orleans' museums, from each of several categories that should appeal to wide range of interests.

Photo courtesy of New Orleans Museum of Art / ©Robert Shelton Images

The New Orleans Museum of Art's Sydney and Walda Besthoff Sculpture Garden showcases more than 50 sculptures.

Art

New Orleans Museum of Art. The museum houses a $200 million collection in 46 galleries: European painting and sculpture from the 16th through 20th centuries; American painting and sculture from the 18th and 19th centuries; Asian, African, Oceanic, Pre-Columbian, and Native-American art; photography; and European and American decorative arts. Special collections include treasures by Peter Carl Fabergé and a Latin-American colonial collection.

Ogden Museum of Southern Art. This nationally respected collection includes paintings, watercolors, drawings, prints, photographs, sculpture, and wood and craft works embodying the visual heritage and history of the South from 1733 to the present.

History

National World War II Museum. Designated by Congress as the nation's official World War II museum, it houses oral histories, images, and artifacts from the Normandy invasion to the battles of the Pacific Islands. The Malcolm S. Forbes Theater shows two exceptional movies: "D-Day Remembered" and "Price for Peace" about the war in the Pacific.

Confederate Museum. The Louisiana Historical Association built the museum in 1891 to hold war records, artifacts, and memorabilia from the Civil War. Varina Howell Davis, wife of Jefferson Davis, the president of the Confederacy, donated a large collection of Davis memorabilia. The museum features Civil War uniforms and other attire worn by officers and enlisted soldiers, as well as personal belongings of Confederate generals.

Photo courtesy of New Orleans African American Museum

The New Orleans African American Museum is housed in one of the finest examples of a Creole villa in the city. Built in 1828-29, the home retains many of its original decorative details.

Children and Family

Louisiana Children's Museum. Hands-on, interactive exhibits help children and families explore art, music, science, math, and health.

Audubon Aquarium of the Americas. 15,000 sea-life creatures represent 600 species living in a state-of-the-art facility.

Audubon Zoo. Among the favored residents are elephants Jean and Panya, a Komodo dragon, and white tiger brothers from California named King Rex and King Zulu. There is also a Cajun houseboat on a lagoon full of 14-foot alligators.

Religion

Old Ursuline Convent. Now used as an archive of the Archdiocese of New Orleans, the convent is the oldest building in the Mississippi Valley and the only surviving structure from the French Colonial period. Tours begin in the Chartres Street Gatehouse and continue through the manicured gardens. Behind the convent is an herb garden maintained by famed New Orleans chef Horst Pfeiffer of Bella Luna Restaurant.

Multicultural

New Orleans African American Museum. Located in the neighborhood of Treme, believed to be the oldest surviving black community in the United States, the museum is dedicated to preserving art and artifacts of Africa and African Americans.

Backstreet Cultural Museum. Also located in Treme, the museum houses artifacts related to Mardi Gras, jazz funerals, and other New Orleans traditions—it is home to the city's largest collection of Mardi Gras Indian costumes. Considered artistic treasures, many of these cost $10,000 or more. ■

MORE INFORMATION

New Orleans Museum of Art
1 Collins Diboll Circle, City Park
(504) 658-4100
www.noma.org

Ogden Museum of Southern Art
925 Camp Street
(504) 539-9600
www.ogdenmuseum.org

National World War II Museum
945 Magazine Street
(504) 527-6012
www.nationalww2museum.org

Confederate Museum
929 Camp Street
(504) 523-4522
www.confederatemuseum.com

Louisana Children's Museum
420 Julia Street
(504) 586-0725
www.lcm.org

Audubon Aquarium of the Americas
1 Canal Street
(504) 581-4629
www.audubooninstitute.org

Audubon Zoo
6500 Magazine Street
(504) 581-4629
www.audubooninstitute.org

Old Ursuline Convent
1100 Chartres Street
(504) 529-3040
www.neworleansmuseums.com/directory/location.php?locationID=1278

New Orleans African American Museum
1418 Gov. Nicholls Street
(504) 566-1136
www.neworleansmuseums.com/directory/location.php?locationID=1243

Backstreet Cultural Museum
1116 St. Claude Avenue
(504) 522-4806
www.backstreetmuseum.org

Addiction-Related Brain Discoveries Advance Clinical Practice

Some of the best and brightest scientists and clinicians will present research findings and practical advice valuable for psychiatrists within and outside of the addiction field.

BY JUN YAN

Exciting advances in brain research and clinical innovations that are likely to improve the treatment of a range of psychiatric disorders—not just addiction—will be presented in the special track sponsored by the National Institute on Drug Abuse (NIDA) at the this year's annual meeting.

Neuroscience has made great strides in uncovering the neurological processes that maintain the balance of impulsivity and self-control, which are crucial to understanding addiction and other psychiatric symptoms intertwined with cognitive functions. These discoveries also suggest potential treatments for addictive disorders that target the faulty brain regions. Several programs in the NIDA track will present these research findings and their implications for clinical use.

The director of NIDA, Nora Volkow, M.D., will give a lecture on Tuesday, May 25, titled "Addiction: Conflict Between Brain Circuits."

Credit: David Hathcox

NIDA Director Nora Volkow, M.D., presents a lecture to a standing-room-only crowd at APA's 2007 annual meeting.

"I'm pleased to be speaking to my psychiatric colleagues about the neuroscience of addiction as a 'Conflict of Brain Circuits,' " Volkow told *Psychiatric News*. "We know that addiction is a complex behavioral disorder with key components of preexisting predisposition, memory and learning, motivation and drive, balanced by circuits involved in judgment and decision making." Thanks to recent research, "we can appreciate the nature of addiction as a condition in which these neural circuits are relatively out of balance." An understanding of these mechanisms, she believes, will help develop successful prevention and treatment strategies.

"Executive Function as a Brain System for Self-Control: The Neurocircuitry of Psychiatric Disorders and Addiction," a symposium on Saturday, May 22, will focus on executive function and self-control, including the neurocircuits responsible for controlling impulses and making decisions, the role of dopamine, and how dysfunctions in the circuitry present in schizophrenia, substance abuse, and other psychiatric disorders.

please see ***Discoveries*** *on page 37*

22 SATURDAY MAY

7 a.m.-5 p.m.
Course Enrollment Open

8 a.m.-Noon
CME Courses 1-3

Seminar 1
Managing Malpractice Risk for Psychiatrists: The Basics and Beyond *Chair: Jacqueline Melonas, J.D.*

Seminar 2
Evidence-Based Psychotherapy for Chronic Major Depression *Chair: Eric Levander, M.D.*

9 a.m.-10:30 a.m.
Lecture

L1. Translational Research in Schizophrenia: Challenges and Promises *Raquel E. Gur, M.D.*

9 a.m.-Noon
Symposia

S1. PTSD in Military Populations: Translating Research Into Practice

A. PTSD in Military Populations: Scope and Treatment Challenges? *Robert J. Ursano, M.D.*

B. Current Evidence-Based Treatment Recommendations for PTSD *Matthew J. Friedman, M.D.*

C. What Is Known and What Needs to Be Learned About Sociodemographic Factors in PTSD? *Paula Schnurr, Ph.D.*

D. Treating PTSD and Other Mental Health Conditions in Military Populations *Joshua Wilk, Ph.D.*

E. Reengineering Systems of Primary Care Treatment for PTSD and Depression in the U.S. Military: Program Description and Implementation *Charles C. Engel, M.D.*

F. APA/APIRE PTSD Performance in Practice Tools *Farifteh F. Duffy, Ph.D.*

S2. Recent Research on Eating Disorders

A. Recent Findings in the Longitudinal Assessment of Bariatric Surgery (Labs) Study *James E. Mitchell, M.D.*

B. Neurocircuitry of Anorexia Nervosa *A. Walter Kaye, M.D.*

C. Bariatric Surgery in Adolescents: Clinical Characteristics and Eating Behavior *Michael Devlin, M.D.*

D. Stress Response to Food Portion Size in Anorexia Nervosa *Katherine Halmi, M.D.*

S3. Smoking and Psychiatric Disorders: Clues About Causal Pathways and Innovative Treatment Approaches *National Institute on Drug Abuse*

A. Psychiatric Disorders as Signals of Sensitivity for Nicotine Dependence *Lisa Dierker, Ph.D.*

B. Nicotine Receptors and Their Genes in Psychosis *Robert Freedman, M.D.*

C. Integrating Tobacco Dependence Treatment Into Mental Health and Addiction Treatment *Douglas M. Ziedonis, M.D.*

S4. Shared Decision Making in Mental Health Care: A Recovery and Person-Centered Approach

A. Shared Decision Making in Mental Health Care *Melody Riefer, M.D.*

B. Shared Decision Making: Making Recovery Real in Mental Health *Laurie Curtis, M.D.*

C. Supporting Consumers' Recovery Through Joint Consumer and Clinician Use of Shared Decision-Making Tools *James Schuster, M.D.*

S5. New Developments in Interpersonal Psychotherapy (IPT)

A. Interpersonal Psychotherapy: A Three-Session Evaluation: Support and Triage (IPT EST) *Helena Verdela, M.D.*

B. Interpersonal Psychotherapy for Depressed Women Undergoing Fertility Treatment: A Randomized, Controlled Trial *Diana Koszycki, Ph.D.*

C. Interpersonal Psychotherapy for Patients With Chronic Posttraumatic Stress Disorder (IPT PTSD) *John C. Markowitz, M.D.*

D. Treating Depression With Evidence-Based Interventions in Routine Daily Practice: Results of a Pragmatic Effectiveness Trial *Frenk Peeters, M.D.*

E. Interpersonal Psychotherapy for Community Patients With Moderate to Severe Major Depressive Disorder and Multiple Comorbidities: A Proof of Concept Study *Hasse Karlsson, M.D.*

S6. Update on Treatments for Child and Adolescent Eating Disorders

A. Family-Based Treatment for Child and Adolescent Eating Disorders *Daniel LeGrange, Ph.D.*

B. Adolescent-Focused Individual Therapy for Anorexia Nervosa *James Lock, M.D., Ph.D.*

C. Cognitive Remediation Therapy for Adolescent Anorexia Nervosa *Kathleen Kara Fitzpatrick, Ph.D.*

S7. Neurodevelopmental Disorders in *DSM-5*: An Update From the Work Group

A. The Neurodevelopmental Disorders in *DSM-5*: What's Changed? What's Staying the Same? *Susan E. Swedo, M.D.*

B. *DSM-5* and the Core Features of Autism Spectrum Disorders *Catherine Lord, Ph.D.*

C. Intellectual Disability in *DSM-5 Walter E. Kaufmann, M.D.*

D. Sex Differences in Autism Spectrum Disorder: Risk Factors, Changes Over Time, Early Signs, and Core Autism Symptoms *Poul Thorsen, M.D.*

E. The Autism Spectrum: How Deep and How Wide? *Bryan King, M.D.*

S8. Aggressive Behaviors in Geropsychiatric Patients: Neurobiology, Assessment, and Management *American Associa-*

continued on page 8

Free Reception

New this year! There will be a reception in the Exhibit Hall at the Morial Convention Center on Monday, May 24, from 12:30 p.m. to 1:30 p.m. Drop by and enjoy a snack while perusing the exhibits and catching up with friends and colleagues.

tion for Geriatric Psychiatry

A. The Neurobiology of Aggression *Randy J. Nelson, Ph.D.*

B. Nonpharmacologic Assessment and Management of Aggressive Behaviors in Geropsychiatric Patients *Patricia A. Arean, Ph.D.*

C. Pharmacologic/Somatic Assessment and Management of Aggressive Behaviors in Geropsychiatric Patients *Helen H. Kyomen, M.D.*

S9. Advances in the Management of Treatment-Resistant Depression

A. The Neurobiology of Depression: Implications for Treatment-Resistant Depression and Personalized Medicine in Psychiatry *Charles B. Nemeroff, M.D.*

B. Unmet Needs in the Treatment of Depression *Michael E. Thase, M.D.*

C. Augmentation and Combination Strategies in Treatment-Resistant Depression *Linda L. Carpenter, M.D.*

D. Management of Comorbid Depression and Substance Abuse *Ihsan M. Salloum, M.D.*

S10. Clinical Trends in Bipolar Disorders *APA, International Society of Bipolar Disorder*

A. Clinical Trials Design in Bipolar Disorder *Mauricio Tohen, M.D.*

B. Evidence-Based Guidelines for Treatment *Lakshmi Yatham, M.D.*

C. Biomarkers: From the Bench to the Clinical Setting *Flavio Kapczinski, M.D.*

D. Advocacy Groups in Bipolar Disorder *Mark Frye, M.D.*

E. Women's Issues in Bipolar Disorder *Aysegul Ozerdeem, M.D., Ph.D*

S11. Culturally Sensitive Assessment of Psychologically Distressed Ethnic and Non-English-Speaking Populations

A. Change in Culturally Specific Complaints and PTSD Severity Across Initial Treatment: Results of Psychiatric Clinic Survey of Cambodian Refugee Patients *Devon E. Hinton, M.D., Mark H. Pollack, M.D.*

B. Culturally Sensitive Care for Older Adults: A Critical Examination of the *DSM-IV* Cultural Formulation *Ladson Hinton, M.D.*

C. Cultural Sensitivity and External Validity of Mental Health and Psychosocial Assessments for Child Soldiers in Nepal *Brandon A. Kohrt, M.D.*

D. Dissociation, Traumatic Exposure, and Self-Reported Psychotic Symptoms in U.S. Latinos *Roberto Lewis-Fernández, M.D.*

E. Assessing Family Conflict in West-African Immigrant Families R*asmussen, Ph.D., Adeyinka Akinsulure-Smith, Ph.D., Tracy Chu, Ph.D.*

S12. Anxiety Treatment: New Research Findings for the Clinician

A. Acute Treatment for Chronic PTSD: PE vs. Sertraline *Norah C. Feeny, Ph.D.*

B. Social Anxiety Pharmacotherapy Improvement (Sapient): Response to Initial SSRI Treatment *Murray B. Stein, M.D.*

C. DCS: A Novel Pharmacological Strategy to Enhance CBT for Anxiety *Mark Pollack, M.D.*

D. Calm: Improving Primary Care Anxiety Outcomes *Peter Roy-Byrne, M.D.*

S13. Family and Behavioral Genetic Studies of Borderline Personality Disorder

A. Behavioral Genetics of Borderline Personality Disorder *Ted Reichborn-Kjennerud, M.D.*

B. Childhood Adversity Associated With Adolescent-Onset Borderline Personality Disorder *Mary Zanarini, Ed.D.*

C. Outcome in Women Diagnosed With Borderline Personality Disorder in Adolescence *Robert Biskin, B.S.*

D. Trauma and Psychopathology in Patients With Borderline Personality Disorder and Their Sisters *Joel Paris, M.D.*

E. Vulnerability to Depressive Symptoms Among Children of Parents With Major Depressive Disorder With or Without Comorbid Borderline Personality Disorder *John Abela, B.A.*

Credit: Carl Purcell / Courtesy New Orleans Convention and Visitors Bureau

9 a.m.-10:30 a.m.

Workshops

W1. Management of the Suicidal Outpatient: Beyond the Contract for Safety *Chair: Jeanne Goodman, M.D.*

W2. The Deadly Years: Preventing Suicide in Asian-American College Students *Caucus of Asian American Psychiatrists; Co-Chairs: Russell Lim, M.D., Velandy Manoharm, M.D.*

W3. A Medicinal Cannabis Update for 2010: Use, Abuse, New Research, New Forensic, and New Political Realities *Chair: Lawrence Richards, M.D.* **(Open to APA members only.)**

W4. Unconscious Projections: The Portrayal of Psychiatry in Recent American Film *Chair: Steven Pflanz, M.D.*

W5. Psychiatric Care at the End of Life *Chair: Jonathan Stewart, M.D.*

W6. Enhancing Risk Assessment Across Services in Mental Health *Chair: Amresh Shrivastava, M.D.*

W7. The "Negative Outcome" in Psychotherapy: Who Is Responsible and How? *Chair: Janet Lewis, M.D.*

W8. Cognitive Therapy for Personality Disorders *Chair: Judith Beck, Ph.D.*

W9. The IMG Journey: Snapshots Across the Professional Lifespan *Co-Chairs: Vishal Madaan, M.D., Durga Bestha, M.B.B.S.*

W10. Bridging the Cultural Divide: Challenges of First-Generation Immigrants With Children With Mental Illness *APA/SAMHSA Minority Fellows Co-Chairs: Timothy Liu, M.D., Steve Koh, M.D.*

W11. A Program of Psychotherapy for Combatants' Dependents—The Effect on Recall Rates: They Are Not Going for Three Weeks and the Fighting Has Begun *Chair: Michael Wise, M.B.B.S.*

W12. New APA Practice Guideline for the Treatment of Patients With Major Depressive Disorder *Co-Chairs: Joel Yager, M.D., Alan Gelenbergm, M.D.*

9 a.m.-4 p.m.

Master Courses

MC01. Update on Pediatric Psychopharmacology *Chair: Christopher J. Kratochvil, M.D.*

MC02. Staying on the Cutting-Edge of Advances in Clinical Psychopharmacology *Chair: Alan F. Schatzberg, M.D.*

CME Courses 4-7

10 a.m.-5 p.m.

APA Member Center Open
Publishers' Bookfair Open
Registration/Course Enrollment Open

11 a.m.-12:30 p.m.

Lecture

L2. The Future of Depression Research *Florian Holsboer, M.D.*

Workshops

W13. Challenges and Opportunities in Teaching Neurology to Psychiatry Residents *Co-Chairs: Claudia Reardon, M.D., Art Walaszek, M.D.*

W14. Dealing With the Difficult Professional Employee: Effective Personnel Management Strategies *Chair: Stephen Soltys, M.D.*

W15. Münchausen Revisited: Factitious Disorder in the Age of Internet and *DSM-5* *Co-Chairs: Damir Huremovic, M.D., Shabneet Hira Brar, M.D.*

W16. Telepsychiatry Education: Teaching to the Near and Far Ends *Chair: John Teshima, M.D.*

W17. Preparing IMG (International Medical Graduate) Psychiatry Residents for a Career in Academic Psychiatry *APA/GlaxoSmithKline Fellows; Co-Chairs: Sosunmolu Shoyinka, M.B.B.S., Oladipo Kukoyi, M.D.*

W18. Is That an Unconscious Fantasy or a Core Belief? A Resident's Perspective on Learning Multiple Therapies Simultaneously *Co-Chairs: Emily Gastelum, M.D., Aerin Hyun, M.D.*

W19. Transplant Psychiatry Update *Co-Chairs: Paula Zimbrean, M.D., Swapna Vaidya, M.D.*

W20. When Disorder Hits Home: Dealing With Serious Psychiatric Disorders in Our Own Families *American Group Psychotherapy Association; Chair: Julia Frank, M.D.*

W21. Lost in Translation: Generational Issues and Mental Health *Association of Women Psychiatrists; Chair: Tana Grady-Weiliky, M.D.*

W22. Diagnosis and Treatment of Psychogenic Nonepileptic Seizures: What Does a Psychiatrist Do Once the Diagnosis Is Made? *Co-Chairs: W. Curt LaFrance Jr. M.D., Andres Kanner, M.D.*

W23. Oral Boards Boot Camp 2010: Focus on Diagnostic Interviewing *Co-Chairs: Elyse Weiner M.D., Eric Peselow, M.D.*

W24. The Behavioral Health Action Network: Reorganizing the Behavioral Health Delivery System in Post-Katrina New Orleans *Chair: Elmore Rigamer, M.D.*

Noon-2:30 p.m.

Industry-Supported Symposia

1 p.m.-5 p.m.

CME Courses 8-10

Seminar 3
Managing Malpractice Risk for Psychiatrists: The Basics and Beyond *Chair: Jacqueline Melonas, J.D.*

Seminar 4
Infidelity and Marital Relationships: Death Knell or Wake-Up Call? *Chair: Scott Haltzman, M.D.*

1:30 p.m.-3 p.m.

Workshops

W25. Adult Pervasive Developmental Disorder: For Better Understanding and Treatment *Co-Chairs: Soonjo Hwang, M.D., Mathew Brams, M.D.*

W26. Dynamic Therapy With Self-Destructive Borderlines: An Alliance-Based Intervention for Suicide *Co-Chairs: Eric Plakun, M.D., Edward Shapiro, M.A.*

W27. Evaluation and Management of Patients With Excessive Daytime

AMERICAN PSYCHIATRIC ASSOCIATION
WWW.PSYCH.ORG

APA General Member
MEMBERSHIP APPLICATION

Join APA Online! Complete your membership application online and submit it electronically to the APA Membership Department at **www.psych.org** JOIN APA.

My application is being submitted in response to your Member-Get-A-Member campaign. I am being referred by:

Member Name: _____ Member ID Number: _____

☐ I am a physician who has completed acceptable psychiatry training (as approved by the Residency Review Committee for Psychiatry of the Accreditation Council for Graduate Medical Education, the Royal College of Physicians and Surgeons (Canada) or the American Osteopathic Association) and I have a valid license to practice medicine or I have an academic, research or governmental position that does not require licensure.

☐ I am applying for membership in the APA through the following District Branch/State Association: _____
(Please see the APA District Branch/State Association list on the back cover of this brochure)

Are you a former member of APA? ☐ Yes ☐ No If YES, please provide your former name: _____

DUES AMNESTY FOR FORMER MEMBERS OWING PAST DUES: Former members who owe past dues may be eligible for a one time "dues amnesty" for past district branch and APA dues. To be eligible, your district branch must participate in the program and waive past district branch dues. Visit www.psych.org/membership for details.

BIOGRAPHICAL INFORMATION

LAST NAME | FIRST NAME | MI | SUFFIX

PREFERRED MAILING ADDRESS (LINE 1) [ ] HOME [ ] OFFICE (**REQUIRED**)

PREFERRED MAILING ADDRESS (LINE 2) | DEGREE (M.D., Ph.D., MPH)

CITY, STATE/PROVINCE, ZIP/POSTAL CODE

AREA CODE AND HOME TELEPHONE | AREA CODE AND OFFICE TELEPHONE | AREA CODE AND FAX NUMBER [ ] HOME [ ] OFFICE

E-MAIL ADDRESS [ ] HOME [ ] OFFICE

M M D D Y Y

DATE OF BIRTH | COUNTRY OF BIRTH | LANGUAGES SPOKEN (OTHER THAN ENGLISH)

OPTIONAL SECONDARY ADDRESS (LINE 1) [ ] HOME [ ] OFFICE

CITY, STATE/PROVINCE, ZIP/POSTAL CODE

DEMOGRAPHIC DATA

The following categories are for statistical purposes only. This information will not be considered in connection with your application for membership.

Gender: ☐ Male ☐ Female

Ethnicity/Race: (Check all that are applicable.)

Are you Spanish/Hispanic/Latino?

- ☐ No, not Spanish/Hispanic/Latino
- ☐ Yes, Mexican, Mexican-American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, Other Spanish/Hispanic/Latino

- ☐ American Indian or Alaska Native
- ☐ Asian: Indian & Indian Subcontinent
- ☐ Asian: Chinese
- ☐ Asian: Filipino
- ☐ Asian: Japanese
- ☐ Asian: Korean
- ☐ Asian: Vietnamese
- ☐ Asian: Other
- ☐ Black: Afro-American
- ☐ Black: Afro-Caribbean
- ☐ Black: African
- ☐ Black: Other
- ☐ Middle Eastern
- ☐ Pacific Islander: Native Hawaiian
- ☐ Pacific Islander: Guamanian or Charmorro
- ☐ Pacific Islander: Samoan
- ☐ Pacific Islander: Other
- ☐ White
- ☐ Other, Specify: _____
- ☐ Unreported

ETHICS

Has your license to practice medicine ever been revoked or suspended?
☐ Yes ☐ No

Are you currently charged with illegal or unethical professional conduct by a regulatory or law enforcement agency or by a professional society?
☐ Yes ☐ No

Have you ever been found guilty of illegal or unethical professional conduct by a regulatory or law enforcement agency or by a professional society?
☐ Yes ☐ No

If you answered YES to any of the three preceding questions, please provide details in a confidential communication to the APA Membership Committee Chair and attach the details to this application.

ACADEMIC TRAINING

MEDICAL SCHOOL

SCHOOL

CITY/STATE OR COUNTRY

STARTED (MONTH/YEAR) FINISHED (MONTH/YEAR) DEGREE

PSYCHIATRY RESIDENCY TRAINING (and other medical specialty training, including fellowship programs; list most recent first.)

Certificate of completion is attached. ☐ Yes ☐ No

TRAINING PROGRAM/SCHOOL

CITY/STATE OR COUNTRY

STARTED (MONTH/YEAR) FINISHED (MONTH/YEAR) SPECIALTY

TRAINING PROGRAM/SCHOOL

CITY/STATE OR COUNTRY

STARTED (MONTH/YEAR) FINISHED (MONTH/YEAR) SPECIALTY

TRAINING: Does the preceding training information reflect recognized completion of residency training in psychiatry approved by the Residency Review Committee for Psychiatry of the Accreditation Council for Graduate Medical Education, the Royal College of Physicians and Surgeons of Canada, or the American Osteopathic Association?

☐ Yes ☐ No If YES, how many full years of psychiatric residency training have you completed? _____

WORK SETTINGS: (Paid and unpaid). Rank answers 1, 2, or 3, by time spent.

- ___ Community Mental Health Center
- ___ Correctional or Forensic Facility
- ___ Federal/Military Setting
- ___ Federal/Veteran's Administration
- ___ Group Office Practice, Traditional
- ___ Inpatient Unit-Private General Hospital, including Partial Hospital
- ___ Inpatient Unit-Private Psych Hospital, including Partial Hospital
- ___ Inpatient Unit-Public General Hospital, including Partial Hospital
- ___ Inpatient Unit-Public Psych Hospital, including Partial Hospital
- ___ Nursing Home
- ___ Outpatient Clinic-Private or Freestand
- ___ Outpatient Clinic-Public Hospital or Freestand
- ___ Residential Treatment Center
- ___ Solo Office Practice
- ___ Group Model HMO Clinic
- ___ Student/College Mental Health
- ___ Other, Specify _____

BOARD CERTIFICATION: Please list any board certifications (i.e. ABFP, ABPN, AOA, RCPS(C), other). List area(s) that you are certified in and include the start date and end date (MM/DD/YYYY) of the certification.

DOCUMENTATION: To expedite the application process, please complete the section below and attach a copy of your medical license.

STATE AND LICENSE NUMBER (**REQUIRED**)

EXPIRATION DATE (IF APPLICABLE)

To avoid unnecessary delay, be sure to submit appropriate documentation.

✓ **License enclosed.** A copy of my current, valid medical license is enclosed with my membership application.

✓ **Residency Training Completion Certificate enclosed.** My residency training completion certificate is enclosed with my membership application.

☐ Not required. I am a physician in an academic, research or governmental position not requiring a license.

AGREEMENT

I agree to abide by the bylaws of APA and its District Branches and State Associations. I understand that the organization will make inquiries about me and that I am not entitled to, and will not ask for, a disclosure of these replies. I will hold APA and its District Branches/State Associations, members, officers, employees, and agents free from all damage and complaint by reason of action taken on this application or by reason of any subsequent action on membership, including the sharing between the APA Office of Membership and District Branches/State Associations of information about my professional conduct. I pledge myself to standards of ethical practice and conduct as specified in the bylaws of APA and in the *Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry*. I certify that the above information is accurate, and I understand that inaccurate information can invalidate my application. My signature means that I agree to the conditions above and on the reverse of this application.

SIGNATURE DATE

MEMBER PROFILE UPDATE

As a member of the American Psychiatric Association (APA), your professional information is secured on the Member Profile Update page. You can update your contact, biographical and practice data information any time by accessing your membership record in Member's Corner at www.psych.org. Periodically checking and updating your membership record will make it easier for other members to get in touch with you (and you with them)—now patient referrals can be dependably made using the most current and up-to-date information possible! ***Another great benefit from the APA.***

APA GENERAL MEMBER • MEMBERSHIP APPLICATION

The American Psychiatric Association/District Branch/State Association membership year runs from January 1 through December 31. Members enrolled in April or after are invoiced a prorated amount for APA/District Branch membership dues. Membership is continuous on an annual basis, unless written notification is received from the member or the membership is terminated for nonpayment of membership dues or failure to meet the APA—District Branch/State Association joint membership requirement. **District Branch/State Association dues are fixed by each individual branch.** Enrollment is effective the first month following approval of your application by the APA Membership Department and your District Branch/State Association. Membership in APA and the District Branch/State Association is simultaneous; you must be a member of both to be a member of either.

To ensure prompt processing of your membership application, be sure to:

- Sign and date the membership application.
- Do NOT send payment for membership dues with this application. You will be billed following enrollment.

Please complete and return this application to:

American Psychiatric Association
Membership Department MS#5 1808
1000 Wilson Blvd., Suite 1825
Arlington, VA 22209-3901

www.psych.org
Email: apa@psych.org
Fax: 703-907-1085

QUESTIONS? Call 1-888-35-PSYCH or 703-907-7300 *01/10*

Sleepiness in Psychiatric Practice *Chair: Dimitri Markov, M.D.*

W28. Vulnerability and Resilience: Katrina's Widespread Impact on First Responders, Clinicians, Youth, and Relocated Survivors *Co-Chairs: Phebe Tucker, M.D., Howard Osofsky, M.D.*

W29. When Adults With Pervasive Developmental Disorders Present in a Community Mental Health Setting *American Association of Community Psychiatrists; Chair: Ann Hackman, M.D.*

W30. From Outreach to Assertive Community Treatment: Transferring Research to Practice in Comprehensive Care for Underserved People Living With HIV/AIDS *Co-Chairs: Gary Morse, Ph.D., Ilze Ruditis, M.S.W.*

W31. Sexual Minority Youth: Clinical Competencies and Training Needs for the 21st Century *American Academy of Child and Adolescent Psychiatry; Chair: Scott Leibowitz, M.D.*

W32. Cognitive-Behavioral Strategies for Weight Loss *Co-Chairs: Sarah Johnson, M.D., Joyce Spurgeon, M.D.*

Foundation Gala to Spin Night of Southern Romance

Credit: Blaine Kern Studios

Imagine sipping fine wine and sampling delicacies inspired by the local culture in a grand Southern mansion while conversing with friends and enjoying floor-to-ceiling views from a loft reached by a sweeping grand stairway. Outside the mansion you can meander in the warm evening on winding walkways and wooden bridges crossing a stream amid moss-draped oaks.

This picturesque setting is the Grand Oaks Mansion on the Mississippi River, where the American Psychiatric Foundation is hosting its annual benefit. It will be held Monday, May 24, from 7 p.m. to 10 p.m. Most fittingly, the theme is "A Night in New Orleans."

Having an opportunity to enjoy some Southern hospitality is one reason to come to New Orleans for APA's annual meeting, but what gives the event a special meaning is that you'll be supporting the work of the foundation. Event proceeds fund the foundation's grants, programs, research awards, and awards that advance public understanding that mental illnesses are real and treatable. The evening's program also includes the presentation of the Awards for Advancing Minority Mental Health.

Please note that the day of the benefit has been changed this year—from Saturday evening to Monday evening. Tickets are $125 each until May 1; after that date, the cost is $150. Tickets may be ordered by visiting <www.psychfoundation.org> or calling (703) 907-8503.

2 p.m.-4 p.m.

S14. Examining the Outcome Continuum of Schizophrenia Into Later Life

A. Community Integration and Associated Factors Among Older Adults With Schizophrenia *Chadi Abdallah, M.D.*

B. Successful Aging in Older Adults With Schizophrenia: Prevalence and Associated Factors *Fayaz A. Ibrahim, M.D.*

C. Clinical Remission and Recovery in Schizophrenia *Carl I. Cohen, M.D.*

D. Well Being and Associated Factors: Quality of Life and Subjective Successful Aging in Older Persons With Schizophrenia *Sukriti Mittal, M.D.*

Psych Residents: Become an Author

Residents interested in learning how to be an author for a medical publication or participate in the *American Journal of Psychiatry (AJP) Residents' Journal* are invited to attend a workshop on Monday, May 24, at APA's 2010 annual meeting in New Orleans. The session, which is titled "Writing for the 'Blue Journal'—The Residents' and Fellows' Edition of the *American Journal of Psychiatry,"* will be led by *AJP* Editor Robert Freedman, M.D., and Sarah Johnson, M.D., the *AJP Residents' Journal* editor in chief.

The *AJP Residents' Journal* is a Web-based publication that is edited and written by residents and fellows and features articles of interest to trainees. It appears each month by free e-mail subscription and on *AJP's* Web site at <http://ajp.psychiatryonline.org>.

In addition to learning about how to be an author, residents will learn how the *Residents' Journal* can be a learning tool in medical education and select topics, editors, and authors for future issues.

The session will meet from 9 a.m. to 10:30 a.m. in room 346/347 at the Morial Convention Center.

2 p.m.-5 p.m.

Presidential Symposium

PS01. The Emerging Neurobiology of Antidepressant Treatment Response *Society of Biological Psychiatry and APIRE; Co-Chairs: Katharina Domschke, M.D., Yvette Sheline, M.D.*

A. Connectivity of the Subgenual Cortex and HPA Axis in Depression *Alan F. Schatzberg, M.D.*

B. Prediction of Antidepressant Treatment Response—A Pharmaco- and Imaging Genetic Contribution *Katharina Domschke, M.D.*

C. The Role of the Default Mode Network (DMN) in Understanding Emotional Circuitry in MDD Pre- and Post-Antidepressant Treatment *Yvette Sheline, M.D.*

D. Resetting Chemical Dysbalance to Modulating Networks—Lessons on the Neurobiology of Treatment-Resistant Depression From Deep Brain Stimulation *Thomas Schlaepfer, M.D.*

Symposia

S15. Spirituality and Mental Health: What Is the Psychiatrist's Role?

A. The Evolving Role of Meditation and Other Mindfulness Practices in Psychotherapy *William M. Greenberg, M.D.*

B. Positive Emotions: Psychiatry's Great Blind Spot *George E. Vaillant, M.D.*

C. Introducing Spirituality Into Psychiatric Education and Care *Marc Galanter, M.D.*

D. Spiritual Aspects of the Treatment of Personality Disorders *C. Robert Cloninger, M.D.*

E. Spiritual Healing: the Psychiatrist as a Facilitator of Integration *Nadine J. Nybus, M.D.*

S16. Burn Psychiatry: Treatment and Outcomes

A. Trauma and Grief After the Coconut Grove and Station Nightclub Fires 1942 and 2003 *Frederick J. Stoddard, M.D.*

B. Psychopharmacology of Neuropsychiatric Disorders in Burn Patients *Shamim H. Nejad, M.D.*

C. An Intervention to Reduce Stress in 0-5 Year-Olds With Burns *Erica Sorrentino, M.A.*

D. Pain Management During Acute Burn Treatment in Children: A Multicenter Study and Psychosocial Outcome Analysis *Tolga A. Ceranoglu, M.D.*

S17. Update on Interventions for Adult Eating Disorders

A. Stepped Care vs. Best Available Treatment for Patients With Bulimia Nervosa *James Mitchell, M.D.*

B. Dialectical Behavior Therapy for Bulimia Nervosa and Binge Eating Disorder *Debra Safer, M.D.*

C. Cognitive Remediation Therapy for Adults With Anorexia Nervosa *James Lock, M.D.*

D. How to Prevent Eating Disorders *C. Barr Taylor, M.D.*

E. Pharmacotherapy of Eating Disorders: Established Agents and New Directions *Allan Kaplan, M.D.*

S18. Translating the Psychopharmacology Evidence Base Into Practice: A Sampler From AsCP

A. Quality of Care in Psychopharmacology: Doing an Actual Visit *John M. Kane, M.D.*

B. Combination Therapy: Psychopharmacology and Psychotherapy *Ira D. Glick, M.D.*

C. Focus on a Specific Patient Group: Geriatric Patients *James Ellison, M.D.*

D. An Ethical Framework for Clinician/Industry Interactions *Michael D. Jibson, M.D., Ph.D.*

S19. Pathophysiology of Psychotic and Mood Disorders: Do We Have Any Solid Evidence of Interest to Clinicians?

A. What Do We Know for Sure About the Pathophysiology of Schizophrenia? *Stephen Lawrie, M.D.*

B. Clinically Relevant Neurobiological Findings in Depression *Gregor Hasler*

C. What Do We Know About the Causes of Bipolar Disorders *Stephen M. Strakowski, M.D.*

D. Shared and Distinct Neurogenetic Mechanisms for Schizophrenia and Bipolar Disorder *Andreas Meyer-Lindenberg, M.D.*

S20. Updating the APA Guidelines for the Treatment of Borderline Personality Disorder *Association for Research in Personality Disorders*

A. Updating the APA Guidelines for the Treatment of BPD: Neurobiology and Genetics of Borderline Personality Pathology *Simone S. Kool, Ph.D.*

B. Emergency Management of Suicidal Crises in Patients With Borderline Personality Disorder (BPD) *Paul S. Links, M.D.*

C. Approaches to Prioritizing Treatment of Borderline Personality Disorder in the Presence of Other Significant Axis I and Axis II Disorders *James H. Reich, M.D.*

D. New Considerations in the Pharmacologic Treatment of Borderline Personality Disorder *Kenneth R. Silk, M.D.*

E. Psychotherapy for Borderline Personality Disorder *John Livesley, M.D.*

S21. How to Get the Corner Office: Practical Leadership Strategies for Women Psychiatrists *Association of Women Psychiatrists*

A. Thriving Not Just Surviving as a Clinical Researcher *Eva Szigethy, M.D.*

B. Ditching the Corner Office to Address Global Health *Mary Kay Smith, M.D.*

C. Women in Organizational Leadership: What, When, and How *Carolyn B. Robinowitz, M.D.*

S22. Culture and Psychiatric Diagnosis: Implications for the International Impact of *DSM-5*

A. Cultural Perspectives on the Current *DSM-5* Work *Renato D. Alarçon, M.D.*

B. The Outline for Cultural Formulation: Current Status and *DSM-5* Revision *Roberto Lewis Fernández, M.D.*

C. Cultural Syndromes Around the World and in *DSM-5:* Why and How Should They Be Included? *Joseph Westermeyer, M.D.*

continued on page 10

S23. Recent Changes to Acute Psychiatric Care: An International Perspective

A. Coercive Measure in Acute Psychiatric Care: An Italian Perspective *Andrea Fiorillo, M.D.*

B. Recent Changes in Acute Psychiatric Care—Romanian Perspective *Adriana A. Mihai, M.D.*

C. Acute Psychiatric Care in Turkey *Defne Eraslan, M.D.*

D. Acute Psychiatric Care in the United States *Abigail L.Donovan, M.D.*

E. Introduction of a Hospitalist System in a Large Acute Psychiatric Service: Evaluating the Impact *Julian Beezhold, M.D.*

S24. Prevention of PTSD: Recent Israeli Practices

A. The IDF PTSD Prevention Program for Combat Medical Teams *Yoram Barak, M.D.*

B. Follow-Up of an Acutely Traumatized Reserve Unit for the Prevention of Combat PTSD *Nathaniel Laor, M.D.*

C. CS71hronic Follow-Up of Traumatized Reserve Units for Prevention and Treatment of Combat PTSD *Haim Y. Knobler, M.D.*

D. A Model for Preventing PTSD Symptoms Among Adolescent Volunteers on Ambulance Teams Exposed to Terrorism *Eli Jaffe, Ph.D.*

S26. Transcultural Psychiatry for Mental Health in a Changing World

A. Cultural Psychiatry Issues in Schizophrenia *Robert Kohn, M.D.*

B. Cultural Contexts of Patient and Family Explanations of Suicidal Behavior *Mitchell Weiss, M.D.*

C. Transcultural Psychiatry *John D. Kinzie, M.D.*

D. Integrating Traditional and Western Mental Health Care *Richard Merkel, M.D.*

S28. Doping in Athletes: The Role of the Sport Psychiatrist

A. Doping Control in Elite Athletics *Eric Morse, M.D.*

B. Helping the Athlete Through the Therapeutic Use Exemption Process *David Conant-Norville, M.D.*

C. The Ethics in Doping Control *Saul Marks, M.D.*

S29. Executive Function as a Brain System for Self-Control: The Neurocircuitry of Psychiatric Disorders and Addiction *National Institute on Drug Abuse*

A. Prefrontal Circuits for Rules, Concepts, and Cognitive Control *Earl K. Miller, Ph.D.*

B. Basic Neurobiology of Self-Control in Decision Making *Todd Hare, M.D.*

C. Imbalance in Cortico-Subcortical Control in Adolescence *B. J. Casey, Ph.D.*

D. Key Circuits and Regions Implicated in Executive Dysfunction and Disruptions of Cognitive Control in Schizophrenia: Genetic Influences and Dopamine Regulation *Karen Faith Berman, M.D.*

E. Core Cognitive Systems for Controlling Craving and Negative Emotion in Substance Abuse and Psychiatric Disorders *Kevin N. Ochsner, Ph.D.*

S30. Addiction Research, Prevention, and Treatment in the U.S. and France: Vive la Difference!

Credit: Courtesy New Orleans Convention and Visitors Bureau

A. Progress in Addiction Research *Nora D. Volkow, M.D.*

B. Patterns of Addiction in High School and University Students *Marc Antoine Crocq, M.D.*

C. The FDA and Tobacco Regulation *Joshua Sharfstein, M.D.*

D. Do Psychiatric Patients Smoke to Self-Medicate, or Is It for Other Reasons? *Renaud de Beaurepaire, M.D.*

E. The State of Treatment of Addictive Disorders in the United States *David Oslin, M.D.*

F. Organization and Health Care Networks for Cannabis Treatment in France *Amine Benyamina, M.D.*

3:30 p.m.-5 p.m.

Workshops

W33. Making the Most of Your 20-Minute Hour: Maximizing the Therapeutic Experience *Co-Chairs: Frederick Guggenheim M.D., Robert J. Boland, M.D.*

W34. Patient Suicide During Psychiatry Residency: A Workshop Discussion *Co-Chairs: Allison Baker, M.D., Christina Mangurian, M.D.*

W35. Feedback on Criteria and Terminology in *DSM-5* *Co-Chairs: David Kupfer, M.D., Darrel A. Regier, M.D.*

W36. The Use of Adjunctive Meditation in Psychiatry *Chair: Michael McGee, M.D.*

W37. Publishing Books for the General Public *Chair: Lewis Cohen, M.D.*

W38. Ethical, Clinical, and Legal Challenges Created by Information Technology *Co-Chairs: Malkah Notman, M.D., Elissa Benedek, M.D.*

W39. Where Science and Social Justice Meet: The Example of Smoking in Persons With Bipolar Disorder *Chair: Annette Matthews, M.D.*

W40. Cognitive-Behavioral Therapy: Troubleshooting Common Challenges *Chair: Donna Sudak, M.D.*

5:30 p.m.-8 p.m.

Industry-Supported Symposia

7 p.m.-10 p.m.

Media Workshop

MW1. Isn't All Horror Psychological? Horror Film Director George Romero and Steve Schlozman, M.D., Discuss Polanski's Classic Film "Repulsion" *Chair: Steven Schlozman, M.D.* ■

APA Store: Show Pride in Your Profession

Please plan to visit the APA Store during APA's 2010 annual meeting in New Orleans to purchase your APA-branded merchandise. The APA Store will be open Saturday through Tuesday, May 22 to 25, from 8 a.m. to 4 p.m. and Wednesday, May 26, from 8 a.m. to 2 p.m. You'll find it in the main registration hall in the Morial Convention Center, next to the APA membership desk. Meeting attendees can purchase a wide variety of logo merchandise for home or office, including shirts, jackets, neckties, desktop organizers, padfolios, and business-card holders. Expanded merchandise selections will be available, including 2010 annual meeting commemorative items. Show pride in your profession by displaying your APA logo merchandise!

Credit: David Hathcox

AJP Explains Publishing 'Mystery'

Have you ever wondered about the decision-making process used to determine which studies are published by the *American Journal of Psychiatry (AJP)?*

At APA's 2010 annual meeting in New Orleans, you'll get some insight into the answer in a symposium led *AJP* Editor Robert Freedman, M.D. He will use the June issue to explain how submission decisions are made as he highlights important research reported in that issue. He will be joined by some of the authors from studies published in that issue.

The symposium, titled "New Studies to Appear in the June *American Journal of Psychiatry*—Presentations by the Authors and Editors," will be held on Monday, May 24, at 2 p.m. in room 225/226 at the Morial Convention Center.

Here are some of the papers that at press time were scheduled to appear in *AJP's* June issue: "A Dissociative Subtype of PTSD: Clinical and Neurobiological Evidence" (lead author: David Spiegel, M.D.); "International Consensus Study of Antipsychotic Dosing" (lead author: David Gardner, M.D.); "A Double-Blind, Placebo-Controlled Trial That Combines Sertraline and Naltrexone for Treating Co-Occurring Depression and Alcohol Dependence" (lead author: Helen Pettinati, Ph.D.); and "Time-to-Attainment of Recovery From Borderline Personality Disorder and Its Stability: A 10-Year Prospective Follow-Up Study" (lead author: Mary Zanarini, Ed.D.). ■

Ralph Hoffman, MD, and research assistant Joan Nye, view functional MR images of a patient's cortical activation during auditory hallucinations.

At Yale-New Haven Psychiatric Hospital. we integrate psychotherapy, medication, neurostimulation and rehabilitation to provide compassionate, personalized care for patients with psychiatric and substance abuse disorders.

Pioneering science for exceptional care

Yale-New Haven is also a place where pioneering science leads clinical care in important new directions. Our researchers are developing experimental treatments for psychiatric and substance abuse disorders that may help patients who fail to respond to standard therapies. For example, we have developed an experimental technique that uses magnetic brain stimulation to suppress auditory hallucinations that failed to respond to any available medications.

Yale-New Haven Psychiatric Hospital is a place where the exciting advances in science are working for our patients.

U.S.News America's Best Hospitals 2009-10

Yale-New Haven Hospital is the primary teaching hospital of Yale School of Medicine and is ranked among the nation's best hospitals by *U.S.News & World Report*.

YALE-NEW HAVEN PSYCHIATRIC HOSPITAL

www.ynhh.org

Get a Jazz Immersion In City That Created It

Jazz aficionados and others who enjoy the unique musical form that was born in the U.S.A. will find old jazz recordings, live performances, and exhibits at the New Orleans Jazz National Historical Park.

BY EVE BENDER

New Orleans is known as the birthplace of jazz and gave rise to Dixieland music in the early 20th century, so it only makes sense that there should be a park celebrating the history and evolution of jazz in that city. Jazz great Louis Armstrong was born here in 1901, and many of his recordings and those of his protégées have provided the city with a homegrown soundtrack to this day.

The New Orleans Jazz National Historical Park celebrates this history and occupies about five acres in the French Quarter. The visitor center is sandwiched between Café du Monde and the flea market in the French Market. The park was established in 1994 to educate visitors about the cultural history of the people and places that helped shape the progression of jazz in New Orleans.

Park visitors are treated to talks about the origins of jazz through live talks and video documentaries, live jazz performances that take place in the visitor center, ranger-guided tours, and maps to self-guided walking tours in six neighborhoods that feature concert venues and homes that were essential to the rise of jazz music in the city.

The self-guided walking tour of jazz sites in New Orleans begins in Louis Armstrong Park and contains 11 stops in or near the French Quarter. The final stop of the tour is located across the Mississippi River from downtown New Orleans in the neighborhood of Algiers Point, next to the Jazz Walk of Fame.

The Jazz Walk of Fame, also part of the park, features a series of lampposts, each dedicated to an influential jazz musician. Brochures are available at the visitor center and offer a self-guided audio tour on top of the levee, a spot that offers spectacular views of downtown New Orleans. Also on the park site stands Perseverance Hall No. 4 (not to be confused with Preservation Hall, where many jazz performances take place), which was built from 1819 to 1820. Originally erected as a Masonic Temple, the building is undergoing renovations and is not open to visitors, but can be viewed from the outside.

On Saturdays from 11 a.m. to noon, kids can bring their own instruments to the visitor center to participate in a traditional jazz workshop and play along with members of the Royal Players Brass Band. Live jazz performances take place in the visitor center from 2 p.m. to 3:30 p.m. each day.

The New Orleans Jazz National Historical Park visitor center is located at 916 North Peters Street. Information is posted at <www.nps.gov/jazz> or available by phone at (877) 520-0677. ■

Credit: National Park Service

Music lovers from around the world visit the New Orleans Jazz National Historical Park in the French Quarter to hear acclaimed live performances by bands such as the Society Brass Band, which performs on Saturday afternoons.

All-White Alligator Named Spots? Only in New Orleans

Kids of all ages flock to New Orleans' acclaimed aquarium to experience exhibits that move beyond the theoretical and allow them to interact with its waterbound residents.

BY RICH DALY

Have you ever touched a cownose stingray? For everyone who isn't an experienced scuba diver, New Orleans' Audubon Aquarium of the Americas offers what is likely the first chance to see and touch some of the region's real-life aquatic natives.

The stingray exhibit and other sealife habitats in the aquarium's Adventure Island are designed as interactive play zones that are as fun as they are educational. It's here—right in the middle of downtown New Orleans—that visitors can touch the cownose rays and even help feed them during the rays' twice-a-day feeding times.

Among the top attractions at the aquarium are its resident penguins, stingrays, sharks, and unusual deep-sea creatures. More shallow-living favorites include the playful sea otters Buck and Emma.

The most diverse range of sealife is found at the aquarium's Caribbean Reef exhibit, which moves visitors through an underwater tunnel to enjoy up-close views of moray eels and other exotic sea creatures. The exhibit also features a popular show that includes a diver hand-feeding the rays and interacting with the crowd.

The largest exhibit at the aquarium is a mockup of the underwater life that surrounds many of the oil rigs in the Gulf of Mexico just off the Louisiana coast. The enormous tank is 17 feet deep and holds 400,000 gallons of saltwater. Its residents include stingrays, sharks, a school of blue runner, a green sea turtle named King Mydas, and other undersea life that thrives off the barnacle-covered pilings of a quarter-scale replica of an offshore oil rig.

Credit: AP Photo/Alex Brandon

A white alligator is on display at the Audubon Aquarium of the Americas at the facility's re-opening after Hurricane Katrina in May 2006. The alligator is not an albino but is leucistic. The refurbishing of the aquarium cost $5 million.

The aquarium's Mississippi River Gallery offers views of the actual waterway that is its neighbor and highlights many of its indigenous inhabitants. A freshwater gallery features catfish, sturgeon, paddlefish, and Spots, a rare white alligator. Despite the common misperception that the aquarium's popular white alligator is an albino, he is actually luecistic—that is, he has a gene mutation that gives him a white color and sea-blue eyes.

But the aquarium doesn't just aim to entertain and educate. It runs several breeding programs to increase the populations of threatened and critically endangered species. The programs are cooperative initiatives among conservation organizations around the world to ensure the continued survival of endangered species such as the region's whooping cranes, which are the most endangered crane in the world. The birds disappeared from the state of Louisiana in the 1930s, and by 1941 their number in the wild had dwindled to 14.

More information on the aquarium is posted at <www.audubooninstitute.org/visit/aquarium>. ■

What Is a 'Seminar'?

APA's annual meeting has a new format this year: seminars. Seminars are four-hour sessions consisting of presentations by one to six experts and a question-and-answer period.

Just like college seminars, they are intended to be personalized learning experiences; they allow for informal exchange with faculty and are tailored to participants' questions. Topics will vary—they may cover a clinical practice issue, a review of a basic psychiatric concept, or a "niche" area.

Seminars evolved from CME course submissions that the Scientific Program Committee thought would appeal to smaller groups of attendees than do typical courses but were important to include in the program.

APA Gives Back

APA members are invited to join APA in its effort to help rebuild New Orleans by donating to its chosen charity, the New Orleans Mission.

The New Orleans Mission is a nonprofit organization that seeks to alleviate the plight of homeless men, women, and children. The mission provides meals, showers, clothing, shelter, literacy classes, and job skills training. More information about the mission is posted at <www.neworleansmission.org>.

Donations may be made online at the Registration Resource Center at <www.xpressreg.net/register/apaa050/xpresstoolkit/login.asp>. ■

7:30 a.m.-5 p.m.
Registration/Course Enrollment Open

7:30 a.m.-10 a.m.
Industry-Supported Symposia

8 a.m.-Noon
CME Courses 11-18

9 a.m.-10:30 a.m.
Workshops

W41. After a Parent's Suicide: Children's Grief and Healing *Chair: Nancy Rappaport, M.D.*

W42. From Narrative and Theory to Evidence-Based Support for Psychiatrists Working Under Extreme Stress *APA Lifers; Chair: Sheila Hafter Gray, M.D.*

W43. Physician Heal Thyself: Scandals, Suicides, and Substance Abuse Among Us *Co-Chairs: Margaret Bishop Baier, M.D., Scott Embley, L.C.S.W.*

W44. Mood Disorders in Women of Reproductive Age *Chair: Natalie Rasgon, M.D.*

W46. Changing Paradigms of Psychiatric Practice in an Era of Health Care Reform *APA Council on Advocacy and Government Relations; Co-Chairs: Javeed Sukhera, M.D., Sarah Vinson, M.D.*

W47. Ambulatory Medical Clinics as Training Sites for Residents and Fellows in Psychosomatic Medicine *Chair: Robert C. Joseph, M.D*

9 a.m.-Noon
Symposia

S31. Understanding Personality Disorders in Children and Adolescents: Current Status and Future Directions *APA and AsPD Joint Symposium*

A. Advancing From Understanding Personality Disorders in Young People Toward Early Detection and Intervention *Andrew Chanen, M.B.B.S.*

B. Why and Under What Circumstances Should We Make the Diagnosis of Personality Disorders in Children and Adolescents? *Joel Paris, M.D.*

C. Measurement and Assessment of PD precursors: Links to Normal Personality and Axis I Problems *Jennifer Tackett, M.D.*

S32. Treatment of Depression in Ethnic Minorities

A. Disparity in Depression Treatment Among Racial and Ethnic Minority Populations in the United States *Margarita Alegria, Ph.D.*

B. Diagnosing Depression in People of African Ancestry: National and International Perspectives *William B. Lawson, M.D.*

C. Ethical and Cultural Considerations in Treating Depression in Patients of Chinese Background *Albert S. Yeung, M.D.*

D. Use of Treatments for Depression Among Blacks, Latinos, and Caucasians *Hector M. González, Ph.D.*

S33. Approaches to Schizophrenia Through Phases of the Illness

A. Early Identification of the Psychosis Prodrome and Clinical Practice *Kristin Cadenhead, M.D.*

B. Management of First-Episode Schizophrenia *John M. Kane, M.D.*

C. Approaches to Schizophrenia *Peter Weiden, M.D.*

D. Evaluation and Intervention for the Persistently Ill Schizophrenic Person *S. Charles Schulz, M.D.*

S34. Diagnosing and Treating the Narcissistic Personality Disorder: Awaiting *DSM-5* *International Society for the Study of Personality Disorders*

A. Observing Narcissistically Vulnerable Traits *Mardi Horowitz, M.D.*

B. Treatment Implications of the Proposed *DSM-5* Representation of Narcissism *Donna S. Bender, Ph.D.*

C. A Self-Regulatory Model and Strategies for Treatment of Narcissistic Personality Disorder *Elsa Ronningstam, Ph.D.*

D. Promoting Awareness of Mental States and Their Triggers and Reducing Feelings of Rejection in Treatment of Narcissistic Pathology *Giuseppe Giancarlo Dimaggio, M.D.*

S35. Sex/Gender Differences and Women-Specific Issues in Drug Abuse: Predicting and Improving Treatment Outcomes *National Institute on Drug Abuse*

A. Gender Differences in Psychiatric Comorbidity With Substance Use Disorder: Implications, Telescoping, and Treatment *Kathleen Brady, M.D.*

B. Significant Role of Sex-Based Biology in Predicting Relapse and Clinical Outcomes in Drug Abuse *Rajita Sinha, Ph.D.*

C. Women-Focused Treatment for Substance Use Disorders: Results From the Women's Recovery Group Study *Shelly F. Greenfield, M.D.*

D. Substance-Abusing Women With PTSD: How Best to Treat? *Denise Hien, Ph.D.*

E. The Use of Motivational Enhancement Therapy and Vouchers to Improve Treatment Utilization and Outcome in Pregnant Substance Users *Theresa Winhusen, Ph.D.*

9 a.m.-4 p.m.
Master Courses

MC03. Psychodynamic Psychotherapy *Chair: Glen O. Gabbard, M.D.*

MC04. Practical Cognitive-Behavior Therapy *Chair: Jesse Wright, M.D., Ph.D.*

CME Courses 19-31

Seminar 5
International Medical Graduates Residents Institute (Institute Registration Required) *Co-Chairs: Nyapati Rao, M.D., Deborah Hales, M.D.*

10 a.m.-4:30 p.m.
Exhibits Open
APA Member Center Open
Publishers' Bookfair Open

11 a.m.-12:30 p.m.
Scientific and Clinical Reports
Session 1. To Be Announced

Workshops

W48. Street to Home: SHAME in Homelessness *Co-Chairs: Prakash Chandra, M.D., Hina Tasleem, M.B.B.S.*

W49. I'm Violent, Admit Me If You Dare: How and Where to Manage Potentially Violent Individuals With Unclear Diagnoses Presenting to Emergency Services *Co-Chairs: Kenneth Certa, M.D., Jessica Mosier, M.D.*

W50. Psychiatric Care in Latin America: Current Challenges and Future Perspectives *Co-Chairs: Pedro Ruiz, M.D., Rodrigo A. Muñoz M.D.*

W51. Update on Parasomnias: A Review for Psychiatric Practice *Co-Chairs: Dimitri Markov, M.D., Marina Goldman, M.D.*

continued on page 15


Credit: Carl Purcell / Courtesy New Orleans Convention and Visitors Bureau

Sessions and Events For Residents and Fellows

APA has planned a full schedule of events for psychiatry residents and fellows so they can meet and socialize with one another, ask questions, share information, and learn more about their chosen profession. For information on the complete resident track for APA's 2010 annual meeting, visit the APA Member Center in the Exhibit Hall at the Morial Convention Center.

MAY 22 — **SATURDAY**

11 a.m.-12:30 p.m. **Preparing IMG (International Medical Graduate) Psychiatry Residents for a Career in Academic Psychiatry**
APA/GlaxoSmithKline Fellows
Room 343/344/345, Morial Convention Center

12:30 p.m.-4:30 p.m. **HIV Psychiatry: What Residents Need to Know**
RSVP by May 17 (see page 19)

1:30 p.m.-3 p.m. **Workshop: Bridging the Cultural Divide: Challenges of First-Generation Immigrants With Children With Mental Illness**
Presentation of the APA Minority Fellows
Room 348, Morial Convention Center

MAY 23 — **SUNDAY**

9 a.m. to 10:30 a.m. **Changing Paradigms of Psychiatric Practice in an Era of Health Care Reform**
Presentation of the APA/BMS Public Psychiatry Fellows
Room 350, Morial Convention Center

10 a.m.-11:30 a.m. **How to Survive the Annual Meeting: Orientation for Students and Residents**
Jasperwood Room, 3rd Floor, Hilton New Orleans Riverside

6 p.m.-7 p.m. **MindGames Competition for Residents**
Room 343/344/345, Morial Convention Center

MAY 24 — **MONDAY**

9 a.m. to 10:30 a.m. **Writing for the 'Blue Journal'—The Residents' and Fellows' Edition of the *American Journal of Psychiatry***
Room 346/347, Morial Convention Center

Noon to 1:30 p.m. **Global Psychiatry: A Session for U.S. and International Residents**
Jasperwood Room, 3rd Floor, Hilton New Orleans Riverside

3:30 p.m.-5 p.m. **Workshop: Disability or Difference? The Cultural and Clinical Needs of Deaf Patients**
Presentation of the APA Minority Fellows
Room 335, Morial Convention Center

MAY 25 — **TUESDAY**

5 p.m.-6:30 p.m. **Poster Session: Minority Fellows' Evening of Excellence**
Grand Salon D, Sections 19/22, Hilton New Orleans Riverside

Stir the Cultural Melting Pot In City's Neighborhoods

Whether swinging, stately, or silent, New Orleans' eclectic neighborhoods are fertile ground for fascinating exploration, offering the visitor new sights at every turn.

BY AARON LEVIN

The French Quarter *is* New Orleans in the minds of most first-time visitors to the city, but New Orleans is much more than the French Quarter.

A short stroll or a streetcar ride leads sightseers to less-explored architectural and cultural havens away from the better known Quarter.

Just east across Esplanade Avenue lies the Faubourg Marigny neighborhood, carved out of a plantation in 1805 and home first to French residents and then successively to Caribbean, German, Irish, Spanish, and Italian immigrants over the next century and a half. A potpourri of architectural styles range from townhouses and Greek Revival homes to simple cottages and shotgun houses.

The humbler architectural examples are found throughout New Orleans. Creole cottages are two rooms wide and two or more deep, with a pitched roof and a front overhang. The shotgun house is one room wide and two to four rooms deep, beneath a continuous gable roof. The name supposedly derives from the open alignment of rooms and doors, so that a shotgun fired at the front of the house would hit nothing till it reached the back wall.

Many of these old buildings fell into disrepair after World War II, but new owners began rehabilitating the neighborhood in the 1970s. Few modern structures intrude into the sense of history, and the Marigny remains one of the nation's most intact 19th-century neighborhoods. The old buildings, framed by banana leaves and palm fronds, make a walk through the district feel like stepping into a film-noir movie or a Somerset Maugham novel.

Credit: Ann Purcell / Courtesy New Orleans Convention and Visitors Bureau

Great cities have great cemeteries. New Orleans pays more attention than most with its ornate monuments.

At night, another New Orleans tradition comes to life in the Marigny. Cutting through the history is Frenchman Street, home to restaurants, bars, and music clubs, like Sweet Lorraine's and the Spotted Cat. Jazz pianist Ellis Marsalis (father of Branford and Wynton) plays weekly at Snug Harbor, an old-fashioned jazz club that serves up authentic local music.

A lucky stroller might also run into one of the less formal jazz bands that station themselves on the sidewalks. (Please contribute when they pass the hat at the end of a set.)

Traveling north along Esplanade Avenue leads to Tremé, possibly the oldest African-American neighborhood in the United States.

"People looking for the real New Orleans will find it in Tremé," said archaeologist Christopher Matthews, Ph.D., now an associate professor of anthropology at Hofstra University and former head of the Greater New Orleans Archaeology Project. Matthews' excavations brought to light thousands of artifacts dating to the 1700s that shed new light on Tremé, illuminating New Orleans' rich racial and ethnic history.

"New Orleans was a backwater during the 18th century," said Matthews in an interview. "Color and ancestry were less important than the sense of community that developed in the city. Here we can see African-American history in a place where it emerged but was not the sole element of identity."

A sobering view of modern New Orleans comes from a visit to the parts of the city inundated after Hurricane Katrina. Breaches in the levee system flooded Lakeview, Gentilly, the Lower Ninth Ward, and other parts of the city.

One tour company bills its three-hour trip as "An eyewitness account of the events surrounding the most devastating natural—and man-made—disaster on American soil!"

Credit: Ann Purcell / Courtesy New Orleans Convention and Visitors Bureau

New Orleans' wealth of Victorian architecture enhances a stroll or streetcar ride along the city's narrow side streets or grand boulevards. Many homes in the Uptown area (above) survived the Katrina flooding because they sit on high ground.

New Orleanians, it should be noted, today emphasize the "man-made" part, blaming the tragedy on poor design and construction of the levee system erected to protect the large areas of the city that lie below sea level.

Driving through the Ninth Ward can be deceptive today. Isolated houses stand amid placid, grassy rectangles. However, what now looks like parkland were once city blocks full of houses before the storm. Reconstruction has been spotty and usually dependent on the resources of the residents.

Traveling to the west of the French Quarter, the St. Charles streetcar leads to Uptown and the Garden District, the latter a National Historic Landmark many of whose homes reflect the kind of faded luxury associated with tropical climates.

The streetcar ride alone is a step into history. The streetcars are part of the oldest continuously operating such system in the world, with cars built in the 1920s.

The Garden District is adjacent to the Mississippi River but is actually at a higher elevation than the worst-hit areas of the city and so was not severely flooded after Katrina.

The Garden District features an array of 19th-century homes set among lush gardens beneath magnolias, palms, and oaks. The grand homes were often built in Greek Revival or Italianate styles by wealthy merchants or plantation owners. Doric, Ionic, and Corinthian columns front the balconied houses, accented by elaborate wrought-iron railings and fences.

Continuing along the St. Charles Street streetcar line leads to Audubon Park and its zoo, one of the city's treasures.

Classical influences also permeate the cities within the city—the cemeteries that are the final destination of those legendary New Orleans jazz funerals. Because of the high water table and frequent flooding, the dead are laid to rest not beneath the earth but in tombs that rise from its surface. That gave architects a chance to show off their talents in thousands of funerary structures. Some are modest, and others are adorned with full-sized statues and at least one sphinx.

The two most prominent cemeteries are the St. Louis Cemetery No. 2, strongly influenced by Paris's Père Lachaise Cemetery, and the Metairie Cemetery, covering 150 acres.

Visitors often decide to wander through these silent cities. Perhaps they serve as a reminder of mortality and human folly in a city situated as precariously as New Orleans. ■

Session Will Help Women Smash the Glass Ceiling

Women psychiatrists are not yet playing on an even field yet. But they can change that.

BY EVA SZIGETHY, M.D., PH.D.

Women psychiatrists who would like to hone their negotiation and self-advocacy skills are invited to attend a breakfast workshop sponsored by the Association of Women Psychiatrists (AWP) at APA's 2010 annual meeting in New Orleans.

The AWP is an allied organization of APA with a mission to help women network to advance in their careers while still balancing life priorities.

The workshop will be held Wednesday, May 26, from 7 a.m. to 8:30 a.m. at the Plismoll Club at 2 Canal Street in New Orleans.

Over the past decade, there has been an increasing number of women applying and getting accepted to medical school and an increasing number of women selecting psychiatry as a career. Even with these increased numbers, women psychiatrists continue to struggle compared with their male counterparts in advancing in their careers in terms of promotion and securing leadership positions.

The workshop, which I will chair, will include presentations from three women leaders in psychiatry: Leah Dickstein, M.D., emerita professor at the University of Louisville; Carol Nadelson, M.D., a professor of psychiatry and director of the Office for Women's Careers at Brigham and Women's Hospital and Harvard Medical School; and Joanne Ritvo, M.D., a private practitioner in Denver. Each speaker will impart pearls of wisdom about how they navigated challenges to succeed in both academic and private practice settings.

The second half of the program will consist of an interactive mentoring experience with members of the AWP executive committee and current and past leaders of APA, including Carol Bernstein, M.D., Carolyn Robinowitz, M.D., Altha Stewart, M.D., Marcia Goin, M.D., Gail Robinson, M.D., and Nada Stotland, M.D.

Areas of interest for the small-group interactions include negotiating contracts, becoming a departmental and national leader, succeeding in research, balancing life and work, weighing part-time work's risks and benefits, and negotiating gender and cultural barriers.

The event, including breakfast, will be complimentary to all AWP members and $5 for nonmembers. Women psychiatrists who are not AWP members are welcome to attend and join the AWP at the event or prior to the event by visiting the AWP's Web site at <www.associationofwomenpsychiatrists.com/membership.php>.

Residents and early career psychiatrists are especially encouraged to attend as the AWP will also be launching a small-group mentorship initiative so that attendees can continue to communicate with the leaders they meet. ■

Eva Szigethy, M.D., Ph.D., is an associate professor of psychiatry at the University of Pittsburgh and president of the Association of Women Psychiatrists.

W52. Cultural Diversities: The Impact on Mental Health Treatment and Evaluation in Jails and Prisons *APA Council on Psychiatry and Law; Chair: Henry Weinstein, M.D.*

W53. Scope of Practice Challenges: Experiences, Successes, and Tribulations From Across the Country *Co-Chairs: Jerry Halverson, M.D., Claudia Reardon, M.D.*

Noon-2:30 p.m.
Industry-Supported Symposia

12:30 p.m.-1:30 p.m.
Business Meeting and Forum
(Open to APA voting members only.)

1 p.m.-5 p.m.
CME Courses 32-40

Seminar 6
Overview of Recovery for Psychiatrists
Chair: Mark Ragins, M.D.

1:30 p.m.-3 p.m.
Scientific and Clinical Reports
Session 2. To Be Announced
Session 3. To Be Announced

Workshops

W54. Making the Most of Your Chief Year: Chief Residents' Forum, Part 1 *Co-Chairs: Rex Huang M.D., Jonathan Horey, M.D.*

W55. Promoting International Medical Graduates' Psychosocial Support During Residency Training *Co-Chairs: Anu Matorin, M.D., Pedro Ruiz, M.D.*

W56. Maintenance Treatment for Opiate Dependence: Terminable or Interminable? *National Institute on Drug Abuse; Co-Chairs: Ivan Montoya, M.D., Herbert Kleber, M.D.*

2 p.m.-3:30 p.m.
Lecture

L3. Manfred L. Guttmacher Award Lecture *Robert I. Simon, M.D., Kenneth Tardiff, M.D.*

2 p.m.-4 p.m.
Symposia

S39. The Medical Home: Is There a Place for Psychiatry in It ? *APA Council on Children, Adolescents, and Their Families*

A. A Primary Care Perspective *Frank Degruy, M.D.*

B. The Pediatric Medical Home: Where Does the Child and Adolescent Psychiatrist Fit In? *Michael Houston, M.D.*

C. Psychiatry and Primary Care Integration: Challenges and Opportunities *Eliot Sorel, M.D.*

S40. Privacy in Electronic Medical Records

A. Privacy Violations and Consequences *Zebulon Taintor, M.D.*

B. Privacy and Control in Health Information Exchanges: More than an Illusion? *Glenn A. Martin, M.D.*

C. The Perspective of Family Members on Privacy in Electronic Medical Records *Edward F. Foulks, M.D.*

D. Health IT and Privacy: Critical Pathways to Improving Mental Health Care *Deven C. McGraw, J.D.*

E. General Medical Views of Electronic Medical Record Privacy *Laura Fochtmann, M.D.*

S41. Health and Mental Health Around the World? Are All Systems Go?

A. The Canadian Health Care System: Pros and Cons *Gail Robinson, M.D.*

B. The Swiss Health System: Private Insurance and Solidarity Are Possible *Olivier Halfon, M.D.*

continued on page 18

Credit: Linda Reineke / Courtesy New Orleans Convention and Visitors Bureau

PAROXETINE HYDROCHLORIDE EXTENDED-RELEASE TABLETS 12.5 mg and 25 mg

℞ only

BRIEF SUMMARY: Please see package insert for full prescribing information.

Suicidality and Antidepressant Drugs

Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents and young adults in short-term studies of major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of paroxetine or any other antidepressant in a child, adolescent, or young adult must balance this risk with the clinical need. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction in risk with antidepressants compared to placebo in adults aged 65 and older. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. Paroxetine is not approved for use in pediatric patients. (See WARNINGS: Clinical Worsening and Suicide Risk, PRECAUTIONS: Information for Patients and PRECAUTIONS: Pediatric Use.)

INDICATIONS AND USAGE: Major Depressive Disorder: Paroxetine hydrochloride extended-release tablets are indicated for the treatment of major depressive disorder.

The efficacy of paroxetine hydrochloride extended-release tablets in the treatment of a major depressive episode was established in two 12 week controlled trials of outpatients whose diagnoses corresponded to the DSM-IV category of major depressive disorder (see CLINICAL PHARMACOLOGY: Clinical Trials in full prescribing information).

A major depressive episode (DSM-IV) implies a prominent and relatively persistent (nearly every day for at least 2 weeks) depressed mood or loss of interest or pleasure in nearly all activities, representing a change from previous functioning, and includes the presence of at least 5 of the following 9 symptoms during the same 2 week period: Depressed mood, markedly diminished interest or pleasure in usual activities, significant change in weight and/or appetite, insomnia or hypersomnia, psychomotor agitation or retardation, increased fatigue, feelings of guilt or worthlessness, slowed thinking or impaired concentration, a suicide attempt, or suicidal ideation.

The antidepressant action of paroxetine in hospitalized depressed patients has not been adequately studied.

Paroxetine hydrochloride extended-release tablets have not been systematically evaluated beyond 12 weeks in controlled clinical trials; however, the effectiveness of immediate-release paroxetine hydrochloride in maintaining a response in major depressive disorder for up to one year has been demonstrated in a placebo-controlled trial (see CLINICAL PHARMACOLOGY: Clinical Trials in full prescribing information). The physician who elects to use paroxetine hydrochloride extended-release tablets for extended periods should periodically reevaluate the long-term usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Concomitant use in patients taking either monoamine oxidase inhibitors (MAOIs), including linezolid, an antibiotic which is a reversible non-selective MAOI, or thioridazine is contraindicated (see WARNINGS and PRECAUTIONS).

Concomitant use in patients taking pimozide is contraindicated (see PRECAUTIONS).

Paroxetine hydrochloride extended-release tablets are contraindicated in patients with a hypersensitivity to paroxetine or to any of the inactive ingredients in paroxetine hydrochloride extended-release tablets.

WARNINGS: Clinical Worsening and Suicide Risk: Patients with major depressive disorder (MDD), both adult and pediatric, may experience worsening of their depression and/or the emergence of suicidal ideation and behavior (suicidality) or unusual changes in behavior, whether or not they are taking antidepressant medications, and this risk may persist until significant remission occurs. Suicide is a known risk of depression and certain other psychiatric disorders, and these disorders themselves are the strongest predictors of suicide. There has been a long-standing concern, however, that antidepressants may have a role in inducing worsening of depression and the emergence of suicidality in certain patients during the early phases of treatment. Pooled analyses of short-term placebo-controlled trials of antidepressant drugs (SSRIs and others) showed that these drugs increase the risk of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults (ages 18 to 24) with major depressive disorder (MDD) and other psychiatric disorders. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction with antidepressants compared to placebo in adults aged 65 and older.

The pooled analyses of placebo-controlled trials in children and adolescents with MDD, obsessive compulsive disorder (OCD), or other psychiatric disorders included a total of 24 short-term trials of 9 antidepressant drugs in over 4,400 patients. The pooled analyses of placebo-controlled trials in adults with MDD or other psychiatric disorders included a total of 295 short-term trials (median duration of 2 months) of 11 antidepressant drugs in over 77,000 patients. There was considerable variation in risk of suicidality among drugs, but a tendency toward an increase in the younger patients for almost all drugs studied. There were differences in absolute risk of suicidality across the different indications, with the highest incidence in MDD. The risk differences (drug vs. placebo), however, were relatively stable within age strata and across indications. These risk differences (drug-placebo difference in the number of cases of suicidality per 1,000 patients treated) are provided in Table 1.

Table 1

Age Range	Drug-Placebo Difference in Number of Cases of Suicidality Per 1,000 Patients Treated
Increases Compared to Placebo	
< 18	14 additional cases
18 to 24	5 additional cases
Decreases Compared to Placebo	
25 to 64	1 fewer case
≥ 65	6 fewer cases

No suicides occurred in any of the pediatric trials. There were suicides in the adult trials, but the number was not sufficient to reach any conclusion about drug effect on suicide.

It is unknown whether the suicidality risk extends to longer-term use, i.e., beyond several months. However, there is substantial evidence from placebo-controlled maintenance trials in adults with depression that the use of antidepressants can delay the recurrence of depression.

All patients being treated with antidepressants for any indication should be monitored appropriately and observed closely for clinical worsening, suicidality and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases.

The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adult and pediatric patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and nonpsychiatric. Although a causal link between the emergence of such symptoms and either the worsening of depression and/or the emergence of suicidal impulses has not been established, there is concern that such symptoms may represent precursors to emerging suicidality.

Consideration should be given to changing the therapeutic regimen, including possibly discontinuing the medication, in patients whose depression is persistently worse, or who are experiencing emergent suicidality or symptoms that might be precursors to worsening depression or suicidality, especially if these symptoms are severe, abrupt in onset, or were not part of the patient's presenting symptoms.

If the decision has been made to discontinue treatment, medication should be tapered, as rapidly as is feasible, but with recognition that abrupt discontinuation can be associated with certain symptoms (see PRECAUTIONS and DOSAGE AND ADMINISTRATION: Discontinuation of Treatment with Paroxetine Hydrochloride Extended-Release Tablets, for a description of the risks of discontinuation of paroxetine).

Families and caregivers of patients being treated with antidepressants for major depressive disorder or other indications, both psychiatric and nonpsychiatric, should be alerted about the need to monitor patients for the emergence of agitation, irritability, unusual changes in behavior, and the other symptoms described above, as well as the emergence of suicidality, and to report such symptoms immediately to healthcare providers. Such monitoring should include daily observation by families and caregivers. Prescriptions for paroxetine should be written for the smallest quantity of tablets consistent with good patient management, in order to reduce the risk of overdose.

Screening Patients for Bipolar Disorder: A major depressive episode may be the initial presentation of bipolar disorder. It is generally believed (though not established in controlled trials) that treating such an episode with an antidepressant alone may increase the likelihood of precipitation of a mixed/manic episode in patients at risk for bipolar disorder. Whether any of the symptoms described above represent such a conversion is unknown. However, prior to initiating treatment with an antidepressant, patients with depressive symptoms should be adequately screened to determine if they are at risk for bipolar disorder; such screening should include a detailed psychiatric history, including a family history of suicide, bipolar disorder, and depression. It should be noted that paroxetine is not approved for use in treating bipolar depression.

Potential for Interaction With Monoamine Oxidase Inhibitors: In patients receiving another serotonin reuptake inhibitor drug in combination with an MAOI, there have been reports of serious, sometimes fatal, reactions including hyperthermia, rigidity, myoclonus, autonomic instability with possible rapid fluctuations of vital signs, and mental status changes that include extreme agitation progressing to delirium and coma. These reactions have also been reported in patients who have recently discontinued that drug and have been started on an MAOI. Some cases presented with features resembling neuroleptic malignant syndrome. While there are no human data showing such an interaction with paroxetine hydrochloride, limited animal data on the effects of combined use of paroxetine and MAOIs suggest that these drugs may act synergistically to elevate blood pressure and evoke behavioral excitation. Therefore, it is recommended that paroxetine hydrochloride extended-release tablets not be used in combination with an MAOI (including linezolid, an antibiotic which is a reversible non-selective MAOI), or within 14 days of discontinuing treatment with an MAOI (see CONTRAINDICATIONS). At least 2 weeks should be allowed after stopping paroxetine hydrochloride extended-release tablets before starting an MAOI.

Serotonin Syndrome or Neuroleptic Malignant Syndrome (NMS)-Like Reactions: The development of a potentially life threatening serotonin syndrome or Neuroleptic Malignant Syndrome (NMS)-like reactions have been reported with SNRIs and SSRIs alone, including paroxetine hydrochloride extended-release tablets treatment, but particularly with concomitant use of serotonergic drugs (including triptans) with drugs which impair metabolism of serotonin (including MAOIs), or with antipsychotics or other dopamine antagonists. Serotonin syndrome symptoms may include mental status changes (e.g., agitation, hallucinations, coma), autonomic instability (e.g., tachycardia, labile blood pressure, hyperthermia), neuromuscular aberrations (e.g., hyperreflexia, incoordination) and/or gastrointestinal symptoms (e.g., nausea, vomiting, diarrhea). Serotonin syndrome, in its most severe form can resemble neuroleptic malignant syndrome, which includes hyperthermia, muscle rigidity, autonomic instability with possible rapid fluctuation of vital signs, and mental status changes. Patients should be monitored for the emergence of serotonin syndrome or NMS-like signs and symptoms.

The concomitant use of paroxetine hydrochloride extended-release tablets with MAOIs intended to treat depression is contraindicated.

If concomitant treatment of paroxetine hydrochloride extended-release tablets with a 5-hydroxytryptamine receptor agonist (triptan) is clinically warranted, careful observation of the patient is advised, particularly during treatment initiation and dose increases.

The concomitant use of paroxetine hydrochloride extended-release tablets with serotonin precursors (such as tryptophan) is not recommended.

Treatment with paroxetine hydrochloride extended-release tablets and any concomitant serotonergic or antidopaminergic agents, including antipsychotics, should be discontinued immediately if the above events occur and supportive symptomatic treatment should be initiated.

Potential Interaction with Thioridazine: Thioridazine administration alone produces prolongation of the QTc interval, which is associated with serious ventricular arrhythmias, such as Torsade de pointes-type arrhythmias, and sudden death. This effect appears to be dose related.

An *in vivo* study suggests that drugs which inhibit CYP2D6, such as paroxetine, will elevate plasma levels of thioridazine. Therefore, it is recommended that paroxetine not be used in combination with thioridazine (see CONTRAINDICATIONS and PRECAUTIONS).

Usage in Pregnancy: ***Teratogenic Effects:*** Epidemiological studies have shown that infants born to women who had first trimester paroxetine exposure had an increased risk of cardiovascular malformations, primarily ventricular and atrial septal defects (VSDs and ASDs). In general, septal defects range from those that are symptomatic and may require surgery to those that are asymptomatic and may resolve spontaneously. If a patient becomes pregnant while taking paroxetine, she should be advised of the potential harm to the fetus. Unless the benefits of paroxetine to the mother justify continuing treatment, consideration should be given to either discontinuing paroxetine therapy or switching to another antidepressant (see PRECAUTIONS: General: *Discontinuation of Treatment with Paroxetine Hydrochloride Extended-Release Tablets*). For women who intend to become pregnant or are in their first trimester of pregnancy, paroxetine should only be initiated after consideration of the other available treatment options.

A study based on Swedish national registry data evaluated infants of 6,896 women exposed to antidepressants in early pregnancy (5,123 women exposed to SSRIs; including 815 for paroxetine). Infants exposed to paroxetine in early pregnancy had an increased risk of cardiovascular malformations (primarily VSDs and ASDs) compared to the entire registry population (OR 1.8; 95% confidence interval 1.1 to 2.8). The rate of cardiovascular malformations following early pregnancy paroxetine exposure was 2% vs. 1% in the entire registry population. Among the same paroxetine exposed infants, an examination of the data showed no increase in the overall risk for congenital malformations.

A separate retrospective cohort study using U.S. United Healthcare data evaluated 5,956 infants of mothers dispensed paroxetine or other antidepressants during the first trimester (n = 815 for paroxetine). This study showed a trend towards an increased risk for cardiovascular malformations for paroxetine compared to other antidepressants (OR 1.5; 95% confidence interval 0.8 to 2.9). The prevalence of cardiovascular malformations following first trimester dispensing was 1.5% for paroxetine vs. 1% for other antidepressants. Nine out of 12 infants with cardiovascular malformations whose mothers were dispensed paroxetine in the first trimester had VSDs. This study also suggested an increased risk of overall major congenital malformations (inclusive of the cardiovascular defects) for paroxetine compared to other antidepressants (OR 1.8; 95% confidence interval 1.2 to 2.8). The prevalence of all congenital malformations following first trimester exposure was 4% for paroxetine vs. 2% for other antidepressants.

Animal Findings: Reproduction studies were performed at doses up to 50 mg/kg/day in rats and 6 mg/kg/day in rabbits administered during organogenesis. These doses are approximately 8 (rat) and 2 (rabbit) times the maximum recommended human dose (MRHD) on a mg/m^2 basis. These studies have revealed no evidence of teratogenic effects. However, in rats, there was an increase in pup deaths during the first 4 days of lactation when dosing occurred during the last trimester of gestation and continued throughout lactation. This effect occurred at a dose of 1 mg/kg/day or approximately one-sixth of the MRHD on a mg/m^2 basis. The no effect dose for rat pup mortality was not determined. The cause of these deaths is not known.

Nonteratogenic Effects: Neonates exposed to paroxetine hydrochloride extended-release tablets and other SSRIs or serotonin and norepinephrine reuptake inhibitors (SNRIs), late in the third trimester have developed complications requiring prolonged hospitalization, respiratory support, and tube feeding. Such complications can arise immediately upon delivery. Reported clinical findings have included respiratory distress, cyanosis, apnea, seizures, temperature instability, feeding difficulty, vomiting, hypoglycemia, hypotonia, hypertonia, hyperreflexia, tremor, jitteriness, irritability, and constant crying. These features are consistent with either a direct toxic effect of SSRIs and SNRIs or, possibly, a drug discontinuation syndrome. It should be noted that, in some cases, the clinical picture is consistent with serotonin syndrome (see WARNINGS: Potential for Interaction with Monoamine Oxidase Inhibitors).

Infants exposed to SSRIs in late pregnancy may have an increased risk for persistent pulmonary hypertension of the newborn (PPHN). PPHN occurs in 1 to 2 per 1,000 live births in the general population and is associated with substantial neonatal morbidity and mortality. In a retrospective case control study of 377 women whose infants were born with PPHN and 836 women whose infants were born healthy, the risk for developing PPHN was approximately 6-fold higher for infants exposed to SSRIs after the 20th week of gestation compared to infants who had not been exposed to antidepressants during pregnancy. There is currently no collaborative evidence regarding the risk for PPHN following exposure to SSRIs in pregnancy; this is the first study that has investigated the potential risk. The study did not include enough cases with exposure to individual SSRIs to determine if all SSRIs posed similar levels of PPHN risk.

There have also been post-marketing reports of premature births in pregnant women exposed to paroxetine or other SSRIs.

When treating a pregnant woman with paroxetine during the third trimester, the physician should carefully consider both the potential risks and benefits of treatment (see DOSAGE AND ADMINISTRATION). Physicians should note that in a prospective longitudinal study of 201 women with a history of major depression who were euthymic at the beginning of pregnancy, women who discontinued antidepressant medication during pregnancy were more likely to experience a relapse of major depression than women who continued antidepressant medication.

PRECAUTIONS: General: ***Activation of Mania/Hypomania:*** During premarketing testing of immediate-release paroxetine hydrochloride, hypomania or mania occurred in approximately 1% of paroxetine-treated unipolar patients compared to 1.1% of active control and 0.3% of placebo-treated unipolar patients. In a subset of patients classified as bipolar, the rate of manic episodes was 2.2% for immediate-release paroxetine and 11.6% for the combined active control groups. Among 1,627 patients with major depressive disorder, panic disorder, social anxiety disorder, or PMDD treated with paroxetine hydrochloride extended-release tablets in controlled clinical studies, there were no reports of mania or hypomania. As with all drugs effective in the treatment of major depressive disorder, paroxetine hydrochloride extended-release tablets should be used cautiously in patients with a history of mania.

Seizures: During premarketing testing of immediate-release paroxetine hydrochloride, seizures occurred in 0.1% of paroxetine treated patients, a rate similar to that associated with other drugs effective in the treatment of major depressive disorder. Among 1,627 patients who received paroxetine hydrochloride extended-release tablets in controlled clinical trials in major depressive disorder, panic disorder, social anxiety disorder, or PMDD, one patient (0.1%) experienced a seizure. Paroxetine hydrochloride extended-release tablets should be used cautiously in patients with a history of seizures. It should be discontinued in any patient who develops seizures.

Discontinuation of Treatment with Paroxetine Hydrochloride Extended-Release Tablets: Adverse events while discontinuing therapy with paroxetine hydrochloride extended-release tablets were not systematically evaluated in most clinical trials; however, in recent placebo-controlled clinical trials utilizing daily doses of paroxetine hydrochloride extended-release tablets up to 37.5 mg/day, spontaneously reported adverse events while discontinuing therapy with paroxetine hydrochloride extended-release tablets were evaluated. Patients receiving 37.5 mg/day underwent an incremental decrease in the daily dose by 12.5 mg/day to a dose of 25 mg/day for one week before treatment was stopped. For patients receiving 25 mg/day or 12.5 mg/day, treatment was stopped without an incremental decrease in dose. With this regimen in those studies, the following adverse events were reported for paroxetine hydrochloride extended-release tablets, at an incidence of 2% or greater for paroxetine hydrochloride extended-release tablets and were at least twice that reported for placebo: Dizziness, nausea, nervousness, and additional symptoms described by the investigator as associated with tapering or discontinuing paroxetine hydrochloride extended-release tablets (e.g., emotional lability, headache, agitation, electric shock sensations, fatigue, and sleep disturbances). These events were reported as serious in 0.3% of patients who discontinued therapy with paroxetine hydrochloride extended-release tablets.

During marketing of paroxetine hydrochloride extended-release tablets and other SSRIs and SNRIs, there have been spontaneous reports of adverse events occurring upon discontinuation of these drugs, (particularly when abrupt), including the following: Dysphoric mood, irritability, agitation, dizziness, sensory disturbances (e.g., paresthesias such as electric shock sensations and tinnitus), anxiety, confusion, headache, lethargy, emotional lability, insomnia, and hypomania. While these events are generally self limiting, there have been reports of serious discontinuation symptoms.

Patients should be monitored for these symptoms when discontinuing treatment with paroxetine hydrochloride extended release tablets. A gradual reduction in the dose rather than abrupt cessation is recommended whenever possible. If intolerable symptoms occur following a decrease in the dose or upon discontinuation of treatment, then resuming the previously prescribed dose may be considered. Subsequently, the physician may continue decreasing the dose but at a more gradual rate (see DOSAGE AND ADMINISTRATION).

See also PRECAUTIONS: Pediatric Use, for adverse events reported upon discontinuation of treatment with paroxetine in pediatric patients.

Akathisia: The use of paroxetine or other SSRIs has been associated with the development of akathisia, which is characterized by an inner sense of restlessness and psychomotor agitation such as an inability to sit or stand still usually associated with subjective distress. This is most likely to occur within the first few weeks of treatment.

Hyponatremia: Hyponatremia may occur as a result of treatment with SSRIs and SNRIs, including paroxetine hydrochloride extended-release tablets. In many cases, this hyponatremia appears to be the result of the syndrome of inappropriate antidiuretic hormone secretion (SIADH). Cases with serum sodium lower than 110 mmol/L have been reported. Elderly patients may be at greater risk of developing hyponatremia with SSRIs and SNRIs. Also, patients taking diuretics or who are otherwise volume depleted may be at greater risk (see Geriatric Use). Discontinuation of paroxetine hydrochloride extended-release tablets should be considered in patients with symptomatic hyponatremia and appropriate medical intervention should be instituted.

Signs and symptoms of hyponatremia include headache, difficulty concentrating, memory impairment, confusion, weakness, and unsteadiness, which may lead to falls. Signs and symptoms associated with more severe and/or acute cases have included hallucination, syncope, seizure, coma, respiratory arrest, and death.

Abnormal Bleeding: SSRIs and SNRIs, including paroxetine, may increase the risk of bleeding events. Concomitant use of aspirin, nonsteroidal anti-inflammatory drugs, warfarin, and other anticoagulants may add to this risk. Case reports and epidemiological studies (case-control and cohort design) have demonstrated an association between use of drugs that interfere with serotonin reuptake and the occurrence of gastrointestinal bleeding. Bleeding events related to SSRIs and SNRIs use have ranged from ecchymoses, hematomas, epistaxis, and petechiae to life-threatening hemorrhages. Patients should be cautioned about the risk of bleeding associated with the concomitant use of paroxetine and NSAIDs, aspirin, or other drugs that affect coagulation.

Use in Patients with Concomitant Illness: Clinical experience with immediate-release paroxetine hydrochloride in patients with certain concomitant systemic illness is limited. Caution is advisable in using paroxetine hydrochloride extended-release tablets in patients with diseases or conditions that could affect metabolism or hemodynamic responses.

As with other SSRIs, mydriasis has been infrequently reported in premarketing studies with paroxetine hydrochloride. A few cases of acute angle closure glaucoma associated with therapy with immediate-release paroxetine have been reported in the literature. As mydriasis can cause acute angle closure in patients with narrow angle glaucoma, caution should be used when paroxetine hydrochloride extended-release tablets are prescribed for patients with narrow angle glaucoma.

Paroxetine hydrochloride extended-release tablet or the immediate-release formulation has not been evaluated or used to any appreciable extent in patients with a recent history of myocardial infarction or unstable heart disease. Patients with these diagnoses were excluded from clinical studies during premarket testing. Evaluation of electrocardiograms of 682 patients who received immediate-release paroxetine hydrochloride in double-blind, placebo-controlled trials, however, did not indicate that paroxetine is associated with the development of significant ECG abnormalities. Similarly, paroxetine hydrochloride does not cause any clinically important changes in heart rate or blood pressure.

Increased plasma concentrations of paroxetine occur in patients with severe renal impairment (creatinine clearance < 30 mL/min.) or severe hepatic impairment. A lower starting dose should be used in such patients (see DOSAGE AND ADMINISTRATION).

Drug Interactions: ***Tryptophan:*** As with other serotonin reuptake inhibitors, an interaction between paroxetine and tryptophan may occur when they are coadministered. Adverse experiences, consisting primarily of headache, nausea, sweating, and dizziness, have been reported when tryptophan was administered to patients taking immediate-release paroxetine. Consequently, concomitant use of paroxetine hydrochloride extended-release tablets with tryptophan is not recommended (see WARNINGS: Potential for Interaction with Monoamine Oxidase Inhibitors: *Serotonin Syndrome*).

Monoamine Oxidase Inhibitors: See CONTRAINDICATIONS and WARNINGS.

Pimozide: In a controlled study of healthy volunteers, after immediate-release paroxetine hydrochloride was titrated to 60 mg daily, coadministration of a single-dose of 2 mg pimozide was associated with mean increases in pimozide AUC of 151% and C_{max} of 62%, compared to pimozide administered alone. The increase in pimozide AUC and C_{max} is due to the CYP2D6 inhibitory properties of paroxetine. Due to the narrow therapeutic index of pimozide and its known ability to prolong the QT interval, concomitant use of pimozide and paroxetine hydrochloride extended-release tablets are contraindicated (see CONTRAINDICATIONS).

Serotonergic Drugs: Based on the mechanism of action of SNRIs and SSRIs, including paroxetine hydrochloride and the potential for serotonin syndrome, caution is advised when paroxetine hydrochloride extended-release tablets are coadministered with other drugs that may affect the serotonergic neurotransmitter systems, such as triptans, linezolid (an antibiotic which is a reversible nonselective MAOI), lithium, tramadol, or St. John's Wort (see WARNINGS: Potential for Interaction with Monoamine Oxidase Inhibitors: *Serotonin Syndrome*). The concomitant use of paroxetine extended-release tablets with MAOIs (including linezolid) is contraindicated (see CONTRAINDICATIONS). The concomitant use of paroxetine extended-release tablets with other SSRI's, SNRIs or tryptophan is not recommended (see PRECAUTIONS: Drug Interactions: *Trytophan*).

Thioridazine: See CONTRAINDICATIONS and WARNINGS.

Warfarin: Preliminary data suggest that there may be a pharmacodynamic interaction (that causes an increased bleeding diathesis in the face of unaltered prothrombin time) between paroxetine and warfarin. Since there is little clinical experience, the concomitant administration of paroxetine hydrochloride extended-release tablets and warfarin should be undertaken with caution (see PRECAUTIONS: Information for Patients: *Drugs That Interfere with Hemostasis*).

Triptans: There have been rare post-marketing reports of serotonin syndrome with the use of an SSRI and a triptan. If concomitant use of paroxetine hydrochloride extended-release tablets with a triptan is clinically warranted, careful observation of the patient is advised, particularly during treatment initiation and dose increases (see WARNINGS: Potential for Interaction with Monoamine Oxidase Inhibitors: *Serotonin Syndrome*).

Drugs Affecting Hepatic Metabolism: The metabolism and pharmacokinetics of paroxetine may be affected by the induction or inhibition of drug metabolizing enzymes.

Cimetidine: Cimetidine inhibits many cytochrome P450 (oxidative) enzymes. In a study where immediate-release paroxetine (30 mg once daily) was dosed orally for 4 weeks, steady-state plasma concentrations of paroxetine were increased by approximately 50% during coadministration with oral cimetidine (300 mg three times daily) for the final week. Therefore, when these drugs are administered concurrently, dosage adjustment of paroxetine hydrochloride extended-release tablets after the starting dose should be guided by clinical effect. The effect of paroxetine on cimetidine's pharmacokinetics was not studied.

Phenobarbital: Phenobarbital induces many cytochrome P_{450} (oxidative) enzymes. When a single oral 30 mg dose of immediate-release paroxetine was administered at phenobarbital steady-state (100 mg once daily for 14 days), paroxetine AUC and $T_{1/2}$ were reduced (by an average of 25% and 38%, respectively) compared to paroxetine administered alone. The effect of paroxetine on phenobarbital pharmacokinetics was not studied. Since paroxetine exhibits nonlinear pharmacokinetics, the results of this study may not address the case where the 2 drugs are both being chronically dosed. No initial dosage adjustment with paroxetine hydrochloride extended-release tablets are considered necessary when coadministered with phenobarbital; any subsequent adjustment should be guided by clinical effect.

Phenytoin: When a single oral 30 mg dose of immediate-release paroxetine was administered at phenytoin steady-state (300 mg once daily for 14 days), paroxetine AUC and $T_{1/2}$ were reduced (by an average of 50% and 35%, respectively) compared to immediate-release paroxetine administered alone. In a separate study, when a single oral 300 mg dose of phenytoin was administered at paroxetine steady-state (30 mg once daily for 14 days), phenytoin AUC was slightly reduced (12% on average) compared to phenytoin administered alone. Since both drugs exhibit nonlinear pharmacokinetics, the above studies may not address the case where the 2 drugs are both being chronically dosed. No initial dosage adjustments are considered necessary when paroxetine hydrochloride extended-release tablets are coadministered with phenytoin; any subsequent adjustments should be guided by clinical effect (see ADVERSE REACTIONS: Post-marketing Reports).

Drugs Metabolized by CYP2D6: Many drugs, including most drugs effective in the treatment of major depressive disorder (paroxetine, other SSRIs, and many tricyclics), are metabolized by the cytochrome P_{450} isozyme CYP2D6. Like other agents that are metabolized by CYP2D6, paroxetine may significantly inhibit the activity of this isozyme. In most patients (> 90%), this CYP2D6 isozyme is saturated early during paroxetine dosing. In one study, daily dosing of immediate-release paroxetine (20 mg once daily) under steady-state conditions increased single-dose desipramine (100 mg) C_{max}, AUC, and $T_{1/2}$ by an average of approximately 2-, 5-, and 3-fold, respectively. Concomitant use of paroxetine with risperidone, a CYP2D6 substrate has also been evaluated. In one study, daily dosing of paroxetine 20 mg in patients stabilized on risperidone (4 to 8 mg/day) increased mean plasma concentrations of risperidone approximately 4-fold, decreased 9-hydroxy-risperidone concentrations approximately 10%, and increased concentrations of the active moiety (the sum of risperidone plus 9-hydroxyrisperidone) approximately 1.4-fold. The effect of paroxetine on the pharmacokinetics of atomoxetine has been evaluated when both drugs were at steady-state. In healthy volunteers who were extensive metabolizers of CYP2D6, paroxetine 20 mg daily was given in combination with 20 mg atomoxetine every 12 hours. This resulted in increases in steady-state atomoxetine AUC values that were 6- to 8-fold greater and in atomoxetine C_{max} values that were 3- to 4-fold greater than when atomoxetine was given alone. Dosage adjustment of atomoxetine may be necessary and it is recommended that atomoxetine be initiated at a reduced dose when given with paroxetine.

Concomitant use of paroxetine hydrochloride extended-release tablets with other drugs metabolized by cytochrome CYP2D6 has not been formally studied but may re quire lower doses than usually prescribed for either paroxetine hydrochloride extended-release tablets or the other drug.

Therefore, coadministration of paroxetine hydrochloride extended-release tablets with other drugs that are metabolized by this isozyme, including certain drugs effective in the treatment of major depressive disorder (e.g., nortriptyline, amitriptyline, imipramine, desipramine, and fluoxetine), phenothiazines, risperidone, tamoxifen, and Type 1C antiarrhythmics (e.g., propafenone, flecainide, and encainide), or that inhibit this enzyme (e.g., quinidine), should be approached with caution.

However, due to the risk of serious ventricular arrhythmias and sudden death potentially associated with elevated plasma levels of thioridazine, paroxetine and thioridazine should not be coadministered (see CONTRAINDICATIONS and WARNINGS).

Tamoxifen is a pro-drug requiring metabolic activation by CYP2D6. Inhibition of CYP2D6 by paroxetine may lead to reduced plasma concentrations of an active metabolite and hence reduced efficacy of tamoxifen.

At steady-state, when the CYP2D6 pathway is essentially saturated, paroxetine clearance is governed by

alternative P_{450} isozymes that, unlike CYP2D6, show no evidence of saturation (see PRECAUTIONS: Drug Interactions: *Tricyclic Antidepressants*).

Drugs Metabolized by Cytochrome CYP3A4: An *in vivo* interaction study involving the coadministration under steady-state conditions of paroxetine and terfenadine, a substrate for CYP3A4, revealed no effect of paroxetine on terfenadine pharmacokinetics. In addition, *in vitro* studies have shown ketoconazole, a potent inhibitor of CYP3A4 activity, to be at least 100 times more potent than paroxetine as an inhibitor of the metabolism of several substrates for this enzyme, including terfenadine, astemizole, cisapride, triazolam, and cyclosporine. Based on the assumption that the relationship between paroxetine's *in vitro* K_i and its lack of effect on terfenadine's *in vivo* clearance predicts its effect on other CYP3A4 substrates, paroxetine's extent of inhibition of CYP3A4 activity is not likely to be of clinical significance.

Tricyclic Antidepressants (TCAs): Caution is indicated in the coadministration of TCAs with paroxetine hydrochloride extended-release tablets, because paroxetine may inhibit TCA metabolism. Plasma TCA concentrations may need to be monitored, and the dose of TCA may need to be reduced, if a TCA is coadministered with paroxetine hydrochloride extended-release tablets (see PRECAUTIONS: Drug Interactions: *Drugs Metabolized by Cytochrome CYP2D6*).

Drugs Highly Bound to Plasma Protein: Because paroxetine is highly bound to plasma protein, administration of paroxetine hydrochloride extended-release tablets to a patient taking another drug that is highly protein bound may cause increased free concentrations of the other drug, potentially resulting in adverse events. Conversely, adverse effects could result from displacement of paroxetine by other highly bound drugs.

Drugs That Interfere with Hemostasis (e.g., NSAIDs, Aspirin and Warfarin): Serotonin release by platelets plays an important role in hemostasis. Epidemiological studies of the case control and cohort design that have demonstrated an association between use of psychotropic drugs that interfere with serotonin reuptake and the occurrence of upper gastrointestinal bleeding have also shown that concurrent use of an NSAID or aspirin may potentiate this risk of bleeding. Altered anticoagulant effects, including increased bleeding, have been reported when SSRIs or SNRIs are coadministered with warfarin. Patients receiving warfarin therapy should be carefully monitored when paroxetine is initiated or discontinued.

Alcohol: Although paroxetine does not increase the impairment of mental and motor skills caused by alcohol, patients should be advised to avoid alcohol while taking paroxetine hydrochloride extended-release tablets.

Lithium: A multiple-dose study with immediate-release paroxetine hydrochloride has shown that there is no pharmacokinetic interaction between paroxetine and lithium carbonate. However, due to the potential for serotonin syndrome, caution is advised when immediate-release paroxetine hydrochloride is coadministered with lithium.

Digoxin: The steady-state pharmacokinetics of paroxetine was not altered when administered with digoxin at steady-state. Mean digoxin AUC at steady-state decreased by 15% in the presence of paroxetine. Since there is little clinical experience, the concurrent administration of paroxetine hydrochloride extended-release tablets and digoxin should be undertaken with caution.

Diazepam: Under steady-state conditions, diazepam does not appear to affect paroxetine kinetics. The effects of paroxetine on diazepam were not evaluated.

Procyclidine: Daily oral dosing of immediate-release paroxetine (30 mg once daily) increased steady-state $AUC_{0\text{-}24}$, C_{max}, and C_{min} values of procyclidine (5 mg oral once daily) by 35%, 37%, and 67%, respectively, compared to procyclidine alone at steady-state. If anticholinergic effects are seen, the dose of procyclidine should be reduced.

Beta-Blockers: In a study where propranolol (80 mg twice daily) was dosed orally for 18 days, the established steady-state plasma concentrations of propranolol were unaltered during coadministration with immediate-release paroxetine (30 mg once daily) for the final 10 days. The effects of propranolol on paroxetine have not been evaluated (see ADVERSE REACTIONS: Post-marketing Reports).

Theophylline: Reports of elevated theophylline levels associated with immediate-release paroxetine treatment have been reported. While this interaction has not been formally studied, it is recommended that theophylline levels be monitored when these drugs are concurrently administered.

Fosamprenavir/Ritonavir: Coadministration of fosamprenavir/ritonavir with paroxetine significantly decreased plasma levels of paroxetine. Any dose adjustment should be guided by clinical effect (tolerability and efficacy).

Electroconvulsive Therapy (ECT): There are no clinical studies of the combined use of ECT and paroxetine hydrochloride extended-release tablets.

Carcinogenesis, Mutagenesis, Impairment of Fertility: ***Carcinogenesis:*** Two year carcinogenicity studies were conducted in rodents given paroxetine in the diet at 1, 5, and 25 mg/kg/day (mice) and 1, 5, and 20 mg/kg/day (rats). These doses are up to approximately 2 (mouse) and 3 (rat) times the (MRHD) on an mg/m^2 basis. There was a significantly greater number of male rats in the high-dose group with reticulum cell sarcomas (1/100, 0/50, 0/50, and 4/50 for control, low-, middle-, and high-dose groups, respectively) and a significantly increased linear trend across dose groups for the occurrence of lymphoreticular tumors in male rats. Female rats were not affected. Although there was a dose related increase in the number of tumors in mice, there was no drug related increase in the number of mice with tumors. The relevance of these findings to humans is unknown.

Mutagenesis: Paroxetine produced no genotoxic effects in a battery of five *in vitro* and two *in vivo* assays that included the following: Bacterial mutation assay, mouse lymphoma mutation assay, unscheduled DNA synthesis assay, and tests for cytogenetic aberrations *in vivo* in mouse bone marrow and *in vitro* in human lymphocytes and in a dominant lethal test in rats.

Impairment of Fertility: A reduced pregnancy rate was found in reproduction studies in rats at a dose of paroxetine of 15 mg/kg/day, which is approximately twice the MRHD on a mg/m^2 basis. Irreversible lesions occurred in the reproductive tract of male rats after dosing in toxicity studies for 2 to 52 weeks. These lesions consisted of vacuolation of epididymal tubular epithelium at 50 mg/kg/day and atrophic changes in the seminiferous tubules of the testes with arrested spermatogenesis at 25 mg/kg/day (approximately 8 and 4 times the MRHD on a mg/m^2 basis).

Pregnancy: ***Pregnancy Category D:*** See WARNINGS: Usage in Pregnancy: *Teratogenic Effects:*.

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

Nursing Mothers: Like many other drugs, paroxetine is secreted in human milk, and caution should be exercised when paroxetine hydrochloride extended-release tablets are administered to a nursing woman.

Pediatric Use: Safety and effectiveness in the pediatric population have not been established (see BOX WARNING and WARNINGS: Clinical Worsening and Suicide Risk). Three placebo-controlled trials in 752 pediatric patients with MDD have been conducted with paroxetine hydrochloride and the data were not sufficient to support a claim for use in pediatric patients. Anyone considering the use of paroxetine hydrochloride extended-release tablets in a child or adolescent must balance the potential risks with the clinical need.

In placebo-controlled clinical trials conducted with pediatric patients, the following adverse events were reported in at least 2% of pediatric patients treated with immediate-release paroxetine hydrochloride and occurred at a rate at least twice that for pediatric patients receiving placebo: emotional lability (including self harm, suicidal thoughts, attempted suicide, crying, and mood fluctuations), hostility, decreased appetite, tremor, sweating, hyperkinesia, and agitation.

Events reported upon discontinuation of treatment with immediate-release paroxetine hydrochloride in the pediatric clinical trials that included a taper phase regimen, which occurred in at least 2% of patients who received immediate-release paroxetine hydrochloride and which occurred at a rate at least twice that of placebo, were: emotional lability (including suicidal ideation, suicide attempt, mood changes, and tearfulness), nervousness, dizziness, nausea, and abdominal pain (see DOSAGE AND ADMINISTRATION: Discontinuation of Treatment with Paroxetine Hydrochloride Extended-Release Tablets).

Geriatric Use: SSRIs and SNRIs, including paroxetine, have been associated with cases of clinically significant hyponatremia in elderly patients, who may be at greater risk for this adverse event (see PRECAUTIONS: Hyponatremia).

In worldwide premarketing clinical trials with immediate-release paroxetine hydrochloride, 17% of paroxetine-treated patients (approximately 700) were 65 years or older. Pharmacokinetic studies revealed a decreased clearance in the elderly, and a lower starting dose is recommended; there were, however, no overall differences in the adverse event profile between elderly and younger patients, and effectiveness was similar in younger and older patients (see CLINICAL PHARMACOLOGY in full prescribing information and DOSAGE AND ADMINISTRATION).

In a controlled study focusing specifically on elderly patients with major depressive disorder, paroxetine hydrochloride extended-release tablets were demonstrated to be safe and effective in the treatment of elderly patients (> 60 years) with major depressive disorder. (See CLINICAL PHARMACOLOGY: Clinical Trials in full prescribing information and ADVERSE REACTIONS: Table 3.)

ADVERSE REACTIONS: The information included under the "Adverse Findings Observed in Short-Term, Placebo-Controlled Trials with Paroxetine Hydrochloride Extended-Release Tablets" subsection of ADVERSE REACTIONS is based on data from eleven placebo-controlled clinical trials. Three of these studies were conducted in patients with major depressive disorder, three studies were done in patients with panic disorder and one study was conducted in patients with social anxiety disorder. Two of the studies in major depressive disorder, which enrolled patients in the age range 18 to 65 years, are pooled. Information from a third study of major depressive disorder, which focused on elderly patients (60 to 88 years), is presented separately as is the information from the panic disorder studies. Information on additional adverse events associated with paroxetine hydrochloride extended-release tablet and the immediate-release formulation of paroxetine hydrochloride is included in a separate subsection (see Other Events Observed During the Clinical Development of Paroxetine).

Adverse Findings Observed in Short-Term, Placebo-Controlled Trials With Paroxetine Hydrochloride Extended-Release Tablets: ***Adverse Events Associated With Discontinuation of Treatment:*** *Major Depressive Disorder:* Ten percent (21/212) of patients treated with paroxetine hydrochloride extended-release tablets discontinued treatment due to an adverse event in a pool of two studies of patients with major depressive disorder. The most common events (≥ 1%) associated with discontinuation and considered to be drug-related (i.e., those events associated with dropout at a rate approximately twice or greater for paroxetine hydrochloride extended-release tablets compared to placebo) included the following:

	Paroxetine Hydrochloride Extended-Release Tablets (n = 212)	Placebo (n = 211)
Nausea	3.7%	0.5%
Asthenia	1.9%	0.5%
Dizziness	1.4%	0.0%
Somnolence	1.4%	0.0%

In a placebo-controlled study of elderly patients with major depressive disorder, 13% (13/104) of patients treated with paroxetine hydrochloride extended-release tablets discontinued due to an adverse event. Events meeting the above criteria included the following:

	Paroxetine Hydrochloride Extended-Release Tablets (n = 104)	Placebo (n = 109)
Nausea	2.9%	0.0%
Headache	1.9%	0.9%
Depression	1.9%	0.0%
LFT's abnormal	1.9%	0.0%

Commonly Observed Adverse Events: ***Major Depressive Disorder:*** The most commonly observed adverse events associated with the use of paroxetine hydrochloride extended-release tablets in a pool of two trials (incidence of 5% or greater and incidence for paroxetine hydrochloride extended-release tablets at least twice that for placebo, derived from Table 2) were: Abnormal ejaculation, abnormal vision, constipation, decreased libido, diarrhea, dizziness, female genital disorders, nausea, somnolence, sweating, trauma, tremor, and yawning.

Using the same criteria, the adverse events associated with the use of paroxetine hydrochloride extended-release tablets in a study of elderly patients with major depressive disorder were: Abnormal ejaculation, constipation, decreased appetite, dry mouth, impotence, infection, libido decreased, sweating, and tremor.

Incidence in Controlled Clinical Trials: Table 2 enumerates adverse events that occurred at an incidence of 1% or more among patients treated with paroxetine hydrochloride extended-release tablets, aged 18 to 65, who participated in two short-term (12 week) placebo-controlled trials in major depressive disorder in which patients were dosed in a range of 25 mg to 62.5 mg/day. Table 3 enumerates adverse events reported at an incidence of 5% or greater among elderly patients (ages 60 to 88) treated with paroxetine hydrochloride extended-release tablets who participated in a short-term (12 week) placebo-controlled trial in major depressive disorder in which patients were dosed in a range of 12.5 mg to 50 mg/day. Table 4 enumerates adverse events reported at an incidence of 1% or greater among patients (19 to 72 years) treated with paroxetine hydrochloride extended-release tablets who participated in short-term (10 week) placebo-controlled trials in panic disorder in which patients were dosed in a range of 12.5 mg to 75 mg/day. Table 5 enumerates adverse events reported at an incidence of 1% or greater among adult patients treated with paroxetine hydrochloride extended-release tablets who participated in a short-term (12 week), double-blind, placebo-controlled trial in social anxiety disorder in which patients were dosed in a range of 12.5 to 37.5 mg/day.

The prescriber should be aware that these figures cannot be used to predict the incidence of side effects in the course of usual medical practice where patient characteristics and other factors differ from those that prevailed in the clinical trials. Similarly, the cited frequencies cannot be compared with figures obtained from other clinical investigations involving different treatments, uses, and investigators. The cited figures, however, do provide the prescribing physician with some basis for estimating the relative contribution of drug and nondrug factors to the side effect incidence rate in the population studied.

Table 2. Treatment Emergent Adverse Events Occurring in ≥1% of Patients Treated with Paroxetine Hydrochloride Extended-Release Tablets in a Pool of Two Studies in Major Depressive Disorder[1,2]

	% Reporting Event	
Body System/Adverse Event	**Paroxetine Hydrochloride Extended-Release Tablets (n = 212)**	**Placebo (n = 211)**
Body as a Whole		
Headache	27%	20%
Asthenia	14%	9%
Infection[3]	8%	5%
Abdominal Pain	7%	4%
Back Pain	5%	3%
Trauma[4]	5%	1%
Pain[5]	3%	1%
Allergic Reaction[6]	2%	1%
Cardiovascular System		
Tachycardia	1%	0%
Vasodilatation[7]	2%	0%
Digestive System		
Nausea	22%	10%
Diarrhea	18%	7%
Dry Mouth	15%	8%
Constipation	10%	4%
Flatulence	6%	4%
Decreased Appetite	4%	2%
Vomiting	2%	1%
Nervous System		
Somnolence	22%	8%
Insomnia	17%	9%
Dizziness	14%	4%
Libido Decreased	7%	3%
Tremor	7%	1%
Hypertonia	3%	1%
Paresthesia	3%	1%
Agitation	2%	1%
Confusion	1%	0%
Respiratory System		
Yawn	5%	0%
Rhinitis	4%	1%
Cough Increased	2%	1%
Bronchitis	1%	0%
Skin and Appendages		
Sweating	6%	2%
Photosensitivity	2%	0%
Special Senses		
Abnormal Vision[8]	5%	1%
Taste Perversion	2%	0%
Urogenital System		
Abnormal Ejaculation[9,10]	26%	1%
Female Genital Disorder[9,11]	10%	< 1%
Impotence[9]	5%	3%
Urinary Tract Infection	3%	1%
Menstrual Disorder[9]	2%	< 1%
Vaginitis[9]	2%	0%

1. Adverse events for which the paroxetine hydrochloride extended-release tablets reporting incidence was less than or equal to the placebo incidence are not included. These events are: Abnormal dreams, anxiety, arthralgia, depersonalization, dysmenorrhea, dyspepsia, hyperkinesia, increased appetite, myalgia, nervousness, pharyngitis, purpura, rash, respiratory disorder, sinusitis, urinary frequency, and weight gain.
2. < 1% means greater than zero and less than 1%.
3. Mostly flu.
4. A wide variety of injuries with no obvious pattern.
5. Pain in a variety of locations with no obvious pattern.
6. Most frequently seasonal allergic symptoms.
7. Usually flushing.
8. Mostly blurred vision.
9. Based on the number of males or females.
10. Mostly anorgasmia or delayed ejaculation.
11. Mostly anorgasmia or delayed orgasm.

Table 3. Treatment Emergent Adverse Events Occurring in ≥ 5% of Patients Treated with Paroxetine Hydrochloride Extended-Release Tablets in a Study of Elderly Patients with Major Depressive Disorder[1,2]

	% Reporting Event	
Body System/Adverse Event	**Paroxetine Hydrochloride Extended-Release Tablets (n = 104)**	**Placebo (n = 109)**
Body as a Whole		
Headache	17%	13%
Asthenia	15%	14%
Trauma	8%	5%
Infection	6%	2%
Digestive System		
Dry Mouth	18%	7%
Diarrhea	15%	9%
Constipation	13%	5%
Dyspepsia	13%	10%
Decreased Appetite	12%	5%
Flatulence	8%	7%
Nervous System		
Somnolence	21%	12%
Insomnia	10%	8%
Dizziness	9%	5%
Libido Decreased	8%	< 1%
Tremor	7%	0%
Skin and Appendages		
Sweating	10%	< 1%
Urogenital System		
Abnormal Ejaculation[3,4]	17%	3%
Impotence[3]	9%	3%

1. Adverse events for which the paroxetine hydrochloride extended-release tablets reporting incidence was less than or equal to the placebo incidence are not included. These events are nausea and respiratory disorder.
2. < 1% means greater than zero and less than 1%.
3. Based on the number of males.
4. Mostly anorgasmia or delayed ejaculation.

A comparison of adverse event rates in a fixed dose study comparing immediate-release paroxetine with placebo in the treatment of major depressive disorder revealed a clear dose dependency for some of the more common adverse events associated with the use of immediate-release paroxetine.

Male and Female Sexual Dysfunction with SSRIs: Although changes in sexual desire, sexual performance, and sexual satisfaction often occur as manifestations of a psychiatric disorder, they may also be a consequence of pharmacologic treatment. In particular, some evidence suggests that SSRIs can cause such untoward sexual experiences.

Reliable estimates of the incidence and severity of untoward experiences involving sexual desire, performance, and satisfaction are difficult to obtain; however, in part because patients and physicians may be reluctant to discuss them. Accordingly, estimates of the incidence of untoward sexual experience and performance cited in product labeling, are likely to underestimate their actual incidence.

The percentage of patients reporting symptoms of sexual dysfunction in the pool of two placebo-controlled trials in nonelderly patients with major depressive disorder, in the pool of three placebo-controlled trials in patients with panic disorder, and in the placebo-controlled trial in patients with social anxiety disorder, are as follows:

	Major Depressive Disorder	
	Paroxetine HCl Extended-Release Tablets	**Placebo**
n (males)	**78**	**78**
Decreased Libido	10%	5%
Ejaculatory Disturbance	26%	1%
Impotence	5%	3%
n (females)	**134**	**133**
Decreased Libido	4%	2%
Orgasmic Disturbance	10%	<1%

There are no adequate, controlled studies examining sexual dysfunction with paroxetine treatment.

Paroxetine treatment has been associated with several cases of priapism. In those cases with a known outcome, patients recovered without sequelae.

While it is difficult to know the precise risk of sexual dysfunction associated with the use of SSRIs, physicians should routinely inquire about such possible side effects.

Weight and Vital Sign Changes: Significant weight loss may be an undesirable result of treatment with paroxetine for some patients but, on average, patients in controlled trials with paroxetine hydrochloride extended-release tablet or the immediate-release formulation, had minimal weight loss (about 1 pound). No significant changes in vital signs (systolic and diastolic blood pressure, pulse, and temperature) were observed in patients treated with paroxetine hydrochloride extended-release tablets, or immediate-release paroxetine hydrochloride, in controlled clinical trials.

ECG Changes: In an analysis of ECGs obtained in 682 patients treated with immediate-release paroxetine and 415 patients treated with placebo in controlled clinical trials, no clinically significant changes were seen in the ECGs of either group.

Liver Function Tests: In a pool of two placebo-controlled clinical trials, patients treated with paroxetine hydrochloride extended-release tablets or placebo exhibited abnormal values on liver function tests at comparable rates. In particular, the extended-release paroxetine versus placebo comparisons for alkaline phosphatase, SGOT, SGPT, and bilirubin revealed no differences in the percentage of patients with marked abnormalities.

In a study of elderly patients with major depressive disorder, 3 of 104 patients treated with paroxetine hydrochloride extended-release tablets and none of 109 placebo patients experienced liver transaminase elevations of potential clinical concern.

Two of the patients treated with paroxetine hydrochloride extended-release tablets dropped out of the study due to abnormal liver function tests; the third patient experienced normalization of transaminase levels with continued treatment. Also, in the pool of three studies of patients with panic disorder, 4 of 444 patients treated with paroxetine hydrochloride extended-release tablets and none of 445 placebo patients experienced liver transaminase elevations of potential clinical concern. Elevations in all four patients decreased substantially after discontinuation of paroxetine hydrochloride extended-release tablets. The clinical significance of these findings is unknown.

In placebo-controlled clinical trials with the immediate-release formulation of paroxetine, patients exhibited abnormal values on liver function tests at no greater rate than that seen in placebo-treated patients.

Hallucinations: In pooled clinical trials of immediate-release paroxetine hydrochloride, hallucinations were observed in 22 of 9,089 patients receiving drug and in 4 of 3,187 patients receiving placebo.

Other Events Observed During the Clinical Development of Paroxetine: The following adverse events were reported during the clinical development of paroxetine hydrochloride extended-release tablet and/or the clinical development of the immediate-release formulation of paroxetine.

Adverse events for which frequencies are provided below occurred in clinical trials with the extended-release formulation of paroxetine. During its premarketing assessment in major depressive disorder, panic disorder and social anxiety disorder, multiple doses of paroxetine hydrochloride extended-release tablets were administered to 1,627 patients in phase three double-blind, controlled, outpatient studies. Untoward events associated with this exposure were recorded by clinical investigators using terminology of their own choosing. Consequently, it is not possible to provide a meaningful estimate of the proportion of individuals experiencing adverse events without first grouping similar types of untoward events into a smaller number of standardized event categories.

In the tabulations that follow, reported adverse events were classified using a COSTART based dictionary. The frequencies presented, therefore, represent the proportion of the 1,627 patients exposed to paroxetine hydrochloride extended-release tablets who experienced an event of the type cited on at least one occasion while receiving paroxetine hydrochloride extended-release tablets. All reported events are included except those already listed in Tables one through four and those events where a drug cause was remote. If the COSTART term for an event was so general as to be uninformative, it was deleted or, when possible, replaced with a more informative term. It is important to emphasize that although the events reported occurred during treatment with paroxetine, they were not necessarily caused by it.

Events are further categorized by body system and listed in order of decreasing frequency according to the following definitions: Frequent adverse events are those occurring on one or more occasions in at least 1/100 patients (only those not already listed in the tabulated results from placebo-controlled trials appear in this listing); infrequent adverse events are those occurring in 1/100 to 1/1,000 patients; rare events are those occurring in fewer than 1/1,000 patients.

Adverse events for which frequencies are not provided occurred during the premarketing assessment of immediate-release paroxetine in phase two and three studies of major depressive disorder, obsessive compulsive disorder, panic disorder, social anxiety disorder, generalized anxiety disorder, and posttraumatic stress disorder. The conditions and duration of exposure to immediate release paroxetine varied greatly and included (in overlapping categories) open and double-blind studies, uncontrolled and controlled studies, inpatient and outpatient studies, and fixed dose and titration studies. Only those events not previously listed for extended-release paroxetine are included. The extent to which these events may be associated with paroxetine hydrochloride extended-release tablets is unknown.

Events are listed alphabetically within the respective body system. Events of major clinical importance are also described in the PRECAUTIONS section.

Body as a Whole: Infrequent were chills, face edema, fever, flu syndrome, malaise; rare were abscess, anaphylactoid reaction, anticholinergic syndrome, hypothermia; also observed were adrenergic syndrome, neck rigidity, sepsis.

Cardiovascular System: Infrequent were angina pectoris, bradycardia, hematoma, hypertension, hypotension, palpitation, postural hypotension, supraventricular tachycardia, syncope; rare were bundle branch block; also observed were arrhythmia nodal, atrial fibrillation, cerebrovascular accident, congestive heart failure, low cardiac output, myocardial infarct, myocardial ischemia, pallor, phlebitis, pulmonary embolus, supraventricular extrasystoles, thrombophlebitis, thrombosis, vascular headache, ventricular extrasystoles.

Digestive System: Infrequent were bruxism, dysphagia, eructation, gastritis, gastroenteritis, gastroesophageal reflux, gingivitis, hemorrhoids, liver function test abnormal, melena, pancreatitis, rectal hemorrhage, toothache, ulcerative stomatitis; rare were colitis, glossitis, gum hyperplasia, hepatosplenomegaly, increased salivation, intestinal obstruction, peptic ulcer, stomach ulcer, throat tightness; also observed were aphthous stomatitis, bloody diarrhea, bulimia, cardiospasm, cholelithiasis, duodenitis, enteritis, esophagitis, fecal impactions, fecal incontinence, gum hemorrhage, hematemesis, hepatitis, ileitis, ileus, jaundice, mouth ulceration, salivary gland enlargement, sialadenitis, stomatitis, tongue discoloration, tongue edema.

Endocrine System: Infrequent were ovarian cyst, testes pain; rare were diabetes mellitus, hyperthyroidism; also observed were goiter, hypothyroidism, thyroiditis.

Hemic and Lymphatic System: Infrequent were anemia, eosinophilia, hypochromic anemia, leukocytosis, leukopenia, lymphadenopathy, purpura; rare were thrombocytopenia; also observed were anisocytosis, basophilia, bleeding time increased, lymphedema, lymphocytosis, lymphopenia, microcytic anemia, monocytosis, normocytic anemia, thrombocythemia.

Metabolic and Nutritional Disorders: Infrequent were generalized edema, hyperglycemia, hypokalemia, peripheral edema, SGOT increased, SGPT increased, thirst; rare were bilirubinemia, dehydration, hyperkalemia, obesity; also observed were alkaline phosphatase increased, BUN increased, creatinine phosphokinase increased, gamma globulins increased, gout, hypercalcemia, hypercholesteremia, hyperphosphatemia, hypocalcemia, hypoglycemia, hyponatremia, ketosis, lactic dehydrogenase increased, nonprotein nitrogen (NPN) increased.

Musculoskeletal System: Infrequent were arthritis, bursitis, tendonitis; rare were myasthenia, myopathy, myositis; also observed were generalized spasm, osteoporosis, tenosynovitis, tetany.

Nervous System: Frequent were depression; infrequent were amnesia, convulsion, depersonalization, dystonia, emotional lability, hallucinations, hyperkinesia, hypesthesia, hypokinesia, incoordination, libido increased, neuralgia, neuropathy, nystagmus, paralysis, vertigo; rare were ataxia, coma, diplopia, dyskinesia, hostility, paranoid reaction, torticollis, withdrawal syndrome; also observed were abnormal gait, akathisia, akinesia, aphasia, choreoathetosis, circumoral paresthesia, delirium, delusions, dysarthria, euphoria, extrapyramidal syndrome, fasciculations, grand mal convulsion, hyperalgesia, irritability, manic reaction,

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manic-depressive reaction, meningitis, myelitis, peripheral neuritis, psychosis, psychotic depression, reflexes decreased, reflexes increased, stupor, trismus.

Respiratory System: Frequent were pharyngitis; infrequent were asthma, dyspnea, epistaxis, laryngitis, pneumonia; rare were stridor; also observed were dysphonia, emphysema, hemoptysis, hiccups, hyperventilation, lung fibrosis, pulmonary edema, respiratory flu, sputum increased.

Skin and Appendages: Frequent were rash; infrequent were acne, alopecia, dry skin, eczema, pruritus, urticaria; rare were exfoliative dermatitis, furunculosis, pustular rash, seborrhea; also observed were angioedema, ecchymosis, erythema multiforme, erythema nodosum, hirsutism, maculopapular rash, skin discoloration, skin hypertrophy, skin ulcer, sweating decreased, vesiculobullous rash.

Special Senses: Infrequent were conjunctivitis, earache, keratoconjunctivitis, mydriasis, photophobia, retinal hemorrhage, tinnitus; rare were blepharitis, visual field defect; also observed were amblyopia, anisocoria, blurred vision, cataract, conjunctival edema, corneal ulcer, deafness, exophthalmos, glaucoma, hyperacusis, night blindness, parosmia, ptosis, taste loss.

Urogenital System: Frequent were dysmenorrhea*; infrequent were albuminuria, amenorrhea*, breast pain*, cystitis, dysuria, prostatitis*, urinary retention; rare were breast enlargement*, breast neoplasm*, female lactation, hematuria, kidney calculus, metrorrhagia*, nephritis, nocturia, pregnancy and puerperal disorders*, salpingitis, urinary incontinence, uterine fibroids enlarged*; also observed were breast atrophy, ejaculatory disturbance, endometrial disorder, epididymitis, fibrocystic breast, leukorrhea, mastitis, oliguria, polyuria, pyuria, urethritis, urinary casts, urinary urgency, urolith, uterine spasm, vaginal hemorrhage.

*Based on the number of men and women as appropriate.

Post-Marketing Reports: Voluntary reports of adverse events in patients taking immediate-release paroxetine hydrochloride that have been received since market introduction and not listed above that may have no causal relationship with the drug include acute pancreatitis, elevated liver function tests (the most severe cases were deaths due to liver necrosis, and grossly elevated transaminases associated with severe liver dysfunction), Guillain-Barré syndrome, toxic epidermal necrolysis, priapism, syndrome of inappropriate ADH secretion, symptoms suggestive of prolactinemia and galactorrhea; extrapyramidal symptoms which have included akathisia, bradykinesia, cogwheel rigidity, dystonia, hypertonia, oculogyric crisis which has been associated with concomitant use of pimozide; tremor and trismus; status epilepticus, acute renal failure, pulmonary hypertension, allergic alveolitis, anaphylaxis, eclampsia, laryngismus, optic neuritis, porphyria, ventricular fibrillation, ventricular tachycardia (including Torsade de pointes), thrombocytopenia, hemolytic anemia, events related to impaired hematopoiesis (including aplastic anemia, pancytopenia, bone marrow aplasia, and agranulocytosis), and vasculitic syndromes (such as Henoch-Schönlein purpura). There has been a case report of an elevated phenytoin level after 4 weeks of immediate-release paroxetine and phenytoin coadministration. There has been a case report of severe hypotension when immediate-release paroxetine was added to chronic metoprolol treatment.

DRUG ABUSE AND DEPENDENCE: Controlled Substance Class: Paroxetine hydrochloride is not a controlled substance.

Physical and Psychologic Dependence: Paroxetine hydrochloride extended-release tablets have not been systematically studied in animals or humans for its potential for abuse, tolerance or physical dependence. While the clinical trials did not reveal any tendency for any drug seeking behavior, these observations were not systematic and it is not possible to predict on the basis of this limited experience the extent to which a CNS active drug will be misused, diverted, and/or abused once marketed. Consequently, patients should be evaluated carefully for history of drug abuse, and such patients should be observed closely for signs of misuse or abuse of paroxetine hydrochloride extended-release tablets (e.g., development of tolerance, incrementations of dose, drug seeking behavior).

OVERDOSAGE: Human Experience: Since the introduction of immediate-release paroxetine hydrochloride in the United States, 342 spontaneous cases of deliberate or accidental overdosage during paroxetine treatment have been reported worldwide (circa 1999). These include overdoses with paroxetine alone and in combination with other substances. Of these, 48 cases were fatal and of the fatalities, 17 appeared to involve paroxetine alone. Eight fatal cases that documented the amount of paroxetine ingested were generally confounded by the ingestion of other drugs or alcohol or the presence of significant comorbid conditions. Of 145 nonfatal cases with known outcome, most recovered without sequelae. The largest known ingestion involved 2000 mg of paroxetine (33 times the maximum recommended daily dose) in a patient who recovered.

Commonly reported adverse events associated with paroxetine overdosage include somnolence, coma, nausea, tremor, tachycardia, confusion, vomiting, and dizziness. Other notable signs and symptoms observed with overdoses involving paroxetine (alone or with other substances) include mydriasis, convulsions (including status epilepticus), ventricular dysrhythmias (including Torsade de pointes), hypertension, aggressive reactions, syncope, hypotension, stupor, bradycardia, dystonia, rhabdomyolysis, symptoms of hepatic dysfunction (including hepatic failure, hepatic necrosis, jaundice, hepatitis, and hepatic steatosis), serotonin syndrome, manic reactions, myoclonus, acute renal failure, and urinary retention.

Overdosage Management: Treatment should consist of those general measures employed in the management of overdosage with any drugs effective in the treatment of major depressive disorder.

Ensure an adequate airway, oxygenation, and ventilation. Monitor cardiac rhythm and vital signs. General supportive and symptomatic measures are also recommended. Induction of emesis is not recommended. Gastric lavage with a large-bore orogastric tube with appropriate airway protection, if needed, may be indicated if performed soon after ingestion, or in symptomatic patients.

Activated charcoal should be administered. Due to the large volume of distribution of this drug, forced diuresis, dialysis, hemoperfusion, and exchange transfusion are unlikely to be of benefit. No specific antidotes for paroxetine are known.

A specific caution involves patients taking or recently having taken paroxetine who might ingest excessive quantities of a tricyclic antidepressant. In such a case, accumulation of the parent tricyclic and an active metabolite may increase the possibility of clinically significant sequelae and extend the time needed for close medical observation (see PRECAUTIONS: Drug Interactions: *Drugs Metabolized by Cytochrome CPY2D6*).

In managing overdosage, consider the possibility of multiple drug involvement. The physician should consider contacting a poison control center for additional information on the treatment of any overdose. Telephone numbers for certified poison control centers are listed in the *Physicians' Desk Reference* (PDR).

DOSAGE AND ADMINISTRATION: Major Depressive Disorder: *Usual Initial Dosage:* Paroxetine hydrochloride extended-release tablets should be administered as a single daily dose, usually in the morning, with or without food. The recommended initial dose is 25 mg/day. Patients were dosed in a range of 25 mg to 62.5 mg/day in the clinical trials demonstrating the effectiveness of paroxetine hydrochloride extended-release tablets in the treatment of major depressive disorder. As with all drugs effective in the treatment of major depressive disorder, the full effect may be delayed. Some patients not responding to a 25 mg dose may benefit from dose increases, in 12.5 mg/day increments, up to a maximum of 62.5 mg/day. Dose changes should occur at intervals of at least one week.

Patients should be cautioned that paroxetine hydrochloride extended-release tablets should not be chewed or crushed, and should be swallowed whole.

Maintenance Therapy: There is no body of evidence available to answer the question of how long the patient treated with paroxetine hydrochloride extended-release tablets should remain on it. It is generally agreed that acute episodes of major depressive disorder require several months or longer of sustained pharmacologic therapy. Whether the dose of an antidepressant needed to induce remission is identical to the dose needed to maintain and/or sustain euthymia is unknown.

Systematic evaluation of the efficacy of immediate-release paroxetine hydrochloride has shown that efficacy is maintained for periods of up to one year with doses that averaged about 30 mg, which corresponds to a 37.5 mg dose of paroxetine hydrochloride extended-release tablets, based on relative bioavailability considerations (see CLINICAL PHARMACOLOGY: Pharmacokinetics in full prescribing information).

Special Populations: *Treatment of Pregnant Women During the Third Trimester:* Neonates exposed to paroxetine hydrochloride extended-release tablets and other SSRIs or SNRIs, late in the third trimester have developed complications requiring prolonged hospitalization, respiratory support, and tube feeding (see WARNINGS). When treating pregnant women with paroxetine during the third trimester, the physician should carefully consider the potential risks and benefits of treatment. The physician may consider tapering paroxetine in the third trimester.

Dosage for Elderly or Debilitated Patients, and Patients with Severe Renal or Hepatic Impairment: The recommended initial dose of paroxetine hydrochloride extended-release tablets is 12.5 mg/day for elderly patients, debilitated patients, and/or patients with severe renal or hepatic impairment. Increases may be made if indicated. Dosage should not exceed 50 mg/day.

Switching Patients to or From a Monoamine Oxidase Inhibitor: At least 14 days should elapse between discontinuation of an MAOI and initiation of therapy with paroxetine hydrochloride extended-release tablets. Similarly, at least 14 days should be allowed after stopping paroxetine hydrochloride extended-release tablets before starting an MAOI.

Discontinuation of Treatment with Paroxetine Hydrochloride Extended-Release Tablets: Symptoms associated with discontinuation of immediate-release paroxetine hydrochloride or paroxetine hydrochloride extended-release tablets have been reported (see PRECAUTIONS). Patients should be monitored for these symptoms when discontinuing treatment, regardless of the indication for which paroxetine hydrochloride extended-release tablets are being prescribed. A gradual reduction in the dose rather than abrupt cessation is recommended whenever possible. If intolerable symptoms occur following a decrease in the dose or upon discontinuation of treatment, then resuming the previously prescribed dose may be considered. Subsequently, the physician may continue decreasing the dose but at a more gradual rate.

Mylan

Mylan Pharmaceuticals Inc.
Morgantown, WV 26505

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23 SUNDAY
MAY

C. The French System: "Health Security" for All? *Gisèle Apter, M.D.*

2 p.m.-5 p.m.

S36. Treating Chronic Pain and Co-Occuring Addiction in Substance Abuse Patients *National Institute on Drug Abuse*

A. Why Do Some Patients Have Persistent Pain and Persistent Opioid Use Following Surgery: An Inception Cohort Study *Ian Carroll, M.D.*

B. Clinical Aspects of Risk Management in Opioid Therapy *Steve Passik, Ph.D.*

C. Behavioral Treatment for Co-Occurring Chronic Pain and Opioid Addiction *Richard Schottenfeld, M.D.*

D. Results of the Prescription Opioid Addiction Treatment Study: A Multi-Site Trial of the NIDA Clinical Trials Network *Roger Weiss, M.D.*

E. Overview of the Treatment of Acute and Chronic Pain in the Patient With a History of Addiction *Sean Mackey, M.D.*

S37. Culturally Sensitive Treatment of Psychologically Distressed Ethnic and Non-English-Speaking Populations

A. Efficacy of a Culturally Adapted Parent-Training Program for Ethnic Minority Families From Low-Income Communities *Esther J. Calzada, Ph.D., Laurie Miller Brotman, Ph.D.*

B. Culturally Sensitive Treatment of Traumatized Refugees and Ethnic Populations: Emotion Regulation Therapy for PTSD *Devon E. Hinton, M.D., Ph.D., David H. Barlow, Ph.D., Michael W. Otto, Ph.D., Mark H. Pollack, M.D.*

C. Adapting Psychosocial Treatments for Mexican Americans With Schizophrenia *Alex Kopelowicz, M.D.*

D. Using Culturally Adapted Motivational Interviewing to Improve Retention of Latino Outpatients in Antidepressant Therapy *Roberto Lewis-Fernández, M.D.*

E. Preventive Interventions for Refugee Families in Resettlement *Stevan Weine, M.D.*

S38. Neuroendocrine and Neuroimmunological Correlates of Bipolar Disorder in Women

A. Reproductive Endocrine Function in Women With Bipolar Disorder and Controls *Natalie Rasgon, M.D., Ph.D.*

B. Inflammatory and Oxidative Pathways in Mood Disorders: Novel Mechanisms and Therapeutic Opportunities *Michael Berk, M.D., Ph.D.*

C. Serum B12 Levels and Thyroid Function in Bipolar Disorder: Is There a Gender Difference? *Aysegul Ozerdem, M.D., Ph.D.*

D. Insulin Disturbance as a Critical Factor in Bipolar Disorder *Roger McIntyre, M.D.*

3 p.m.- 4:30 p.m.

Scientific and Clinical Reports
Session 4. To be announced
Session 5. To be announced

Workshops

W57. Making the Most of Your Chief Year: Resident's Forum, Part II *Chair: Rex Huang, M.D.*

4:30 p.m.-6:30 p.m.

Opening Session and Presidential Address (Note new time.)

6 p.m.-8 p.m.

Industry-Supported Symposia

7 p.m.-10 p.m.

Media Workshop

MW2. Voicing the Unspeakable: Reflections on, and Discussion About, Overcoming Loss by Suicide *Chair: Sally Heckel, B.A.* ■

Fisher

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a teenager and in 1973 appeared in the hit Broadway revival "Irene." She enrolled in the London Central School of Speech and Drama and made her movie debut in the 1975 film "Shampoo."

It was "Star Wars" in 1977 that catapulted Fisher into international fame. Playing opposite Harrison Ford and Mark Hamill, she played the hard-boiled, sharp-tongued Princess Leia, revealed in "The Return of the Jedi" to be twin sister of Luke Skywalker and a daughter of Darth Vader.

Her first novel, *Postcards from the Edge*, appeared in 1986. It became a bestseller, and she received the Los Angeles Pen Award for Best First Novel. *Surrender the Pink* was published in 1991, followed by *Delusions of Grandma* in 1993. *The Best Awful There Is"* was published in 2004, followed by *Wishful Drinking* in 2008. The last was made into a one-woman play that has played in New York, Los Angeles, and Washington, D.C.

Fisher brings a self-deprecating but sharp-tongued tone to her writing and her speaking style. In *Wishful Drinking*, she writes, "I am truly a product of Hollywood. I'm a product of Hollywood inbreeding. When two celebrities mate, something like me is the result. I grew up visiting sets, playing on back lots, and watching movies. In consequence, and for a few other reasons, I find that I don't have a conventional sense of reality. (Not that I've ever had much use for reality—having spent much of what I laughingly refer to as my adult life attempting to wave it away with drug use.)"

Fisher has also become a forceful speaker about the realities of mental illness and addiction, combating stigma and speaking before Congress to advocate for funding of treatment and research. In *Wishful Drinking*, she had this to say, "Having waited my entire life to get an award for something, anything (okay fine, not acting, but what about a tiny award for writing? Nope), I now get awards all the time for being mentally ill. I'm apparently very good at it and am honored for it regularly. . . . [I]t's better than being bad at being insane, right? How tragic would it be to be runner-up for Bipolar Woman of the Year?" ■

Buprenorphine Training Course Offered

The buprenorphine training course satisfies legal requirements for a physician waiver that allows a general psychiatrist to provide office-based buprenorphine treatment for opioid addiction.

BY JUN YAN

A day-long course at the 2010 annual meeting in New Orleans will teach psychiatrists everything they need to know about buprenorphine as well as a general review of patient management of and treatment for opioid dependence.

The Drug Addiction Treatment Act of 2000 allows qualifying physicians to prescribe, dispense, and administer treatment for opioid dependence using medications designated Schedule III through Schedule V. Buprenorphine hydrochloride, either alone or in combination with naloxone, is currently the only pharmacotherapy approved for office-based treatment of opioid addiction.

Compared with methadone, a Schedule II medication that must be administered at methadone clinics, buprenorphine has a lower risk of diversion and overdose, Petros Levounis, M.D., director of this course, told *Psychiatric News*. "Based on our experience with buprenorphine so far, 95 percent of patients surveyed [in a recent study] felt buprenorphine was very or extremely helpful, and 60 percent were still in treatment after the first six months," he said.

Because of its unique pharmacological properties, buprenorphine treatment can be given at a physician's office, and patients who have been stabilized can take home a 30-day supply of buprenorphine for long-term treatment. Thus, compared with methadone, buprenorphine offers patients a treatment option with a higher level of privacy and lessens the concerns of stigma. "Buprenorphine is the first-line treatment for opioid dependence in 2010," said Levounis.

However, "there are still many patients who do better on methadone than on buprenorphine," Levounis emphasized.

Although the course will focus on the pharmacology and therapeutics of buprenorphine, other treatment options for opioid dependence, including methadone, will be addressed. Even for psychiatrists who do not plan to prescribe buprenorphine immediately, the course can serve as a useful review on treatment of opioid dependence.

To provide office-based treatment for patients with opioid addiction, a physician must apply for a waiver from the Center for Substance Abuse Treatment (CSAT), an agency of the Substance Abuse and Mental Health Services Administration. Physicians who are granted the waiver receive a special identification number assigned by the Drug Enforcement Administration (DEA), which is necessary for prescribing buprenorphine. Physicians who do not specialize in addiction medicine or addiction psychiatry can qualify for the waiver after undergoing at least eight hours of training provided by professional organizations deemed acceptable by CSAT, including APA and the American Academy of Addiction Psychiatry.

The eight-hour course satisfies the legal requirement for buprenorphine prescribing. Psychiatrists who successfully complete the course will learn the steps from applying for the physician waiver, to registering with the DEA, and maintaining documentation to comply with federal regulations.

Among the course instructors, Levounis is director of the Addiction Institute of New York, chief of the Division of Addiction Psychiatry at St. Luke's and Roosevelt Hospitals, and an associate clinical professor of psychiatry at Columbia University. Additional course instructors include Andrew Saxon, M.D., a professor of psychiatry at the University of Washington and director of the Addictions Treatment Center at VA Puget Sound Health Care System; Laura McNicholas, M.D., an assistant professor of psychiatry at the University of Pennsylvania and the Philadelphia VA Medical Center; and John Renner, M.D., an associate professor of psychiatry at Boston University School of Medicine and associate chief of psychiatry for the VA Boston Healthcare System.

The course, "Office-Based Buprenorphine Treatment of Opioid-Dependent Patients," will be held on Tuesday, May 25. The course fee is $270 for advance registration and $310 on site. ■

HIV/AIDS: Practical Strategies

More and more, primary care providers are recognizing the neuropsychiatric and psychiatric sequelae of HIV infection. With more than 1 million people currently infected in the United States, chances are that you will be asked to play a role in their health care.

APA's Office of HIV Psychiatry and the APIRE HIV Steering Committee will offer several programs to address the mental health and well-being of HIV-infected patients at APA's 2010 annual meeting. Geared to psychiatrists with varying levels of expertise, the programs will provide updated information on HIV-related complications and treatments.

MAY 22 — SATURDAY

12:30 p.m.-4:30 p.m. **HIV Psychiatry: What Residents Need to Know**
Eglinton Winton Room, 2nd Floor, Hilton New Orleans Riverside
A panel of experts will present a special program designed for psychiatry residents. It provides practical information on neuropsychiatric aspects of HIV, drug-drug interactions, ethical dilemmas in treating patients with HIV, and a model for complex clinical decision making. Discussion and case studies will allow residents time to deepen and integrate the lecture material. RSVP by May 17 by calling (703) 907-8641 or e-mailing AIDTemp01@psych.org.

1:30 p.m.-3 p.m. **Workshop: From Outreach to Assertive Community Treatment: Transferring Research to Practice in Comprehensive Care for Underserved People Living with HIV/AIDS**
Room 340, Morial Convention Center
This discussion will center on research-based interventions to assist in recovery for persons with HIV/AIDS and behavioral disorders, provide outcome information of evidence-based interventions for persons living with HIV/AIDS and comorbid behavioral health conditions, and analyze the feasibility, barriers, solutions, and potential opportunities for providing comprehensive mental health services for persons with HIV/AIDS.

MAY 25 — TUESDAY

9 a.m.-Noon **Symposium: The Public Health and Clinical Interface Between HIV, STDs, and Mental Health**
Room 225/226, Morial Convention Center
Faculty will discuss the public health and clinical interface between HIV, sexually transmitted diseases, and mental health and explore the underlying etiological mechanisms for interaction between these diseases and their risk factors. There will be an interactive discussion with participants of potential clinical strategies that may be helpful in addressing and/or preventing mental health problems caused by HIV and STDs and behavioral risks caused by mental illness.

MAY 26 — WEDNESDAY

2 p.m.-5 p.m. **Symposium: Comprehensive HIV Psychiatry Update**
Room 348-349, Morial Convention Center
This comprehensive symposium reviews the latest challenges that face persons with HIV and AIDS and how psychiatric care can help to meet those challenges. The program includes a medical update to provide epidemiological information; guidelines for antiretroviral therapy and considerations for patients with psychiatric comorbidities; a neuropsychiatric overview presenting epidemiology, differential diagnosis, and the role of the psychiatrist in prevention; and information on neurocognitive decline including pathophysiology, diagnostic criteria, and pharmacologic treatment.

Bradshaw

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country singer, motivational speaker, *New York Times* best-selling author, and breeder of championship quarter horses.

Bradshaw has also been a forceful advocate for bringing mental illness out of the closet. He spoke at a foundation "Toast of New York" fundraising event at the Empire State Building sponsored by the foundation at APA's 2004 annual meeting. "I sure don't have the average job," Bradshaw said at the time, "but I know how depression and anxiety can affect how you feel about your work.

> **"Looking back, I wish someone could have told me that what I was feeling was depression and that help was available."**

"Looking back, I wish someone could have told me that what I was feeling was depression and that help was available. Now with proper treatment, I feel good all day and can focus on the things that matter to me like my career and my family" (*Psychiatric News*, July 16, 2004).

In an interview with USA Today that same year, Bradshaw talked about the deep depression he experienced following a divorce. After consulting with his pastor, Bradshaw began treatment first with a psychologist, then with a psychiatrist who prescribed antidepressant medication.

"Stigma is incredibly powerful," Bradshaw told *USA Today*. "We'll talk about cancer and every other disease, including alcohol and drug abuse, but people do not want to talk about depression. There's something about depression that seems to say, 'I'm a tremendous failure.' "

Following his successful treatment, he began a tour to talk about his experience.

"One of the reasons why I am doing this campaign— what I call my Depression Tour—is I want to tell people that it's O.K. to be depressed," he said at the time. "Lots of people are depressed— you're not alone—and I want them to know that if you're clinically depressed, there's a solution for you."

He continued, "Depression is a physical illness. The beauty of it is that there are medications that work. Look at me. I'm always happy-go-lucky, and people look at me and find it shocking that I could be depressed."

The first player chosen in the 1970 draft, the 6-foot-3-inch Bradshaw became one of the most prolific quarterbacks in history. He was the first quarterback to win four Super Bowl championships (1975, 1976, 1979, and 1980), making him a perfect 4-0 Super Bowl play, a feat that has been duplicated only once—10 years later by Joe Montana. He still holds the Super Bowl passing records for average gain per attempt in career (11.10 yards) and average gain in a game (14.71 yards in Super Bowl XIV).

Bradshaw segued to broadcasting as a guest commentator for CBS Sports' NFC postseason broadcasts (1980-1982). He joined CBS Sports as an NFL game analyst in 1984, then became a studio analyst on "The NFL Today" for four seasons beginning in 1990. In 2006 the nationally prominent Davies-Brown Index rated him the best-known broadcaster in all of sports. His work on "Fox NFL Sunday" earned him Emmy awards in the Outstanding Sports Personality/Analyst category in 1999, 2001, and 2009, and he was named *TV Guide's* "Favorite Sportscaster" in 1999.

Bradshaw is also the author of five books and is a widely sought-after motivational speaker, speaking to Fortune 500 companies and major corporations across the country.

The American Psychiatric Foundation launched the "Conversations" series in 2002 so that psychiatrists could hear from people whose daily lives have been affected by mental illness. ■

Way to New Orleans' Heart Is Through Your Stomach

New Orleans is justly renowned for its creative cuisine. Here is a culinary potpourri of choices, many of them known mostly to food-loving locals and cover all price points and many cuisines.

BY JUSTIN SPOONER, M.D.
JOHN ROBERTS III, M.D.

Whenever you read about a popular convention destination, you're bound to come across the obligatory article that says the city is home to world-class restaurants and offbeat eateries offering the most interesting and delectable food imaginable.

Well, we must apologize right now because that's exactly what we are going to say about New Orleans—and we don't even have to exaggerate! (Just one note as you plan your schedule: restaurants are frequently closed Sunday and Monday, and a few are closed for lunch.)

To begin with, the city exhibits a meat- and seafood-heavy cuisine, but for those less inclined for surf or turf, many finer restaurants craft dishes not even on the menu.

The French Quarter hosts a full mandala of restaurants, and we have selected some of our favorites. For those of you with hefty travel budgets, **Bayona** ($$$; 430 Dauphine Avenue) is a must with many Creole cuisine options. Susan Spicer is one of the city's most innovative chefs, devising funky dishes such as andouille-stuffed rabbit roulade. **NOLA** ($$; 534 Saint Louis Street) is our favorite (and cheapest) of Emeril's three restaurants in town. We recommend its shrimp and grits or duck and fried egg pizza. **Stella** ($$$; 1032 Chartres Street) is a quiet must-dine experience known for its scrumptious desserts and kobe beef.

Lastly, no trip is complete without a traditional breakfast at **Brennan's** ($$$; 417 Royal Street), featuring eggs Benedict and bananas Foster.

New Orleans is famous as well for its bivalves, and the best can be found at Acme Oyster House ($; 724 Iberville Street), and then you can drop in at **Drago's** ($$; 2 Poydras Street) for more great seafood.

Moving slightly uptown, the central business district and adjoining warehouse district feature locally inspired Continental cuisine.

- **Herbsaint** ($$$; 701 Saint Charles Avenue): Try the roasted kurobuta pork belly with abalone mushrooms.
- **August** ($$$; 301 Tchoupitoulas Street): The acorn squash-satsuma-chestnut-fennel mezze is a must.
- **Cuvee** ($$$; 322 Magazine Street): You cannot go wrong with sea bass or shellfish.
- **Riomar** ($$; 800 South Peter Street): This restaurant is known for its ceviche and tapas.
- **Mother's Po-Boy** ($; 401 Poydras Street): This is just a 10-minute walk from the French Quarter and a great place to get authentic New Orleans po-boy sandwiches.

Uptown district restaurants are generally less expensive and less crowded. This area hosts a wealth of culinary favorites accessible from the St. Charles streetcar followed by a short walk or by taxi. Here is a sampling:

- **Gautreau's** ($$$; 1728 Soniat Street): For the third time this restaurant has earned *Food and Wine* magazine's "Best New Chefs" designation. The award-winning chef is Sue Zemanick. The restaurant also boasts a great wine list.
- **Commander's Palace** ($$$; 1403 Washington Avenue): This is one of New Orleans' oldest and most renowned restaurants, made famous by its bread-pudding soufflé and turtle soup.
- **Lilette** ($$; 3637 Magazine Street): This restaurant prepares the best gnocchi outside of Tuscany! It is best accessed by taxi.
- **La Crepe Nanou** ($; 1410 Robert Street): This is a great bistro worth the no-reservations wait.
- **Juan's Flying Burrito** ($; 2018 Magazine Street): Cheap, New Orleans funk meets South of the Border here. Note that it's a long walk from the streetcar.
- **Domilise's** ($; 5240 Annunciation Street): If you are looking for the best po-boys in the city, this is it. You'll like the quaint atmosphere.

Past Uptown, for the more adventurous palate, the best Cajun cuisine is found on Oak Street near the end of the St. Charles streetcar line. How about alligator cheesecake at **Jacques-Imo's** ($$; 8324 Oak Street) with its bohemian atmosphere and exotic menu?

Credit: Sarah Essex / Courtesy New Orleans Convention and Visitors Bureau

The dishes prepared at New Orleans' many restaurants aren't just a pleasant way to fill your stomach; they make up a passionate art form and a celebration of the area's local cultures and their melding.

Credit: Richard Nowitz / Courtesy New Orleans Convention and Visitors Bureau

Commander's Palace is considered one of New Orleans' best restaurants. Its jazz trio plays requests while diners enjoy inspired kitchen specialties like gumbo du jour.

Close by in the Riverbend area lies local favorite **Brigtsen's** ($$$; 723 Dante Street), worth the price of a taxi ride. It has an award-winning menu whose interpretation of Creole/Acadian food sets a high standard.

Lastly, if your taste buds are watering for the best fried chicken ever, drop by **Willie Mae's Scotch House** ($; 2401 Saint Ann Street) in mid-city. Take a taxi.

We hope this guide helps add some gustatory satisfaction to your experience at APA's annual meeting in May. ■

John Roberts III, M.D., and Justin Spooner, M.D., are residents in the Tulane University Department of Psychiatry.

from the president

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Kleber, M.D.), and personality disorders (John Oldham, M.D., and Andrew Skodol, M.D.) Other sessions for which chairs have not been designated yet are on correctional psychiatry, psychosomatic medicine, antipsychotic medications, and family assessment and intervention.

The Scientific Program Committee has expanded the Advances in Medicine series, including the review of the "Top 10 Medical Articles of 2009." I am also pleased to note that former NIMH director and APA president Herbert Pardes, M.D., will return as chair of Advances in Research. He has organized a panel of outstanding academic and clinical psychiatric researchers to give state-of-the-art presentations regarding some of the major psychiatric disorders including disorders of children as well as schizophrenia disorders, anxiety disorders, and affective disorders.

Attendees will have the opportunity to be in the vanguard regarding *DSM-5*. Several sessions will give attendees insight into the evolving manual and will solicit their opinions on a number of key questions regarding proposed changes aimed at improving assessment and diagnosis.

There is also a lighter side to learning that we have not ignored. Carrie Fisher, international star of film, television, and stage and acclaimed novelist and playwright will be our Convocation speaker (see page 2). Her autobiographical show "Wishful Drinking" was a hit on Broadway and in regional theaters, and she has a best-selling memoir of the same title. This should be a terrific session.

Richard Kogan, M.D., back by popular demand, will present a piano forum on Chopin. We are also experimenting with evening programming, so join us for CME Media Workshops on "movie nights" (see page 23). George Romero, director of the 1968 classic "Night of the Living Dead," and Steve Schlozman, M.D., will screen and discuss the film "Repulsion" in the session "Isn't All Horror Psychological?" And you can have a rollicking good time at MindGames, where three finalist residency program teams vie for the winner's cup in a Jeopardy-style game show (see page 35).

Look for additional articles in this and future issues of *Psychiatric News* on scientific sessions, special events, and our host city. The Scientific Program Committee has worked hard to craft a program not only taking stock of where we are in 2010 but charting an exciting path to future science and practice.

Start making your plans for New Orleans! ■

Win Free Registration for the 2011 Annual Meeting in Hawaii

Enjoy APA's 2010 annual meeting in New Orleans, and your district branch could win three free registrations to the 2011 annual meeting in Hawaii! Here's how it works: The district branch in each Area with the highest percentage of members attending the 2010 annual meeting in New Orleans will be awarded three free registrations for the 2011 meeting. So encourage colleagues in your Area to attend the 2010 meeting, and watch your district branch newsletter for information on how the free 2011 registrations will be distributed.

6:30 a.m.-9 a.m.
Industry-Supported Breakfast Symposia

7:30 a.m.-6.p.m.
Registration/Course Enrollment Open

8 a.m.-Noon
CME Courses 41-48

9 a.m.-10:30 a.m.
Advances in Medicine

AM01. Delirium: Neurobiology, Prevention, and Treatment Approaches *Chair: Jose R. Maldonado, M.D.*

Case Conference 1
Robert Ursano, M.D., on Posttraumatic Stress Disorder (PTSD)
(Open to APA members only.)

Lectures

L4. Vestermark Award Lecture *Glen O. Gabbard, M.D.*

L5. The Perplexities and Provocations of Eating Disorders *Katherine A. Halmi, M.D.*

Scientific and Clinical Reports
Session 6. Psychotherapy and Depression

SCR16. Sudden Gains in Supportive Expressive Psychotherapy in Depression: A Replication and Extension *Dahlia Mukherjee, M.A.*

SCR17. Short-Term Psychodynamic Psychotherapy Versus Pharmacotherapy Versus Pill Placebo for Major Depressive Disorder in an Urban, Disadvantaged Sample *Jacques Barber, Ph.D.*

SCR18. The Relation of Specific, Common, and Unintended Factors to Outcome in Psychodynamic Therapy for Depression *Kevin McCarthy, M.A.*

Session 7. Borderline Personality Disorder and Emotion Dysregulation

SCR19. Neural Sensitization as a Possible Mechanism of Emotional Reactivity: A Comparison of Borderline and Avoidant Personality Disorder and Healthy Controls *Harold Koenigsberg,Investigator*

SCR20. Short-Term Versus Long-Term Dialectical Behavior Therapy for Patients With Borderline Personality Disorder: Predictors of Response and Elements of Choice *Nader Perroud, M.D.*

SCR21. Dysregulated Brain Networks in the Cognitive Control of Emotion in Borderline Personality Disorder: An fMRI Study *Harold Koenigsberg, M.D.*

Small Interaction Sessions

SI01. *Terence A. Ketter, M.D., on* Diagnosis and Evidence-Based Treatment of Bipolar Disorder (Meet the Author)

SI02. *Dilip V. Jeste, M.D., on* Successful Cognitive and Emotional Aging: How Can We Get There? (Meet the Author)

SI03. *Steven S. Sharfstein, M.D., on* The Crisis of Access to Psychiatrists in an Era of Health Reform

SI04. *Timothy Lineberry, M.D.,* on Suicide and Suicide Risk Assessment: Practical Information and Application

Focus Live 1
Steven B. Levine, M.D., on Disorders of Sleep, Eating, and Sex

New Research Young Investigators' Poster Session 1

Workshops

W59. Interviewing Patients Who Hate or Fear Psychiatrists *Chair: James L. Griffith, M.D.*

W60. Patients as Practice Partners: Catalyzing Recovery Through Collaboration *Chair: Peter Buckley, M.D.*

W61. Disaster Preparedness, Evacuation, and Rebuilding: Lessons Learned From Katrina Applied to Gustav and Ike *Chair: Erich Conrad, M.D.*

W62. The Explosion of Social Media: Why, Where, When, and How Can Psychiatrists Catch Up With the Trend? *APA Council on Communications; Chair: Gabriela Cora, M.D.*

W63. Treating the Aggressive Child and Teen: Integrated Techniques for Management and Intervention *Co-Chairs: Niranjan Karnik, M.D., Hans Steiner, M.D.*

W64. Guided Self-Help, A New Intervention to Overcome Anxiety Complaints *Chair: Christine Van Boeijen, M.D.*

W65. Preventing Late-Life Sequelae Resulting From Early-Life Trauma *Chair: Erikka Dzirasa, M.D.*

W66. Behavioral Complications of Dementia: A Comprehensive Multidisciplinary Treatment Approach *Chair: Sanjay Vaswani, M.D.*

W67. Core Competencies in Europe and the United States of America: An Educational Model *Co-Chairs: Pedro Ruiz, M.D., Deborah Hales, M.D.*

W68. Writing for the 'Blue Journal': The Residents' and Fellows' Edition of the *American Journal of Psychiatry* *Chair: Robert Freedman, M.D.*

W69. A Resident's Guide to Borderline Personality Disorder From the Experts: Part I *Chair: John Gunderson, M.D.* **(Open to residents only.)**

W70. If a Patient Googles Me, What Will They Find?—The Information Age and Its Impact on Residency Training *Co-Chairs: Don Hilty, M.D., Deborah Cabaniss, M.D.*

continued on page 22

9 a.m.-Noon

Advances in Series

A01. Advances in Correctional Psychiatry From Provision of Care to Malpractice Prevention *Chair: Charles Scott, M.D.*

A02. Advances in Psychosomatic Medicine *Chair: James L. Levenson, M.D.*

Presidential Symposium

PS02. Comparative Effectiveness of Psychotropic Drugs: What Can We Learn From Practical Clinical Trials? *American Psychiatric Publishing Inc.; Editorial Board Chair: Jeffrey Lieberman, M.D.*

1. Bipolar Affective Disorder: Lithium Anticonvulsant Comparative Evaluation (BALANCE): An International, Open-Label, Randomized, Clinical Trial *John Geddes, M.D.*
2. Lithium Moderate Dose Study (LiTMUS): A Practical Clinical Trial for Bipolar Disorder *Andrew Nierenberg, M.D.*
3. Practical Clinical Trials in Schizophrenia *T. Scott Stroups, M.D.*
4. Practical Clinical Trials in Child and Adolescent Psychiatry *John Walkup, M.D.*
5. Practical Clinical Trials in Child and Adolescent Psychiatry *John S. March, M.D.*
6. The FDA's Perspective on Comparative Efficacy and Safety *Jing Zhang, M.D.*

Symposium

S42. Update on Medications Development: Promising New Treatments for Drug Addiction *National Institute on Drug Abuse*

A. Modafinil as a Novel Medication in the Treatment of Cocaine Addiction *Charles O'Brien, M.D.*

B. D-Cycloserine in the Treatment of Cocaine and Nicotine Dependence *Kathleen Brady, M.D.*

C. Bupropion for the Treatment of Methamphetamine Addiction *David J. McCann, Ph.D.*

D. Dronabinol for Cannabis Addiction Treatment *Frances R. Levin, M.D.*

E. NicVAX: An Innovative Vaccine Treatment for Nicotine Addiction *Raafat Fahim, Ph.D.*

9 a.m.-4 p.m.

CME Courses 49-55

10 a.m.-12:30 p.m.

Advances in Research *Herbert Pardes, M.D.*

10 a.m.-5:30 p.m.

Exhibits Open
APA Member Center Open
Publishers' Bookfair Open

11 a.m.-12:30 p.m.

Advances in Medicine

AM02. Top 10 Medical Articles of 2009: A Comprehensive and Practical Review of What We Need to Know *Chair: Monique Yohanan, M.D.*

Focus Live 02

Marc Rappaport, M.D., *on* Psychotherapy

Forums

1. Piano Forum—Chopin at 200: His Mind and His Music *Chair: Richard Kogan, M.D.*

2. *DSM-5:* Progress in Research and Development *David J. Kupfer, M.D.*

Lectures

L7. Neuroimaging Clue to the Causes of Bipolar Disorder: Where We Are and Where We Are Going *Stephen M. Strakowski, M.D.*

L8. Optogenetics: Development and Application *Karl Deisseroth, M.D., Frontiers of Science Lecture*

Small Interactive Sessions

SI05. *Donald Goff, M.D., on* Antipsychotic Polypharmacy: An Evidence-Based Perspective

SI06. *Silvia Karasu, M.D., on* The Gravity of Weight: The Impossible Heaviness of Being (Meet the Author)

SI07. *Barbara Coffey, M.D., on* Child Psychopharmacology: SSRIs, Stimulants, and Safety Issues

SI08. *James Rundell, M.D., on* Delirium Assessment and Management

Workshops

W71. American Board of Psychiatry and Neurology Update: Certification in Psychiatry and Its Subspecialties *Chair: Larry R. Faulkner, M.D.*

W72. Transcranial Magnetic Stimulation in Clinical Practice: A Pragmatic Approach to a New Psychiatric Procedure *Chair: Timothy Derstine, M.D.*

W73. To File or Not to File: Guardianship for Older Adults With Dementia *Co-Chairs: Asghar Ali, M.D., Sheila LoboPrabhu, M.D.*

W74. The Vicissitudes of the Doctor-Patient Relationship in Modern Medicine: Endurance, Erosion, or Transformation *Chair: Robert C. Joseph, M.D.*

W75. When Is Psychiatric Illness Terminal? *Co-Chairs: Melinda Henderson, M.D., Kate Payne, J.D.*

W76. Neonaticide: Phenomenology and Prevention *Chair: Renee Sorrentino, M.D.*

W77. Integrating CAM (Complementary Alternative Medicine) in Psychiatric Care: New Paradigms and Perspectives *Chair: Simon Chiu, M.D.*

W78. The Use of Research Measures in Clinical Practice *Chair: Joan Busner, Ph.D.*

W79. Taking It Personal: Integrating Pharmacogenetics Into the Management of Depression *Chair: Sheldon H. Preskorn, M.D.*

W80. Telepsychiatry and the Changing Face of Access for Rural America's Children and Adolescents *APA Council on Children, Adolescents, and Their Families; Chair: L. Charolette Lippolis, D.O.*

W81. Guardianship and Powers of Attorney: Issues in Geriatric Psychiatry *Co-Chairs: David Casey, M.D., Robert Roca, M.D.*

W82. Practical Pharmacotherapy of Mood Disorders *Co-Chairs: Gary Miller, M.D., Richard Noel, M.D.*

Scientific and Clinical Reports

Session 8. Borderline Personality Disorder

SCR22. Gender Differences in the Development of Borderline Personality Disorder *Uday Patil, M.A.*

SCR23. Recurrent Suicide Attempts and Medical Lethality in Borderline Personality Disorder *Paul Soloff, M.D.*

SCR24. Time to Attainment of Recovery From Borderline Personality Disorder and Its Stability: A 10-Year Prospective Follow-Up Study *Mary Zanarini, Ed.D.*

Session 9. Childhood Abuse

SCR25. Clinical Phenomenology of Childhood Abuse–Related Complex PTSD Patients: Differential Patterns of Personality Disturbance *Ethy Dorrepaal, M.D.*

SCR26. Effect of Cognitive-Behavioral Stabilizing Group Treatment on Brain Activity in Childhood Abuse–Related Complex PTSD Patients *Kathleen Thomaes, M.D.*

SCR27. Childhood Maltreatment in Women With Binge Eating Disorder: Associations With Psychiatric Comorbidity, Psychological Functioning, and Eating Pathology *Daniel Becker, M.D.*

Noon-1:30 p.m.

Exhibit Hall Open

Credit: Richard Nowitz / Courtesy New Orleans Convention and Visitors Bureau

Learn From Minority Fellows

APA's minority fellows are featured in the following sessions at APA's 2010 annual meeting in New Orleans:

MAY 22 — SATURDAY
1:30 p.m.- 3 p.m.
Workshop: "Bridging the Cultural Divide: Challenges of First-Generation Immigrants With Children With Mental Illness"
Chair: Steve Koh, M.D.; Co-Chair: Timothy Liu, M.D.
Room 348, Morial Convention Center

MAY 23 — SUNDAY
7:30 a.m.-10 a.m.
National Minority Mentors Network Orientation Breakfast
Kabacoff Room, Hilton New Orleans Riverside

MAY 24 — MONDAY
3:30 p.m.-5 p.m.
Workshop: "Disability or Difference? The Cultural and Clinical Needs of Deaf Patients"
Chair: Neil Aggarwal, M.D.
Room: 335, Morial Convention Center

MAY 25 — TUESDAY
5 p.m.-6:30 p.m.
Poster Session: Minority Fellows' Evening of Excellence
Grand Salon D, Sections 19/22 1st Floor, Hilton New Orleans Riverside

24 MONDAY MAY

12:30 p.m.-2 p.m.
New Research Young Investigators' Poster Session 2

1 p.m.-5 p.m.
CME Courses 57-64

1:30 p.m.-2:30 p.m.
Lectures

L8. Adolf Meyer Award Lecture *Solomon H. Snyder, M.D.*

L9. Your Bipolar Dad Is a Bad Reason to Become a Psychiatrist: Advocacy Adventures of a Bewildered Boy Who Grew Up to Become NAMI's Medical Director *Kenneth S. Duckworth, M.D.*

1:30 p.m.-3 p.m.
Scientific and Clinical Reports
Session 10. Cognitive Disorders

SCR28. Incidence Rates and Probability to Develop Dementia and Alzheimer's Disease in a Southern European City: The Zarademp Project *Antonio Lobo, M.D.*

SCR29. Art and Dementia: Pathological and Clinical Features of Different Subtypes of Dementia, With a Focus on the Changes in Art Production *Laura Safar, M.D.*

SCR30. Metacognitive Capacity Mediates of the Impact of Neurocognitive Deficits on Function in Schizophrenia *Paul Lysaker, Ph.D.*

Session 11. Diagnostic Issues and *DSM-5*

SCR31. Intellectual Disability in *DSM-5 Walter Kaufmann, M.D.*

SCR32. Adding Dimensional Assessments of Psychopathology to Psychiatric Diagnoses: Implications for *DSM-5 William Narrow, M.D.*

SCR33. Nosology for Beginners: Historical and Current Perspectives on the Fundamental Issues and Problems in the Classification of Psychiatric Disorders *Avram Mack, M.D.*

Workshops

W83. Malpractice Defense: Strategies for Success *Co-Chairs: Abe Rychik, J.D., Eugene Lowenkopf, M.D.*

W84. The Psychiatrist's Role in Integrating Primary Care and Behavioral Health Care: Friend or Foe? *Chair: Ruth Shim, M.D.*

2 p.m.-5 p.m.
Focus Live 3
Genetics and Genomics *Co-Chairs: Carlos Pato, M.D., Michele Pato, M.D.*

2 p.m.-5 p.m.
Advances in Series

A03. Advances in Forensic Psychiatry *Chair: Robert I. Simon, M.D.*

A04. Advances in Psychotherapeutic Treatments *Chair: Glen O. Gabbard, M.D.*

Media Workshop

MW3. "Patrik, Age 1.5": A Swedish Film About Unexpected and Gay Adoption *American Academy of Child and Adolescent Psychiatry; Chair: Richard Pleak, M.D.*

Presidential Symposium

PS03. Can Basic and Translational Neuroscience Improve Treatment in Psychiatry? *Co-Chairs: Alan F. Schatzberg, M.D., Karl Deisseroth, M.D.*

1. Translational Studies in Genetics: Genetic Tools in Animal Models to Understand Heritable Risk Factors in Depression and Posttraumatic Stress Disorder *Kerry Ressler, M.D.*

2. Emotion Regulation: Toward a Neurobiological Understanding of Psychotherapy *Amit Etkin, M.D.*

3. Optogenetics: Development and Application *Karl Deisseroth, M.D.*

4. Using Optogenetic Tools and Information Theory to Elucidate Prefrontal Microcircuit Dysfunction in Schizophrenia *Vikaas Sohal, M.D.*

Symposia

S43. Early Detection and Intervention in Schizophrenia: An Idea Whose Time Has Come

A. Early Intervention in Psychiatry: Lessons From Psychosis *Patrick McGorry, M.D.*

B. Why Treating Early, Treating Well, and Treating for Life Is Important in Schizophrenia *Renée Kahn, M.D.*

C. Selective and Indicated Prevention for Schizophrenia: An NIMH Perspective on Current and Future Possibilities *Robert Heinssen, M.D.*

D. Portland Identification and Early Referral (PIER): Prevention of Psychosis as a Public Health Intervention *William McFarlane, M.D.*

E. At Clinical High Risk for Psychosis—What Is the Outcome? *Jean Addinton, Ph.D.*

F. Early Detection and Intervention in Psychotic Disorders: Making It Ready for Prime Time *Jeffrey Lieberman, M.D.*

S44. An Examination of CNS Trial Methodologies

A. Placebo Response Is Not Necessarily Response to Placebo: Factors Inflating Placebo Response in CNS Trials *Armin Szegedi, M.D.*

B. Does De-Coupling of Entry Criteria Improve Outcomes in CNS Trials? *Charlotte Kremer, M.D.*

C. Comparison of Site-Based Versus Centralized Ratings in a Study of Generalized Anxiety Disorder (GAD) *Judith Dunn, Ph.D.*

D. Evaluation of Centralized Ratings in a Clinical Trial of Major Depressive Disorder (MDD) *Steven D. Targum, M.D.*

E. The Use of Independent Assessments for Patient Eligibility for CNS Trials *Maurizio Fava, M.D.*

S45. Interpersonal and Social Rhythm Therapy (IPSRT) for Bipolar Disorder: New Applications, New Populations, and New Evidence

A. Comparison of IPSRT Monotherapy and Quetiapine for the Treatment of Bipolar II Depression: A Proof of Concept Trial *Holly A. Swartz, M.D.*

B. Early Intervention for Adolescent Offspring of Parents With Bipolar Disorder: Pilot Study of Interpersonal and

continued on page 24

At the Movies: Media Workshops

If you are looking for something informative as well as entertaining while at APA's 2010 annual meeting, consider attending the media workshops. They are three-hour sessions in which a feature-length film is shown and discussed. And this year, a number will be held in the evening, giving you a cost-effective option of how to spend your downtime in New Orleans.

MAY 22 — SATURDAY

7 p.m.-10 p.m. **Isn't All Horror Psychological? Horror Film Director George Romero and Steve Schlozman, M.D., Discuss Polanski's Classic Film "Repulsion"**
Chair: Steven Schlozman, M.D.
MW1
Film director and screenwriter George Romero, creator of "Night of the Living Dead," and Steve Schlozman, M.D., will discuss Roman Polanski's classic film "Repulsion." Discussion will focus on the nature of modern horror cinema, the relationship of horror to psychological distress, the techniques that are central to creating classic horror films, and the pitfalls and potential benefits to having psychiatric illness as a central theme in this film genre.

MAY 23 — SUNDAY

7 p.m.-10 p.m. **Voicing the Unspeakable: Reflections on, and Discussion About, Overcoming Loss by Suicide**
Chair: Sally Heckel, B.A.
MW2
On a bright spring morning in May, George Heckel, M.D., climbed the stairs to the attic of his home in Rochester, N.Y., and shot himself. Twenty years later, his daughter, filmmaker Sally Heckel, started making a nonfiction film, "Unspeakable," exploring her father's despondent state of mind and her relationship to this tragic event. Heckel will be joined by psychiatrist Michael Myers, M.D., and writer Carla Fine to talk about overcoming the grief of the death of a loved one by suicide. They are the coauthors of *Touched By Suicide: Hope and Healing After Loss* (Gotham Penguin Books, 2006).

MAY 24 — MONDAY

2 p.m.-5 p.m. **"Patrik, Age 1.5": A Swedish Film About Unexpected and Gay Adoption**
American Academy of Child and Adolescent Psychiatry; Chair: Richard Pleak, M.D.
MW3
"Patrik, Age 1.5" is a 2008 Swedish film that explores issues of child and adolescent adoption by a gay male couple. After a string of disappointments at the adoption agency, Sven and Goran get what appears to be good news in the form of an infant named Patrik, aged 1.5. But one small typo leads to the arrival of a homophobic and very troubled teenaged punk. The presenters, child and adolescent psychiatrists with expertise in LGBT issues, will engage the audience in discussion of the issues raised in this inspiring film.

7 p.m.-10 p.m. **National Disasters: Developing a Road Map for Preparedness and Interventions**
World Psychiatric Association; Chair: Arshad Husain, M.D.
MW4
Although the humanitarian and rescue responses to man-made and natural calamities are universal, abundant, and varied, the evidence-based consensus has been often lacking. The presenters will share information based on their personal experiences and the scientific literature on disaster psychiatry to encourage participants to use evidence-informed approaches to preparedness and interventions in the aftermath of disaster.

MAY 25 — TUESDAY

2 p.m.-5 p.m. **Novel Programs to Promote Mental Wellness in Medical Students**
American Foundation for Suicide Prevention; Chair: Julie Chilton, M.D.; Co-Chair: Leah Dickstein, M.D.
MW5
The FREDDIE award–winning AFSP documentary "Struggling in Silence: Physician Depression and Suicide," underwritten by the American College of Psychiatrists and Wyeth, will be shown, and then suicide-prevention programs initiated at various medical schools will be discussed. Resources will be available that participants can take home to help develop similar programs at their institutions.

7 p.m.-10 p.m. **MW6. "Boy Interrupted"**
Chair: Nancy Rappaport, M.D.; Co-Chair: Joanne Harpel, J.D.
MW6
"Boy Interrupted" is an exploration by two parents who are documentary filmmakers seeking answers after the suicide of their son at age 15. Dana Perry gathered home movies, photographs, and a variety of different documents to tell the story of her son, Evan: his bipolar illness, his life, and his death, and the impact on those who loved him the most. Rappaport, Perry, and Joanne Harpel of the AFSP will lead a discussion about how this movie can shape psychiatric practice, and Rappaport will speak about the fragile alliance between the teenager and the child psychiatrist.

MAY 26 — WEDNESDAY

9 a.m.-Noon **Building Bridges: The Intersection Between Faith and Mental Health**
Chair: Asghar-Ali Ali, M.D.; Co-Chair: Cecil Webster, M.D.
MW7
APA's Practice Guideline for the Psychiatric Evaluation of Adults now includes a recommendation for a sensitive evaluation of the patient's religious/spiritual beliefs and any important religious influences in the patient's life. APA's Office of Minority and National Affairs recommends several strategies to reduce mental health disparities in diverse ethnic groups. One is to address stigma through programs and foster collaborations between mental health professionals and faith and community leaders. This workshop will educate participants on using the media to address stigma.

2 p.m.-5 p.m. **Rachel Is Getting Married, Kym Is Getting Sober, Everyone Is Losing It**
American Academy of Addiction Psychiatry; Chair: Petros Levounis, M.D.
MW8
In "Rachel Getting Married," director Jonathan Demme introduces viewers to a world of interpersonal destruction and reconstitution in the context of a family reunion. Kym, the identified family problem, gets a pass from an inpatient addiction rehabilitation center to attend the wedding of her sister Rachel, the trained psychotherapist. Workshop discussants will propose a psychodynamic formulation of Kym based on the complex relationships in the film. The discussants will also explore the role of the psychotherapist in addressing problems in her or his own life as reflected in Rachel's dilemmas.

Social Rhythm Therapy (IPSRT) *Tina Goldstein, Ph.D.*

C. Interpersonal and Social Rhythm Therapy for Adolescents With Bipolar Disorder: Treatment Development and Results From an Open Trial *Stefanie A. Hlastala, Ph.D.*

D. IPSRT for Bipolar Disorder in the Perinatal Period *Suzanne Luty, Ph.D.*

S46. Ensuring a Public Health Impact: Partnering With Consumers and Community Stakeholders to Improve Access and Quality of Care for Mental Disorders

A. A Public Health Initiative to Address Depression and Posttraumatic Stress Disorder in a Post-Disaster Setting *Benjamin Springgate, M.D.*

B. CBPR in the Arkansas Delta: Developing an Implementation Partnership With Rural Underserved Community Health Centers *Justin B. Hunt, M.D.*

C. A Partnership for Wellness: Addressing Stress and Violence in West and Southwest Philadelphia *Glenda Wrenn, M.D.*

D. GROOVI Care: A Community Coalition to Engage With Veterans of Operations Enduring Freedom and Iraqi Freedom (OEF/OIF) About Their Mental Health *Patrick E. Link, M.D.*

E. Using a Community-Partnered Participatory Research Approach to Implement a Randomized, Controlled Trial: Designing of Community Partners in Care *Bowen Chung, M.D.*

S47. New Studies Appear in the June *American Journal of Psychiatry*—Presentations by the Authors and Editors

S48. Reducing Harm: Safer Injection and Other Strategies

A. Creating An Inclusive Drug Strategy: The Experience of Establishing Vancouver's Supervised Injection Site *Liz Evans, B.S.N.*

S49. Advances in the Treatment of Bipolar Disorder

A. Advances in Maintenance Treatment of Bipolar Disorder *Terence A. Ketter, M.D.*

B. Advances in Treatment of Bipolar Depression *Po W. Wang, M.D.*

C. Treatment of Children and Adolescents With Bipolar Disorder *Kiki Chang, M.D.*

D. Treatment of Pregnant Women With Bipolar Disorder *Katherine E. Williams, M.D.*

E. Management of Bipolar Disorders in Older Adults *John Brooks, Ph.D.*

S50. Challenges in Providing Mental Health Care for College and University Students *APA Council on Children, Adolescents, and Their Families*

A. The Magnitude of Clinical Demands *Jerald Kay, M.D.*

B. Discussant *Victor I. Schwartz, M.D.*

C. Psychiatric Hospitalization and Follow-Up Care of the College Student *Rachel L. Glick, M.D.*

D. Violence Assessment and Administrative Responses *Gregory T. Eells, Ph.D.*

E. Managing the Suicidal College Student *Morton Silverman, M.D.*

S51. Geriatric Psychopharmacology of Late-Life Mood Disorders: Focus on the Use of Biomarkers as Predictors of Response

A. Psychopharmacology of Geriatric Depressions: The Use of Aging Biomarkers to Predict Treatment Response *Helen Lavretsky, M.D.*

B. Geriatric Bipolar Disorder: Clinical Diagnosis and Treatment *Martha Sajatovic, M.D.*

C. The Use of Structural MRI as a Predictor of Antidepressant Response in Older Adults *Yvette Sheline, M.D.*

S52. Innovations in Integrated Treatment of Substance Use and Psychiatric Disorders *National Institute on Drug Abuse*

A. Integrated Treatment of Depression and Substance Use Disorders in Adolescents *Paul Rohde, Ph.D.*

B. Posttraumatic Stress Disorder and Drug Abuse: Etiology and Treatment Linkages *Kathleen Brady, M.D.*

C. Integrated Group Therapy for Patients With Co-Occurring Bipolar Disorder and Substance Use Disorder *Roger D. Weiss, M.D.*

D. Advances in Pharmacotherapy for Comorbid Depression and Addictions *Edward V. Nunes, M.D.*

E. Treatment of Cannabis Use Disorder in Patients With Schizophrenia *Alan I. Green, M.D.*

S53. Genotypes and Biomarkers—The New Decision Makers for Tailored Treatment

A. Introduction to Session *Florian Holsboer, M.D., Ph.D.*

B. Genetic and Other Biomarkers of Antidepressant Outcome *Francis McMahon, M.D.*

C. Individualized Antipsychotic Therapy for Schizophrenic Patients *Edwin J.C.G. van den Oord, Ph.D.*

D. Gene Expression Profile in Persons Exposed to the WTC With and Without PTSD *Rachel Yehuda, Ph.D.*

S54. Substance Related Disorders in *DSM-5:* Progress Report

A. The Search for Specific Criteria: A Report From the Criterion Subcommittee *Marc Schuckit, M.D.*

B. Abuse and Dependence: Combining the Disorders Into a Single Category *Deborah S. Hasin, Ph.D.*

C. Non Substance-Related Addictions: Their Place in *DSM-5 Nancy M. Petry, Ph.D.*

D. Terminology of Substance Use Disorders for *DSM-5 Wilson M. Compton III, M.D.*

E. Severity of Substance Use Disorders *Thomas J. Crowley, M.D.*

S55. *DSM-5* Update Series, Part I: Reports From the Work Groups

A. Approaches to the Diagnosis and Classification of Eating Disorders in *DSM-5 B. Timothy Walsh, M.D.*

B. Key Recommendations From the *DSM-5* Sexual and Gender Identity Disorders Work Group *Kenneth J. Zucker, Ph.D.*

C. Update From the Somatic Symptoms Work Group *Joel E. Dimsdale, M.D.*

D. Toward a Better, Practical Understanding of Sleep Disturbances in People Living With or at Risk for Mental Illness *Charles Reynolds, M.D.*

E. Neurocognitive Disorders in *DSM-5 Dilip V. Jeste, M.D.*

S56. Focal Brain Stimulation for Psychiatric Disorders: Clinical Update

A. The Clinical Safety and Efficacy of Transcranial Magnetic Stimulation: Results From Recent Pivitol Clinical Trials *William M. McDonald, M.D.*

B. Clinical Update on Magnetic Seizure Therapy (MST) *Sarah H. Lisanby, M.D.*

C. Clinical Update on Vagus Nerve Stimulation (VNS) *Linda L. Carpenter, M.D.*

D. The Promise of Direct Epidural Cortical Stimulation (DCS) in Refractory MDD: The PROSPECT Experience and Future Directions *Jerry L. Halverson, M.D.*

E. Deep Brain Stimulation for Psychiatric Disorders: Clinical Update *Paul Holtzheimer, M.D.*

S57. Depression, Metabolic Syndrome, and Obesity

A. Depression and Abdominal Obesity *Brenda Penninx, Ph.D.*

B. Depression and Diabetes: A Potentially Lethal Comorbidity *Wayne J. Katon, M.D.*

C. Brain Correlates of Comorbid Diabetes and Geriatric Depression *Anand Kumar, M.D.*

D. Depression Is Associated With Increased Severity of Comorbidities in Bariatric Surgical Candidates *Mohamed R. Ali, M.D.*

E. Should Mood Syndromes Be Reclassified as Metabolic Syndrome Type II? *Roger S. McIntyre, M.D.*

S58. Neurobiology of Obesity: Why We Can Get Too Motivated to Eat *National Institute on Drug Abuse; Chair: Joseph Frascella, Ph.D.*

A. Overview of Why We Eat Too Much *David Kessler, M.D.*

B. Central Control of Food Intake: Appetite Control and the Reward Driven *Hans-Rudolf Berthoud, Ph.D.*

C. Sweetness as a Super Reward: Comparison With Cocaine and Heroin *Serge Ahmed, Ph.D.*

D. Individual Differences in the Neurophysiology of Reward and the Obesity Epidemic *Dana Small, Ph.D.*

E. Neurocircuitry of Addiction and Obesity *Nora D. Volkow, M.D.*

3 p.m.-5 p.m.

New Research Poster Session 3

3:30 p.m.-5 p.m.

Scientific and Clinical Reports

Session 12. Psychosomatics and Cardiac Vulnerability

SCR34. Sex Differences in the SADHART CHF Trial *Jonathan Lee, M.D.*

SCR35. Psychosomatic Medicine and the Philosophy of Life *Michael Schwartz, M.D.*

SCR36. Broken Hearts: Cardiovascular and Emotional Stress Measures in Relocated Katrina Survivors *Phebe Tucker, M.D.*

Session 13. Addictive Behavior

SCR37. Disparities in Substance Abuse Prevalence: Is It Time to Strategize and Refocus? *Deepak Prabhakar, M.D.*

SCR38. Pathological Gambling: An Impulse Control Disorder? Measurement of Impulsivity Through Neurocognitive Tests *Pinhas Dannon, M.D.*

SCR39. Quitting Cannabis Use Without Formal Treatment in Adults *David Gorelick, M.D.*

Workshops

W85. Teaching Psychiatry in New Medical Schools *Chair: Marcia Verduin, M.D.*

W86. Deafness—Disability or Difference? The Cultural and Clinical Needs of Deaf Patients *APA/SAMHSA Minority Fellows; Co-Chairs: Neil Aggarwal, M.D., Christopher Tjoa, M.D.*

5:30 p.m.-6:30 p.m.

Convocation of Distinguished Fellows *Carrie Fisher, William C. Menninger Memorial Lecture*

7 p.m.-10 p.m.

Media Workshop

MW4. National Disasters: Developing a Road Map for Preparedness and Interventions *World Psychiatric Association; Chair: Arshad Husain, M.D.* ■

Credit: Jack Edwards / Courtesy New Orleans Convention and Visitors Bureau

7:30 a.m.-6.p.m.
Registration/Course Enrollment Open

8 a.m.-Noon
CME Courses 65-67

8 a.m.-5 p.m.
CME Course 68

9 a.m.-10:30 a.m.
Advances in Medicine

AM03. Movement Disorders in Psychiatric Patients *Chair: Laura Marsh, M.D.*

Case Conference 2
Michael Myers, M.D., on Death of a Physician by Suicide
(Open to APA members only.)

Forum

F03. Is a Game-Changing Psychotropic Too Much to Expect? *Phil Ninan, M.D.*

Lectures

L11. Addiction: Conflict Between Brain Circuits *Nora D. Volkow, M.D., Frontiers of Science Lecture*

L12. From Circuits to Cells to Molecular Regulation: Identifying Novel Targets for the Treatment of Psychotic Disorders *Francine M. Benes, M.D.*

Scientific and Clinical Reports
Session 14. Anxiety Disorders

SCR40. The Long-Term Treatment of Obsessive-Compulsive Disorder *Afia Sadiq, M.D.*

SCR41. Acute Treatment of Panic Disorder With Clonazepam or Paroxetine: A Randomized, Naturalistic Open Study *Antonio Nardi, M.D.*

SCR42. Recurrence of Panic Attacks Following Medication Discontinuation *Svetoslav Hristov, M.D.*

Small Interactive Sessions

SI09. *Sheldon Benjamin, M.D., on* Neuropsychiatric Assessment for General Psychiatrists

SI10. *Mina K. Dulcan, M.D., on* What's New in Child and Adolescent Psychiatry? (Meet the Author)

SI11. *Philip R. Muskin M.D., on* Requests to Evaluate Patients' Decisional Capacity in the Medical Setting: What Are They Really Asking For?

SI12. *Carol C. Nadelson M.D., on* Career Development for Women Psychiatry Residents—Challenges and Solutions
(Open to APA resident members only.)

SI13. *Jarrett W. Richardson M.D., on* Psychiatric Issues in Palliative Care

Workshops

W87. Aging Heroically in An Urban Setting: The Diary of Jessie Sylvester The Beautiful Hills of Brooklyn *Chair: David Preven, M.D.*

W88. Transcranial Magnetic Stimulation (TMS) in the Treatment of Major Depression: A New Therapeutic Tool for Psychiatry *Chair: John P. O'Reardon, M.D.*

W89. Understanding CPT Coding and How Fees Are Calculated *APA Committee on RBRVS, Codes, and Reimbursement; Chair: Ronald Burd, M.D.*

W90. Practical Challenges for Psychiatrists Implementing the Recovery Model *Chair: Mark Ragins, M.D.*

W91. Cognitive-Behavioral and Psychodynamic Approaches to Medication Adherence in Severe Mental Illness *Co-Chairs: Jesse Wright, M.D., Glen O. Gabbard, M.D.*

W92. CAM or sCAM for Mood Disorders: Herbals and Beyond! *Co-Chairs: Vishal Madaan, M.D., Diana Domnitei, M.D.*

9 a.m.-Noon
Advances In Series 5

A05. Family Assessment and Intervention for Psychiatrists *Chair: Gabor I. Keitner, M.D.*

Advances In Series 6

A06. Advances in the Use of Antipsychotic Medications *Co-Chairs: Anthony J. Rothschild, M.D., Kristina Deligiannidis, M.D.*

Presidential Symposia

PS04. Recent Advances in Psychiatric Genetics: From Fundamental Discovery to Clinical Implication *Co-Chairs: Alan Schatzberg, M.D., Solomon Snyder, M.D.*

1. Opportunities and Pitfalls in Psychiatric Genetics in 2010: Clinical Implications *Douglas F. Levinson, M.D.*
2. The Genetics of Autism *Daniel Geschwind, M.D.*
3. A TOMM-40 Variable Length polyT Repeat Polymorphism, Inherited

continued on page 26

Through Evolution, Determines the Age of Onset Distribution of Late-Onset Alzheimer's Disease *Allen Roses, M.D.*

4. New Directions in the Genetics of Bipolar Disorder *Pamela Sklar, Ph.D.*

5. Progress in Schizophrenia Genetics *Patrick F. Sullivan, M.D.*

6. Genomics of Ethnic Minority Groups: Pharmacogenomics of Depression in Mexican Americans *Julio Licinio, M.D.*

PS05. Health Reform and Psychiatry *Chair: Steven S. Sharfstein, M.D.*

1. What Will Be the Role of the Public Sector Following Health Reform? *Howard H. Goldman, M.D.*

2. The Impact of Health Reform on Inpatient and Outpatient Psychiatric Practice *Steven S. Sharfstein, M.D.*

3. Health Care Reform: An Academic Exercise? *Anthony Lehman, M.D.*

4. The Role of Managed Care in Health Care Reform *Henry Harbin, M.D.*

5. The Impact of Health Reform on Psychotherapy by Psychiatrists *Eric M. Plakun, M.D.*

Symposia

S59. Psychiatrists in the World: Advocating for LGBT Mental Health

A. The Psychiatrist as Advocate: The Case of AGLP *Mary Barber, M.D.*

B. The GAP Online Curriculum on LGBT Mental Health *Serena Y. Volpp, M.D.*

C. The Psychiatrist as Advocate: The Case of AGLP *Ubaldo Leli, M.D.*

D. The GAP Online Curriculum on LGBT Mental Health *Vernon A. Rosario, M.D.*

E. A Picture's Worth a Thousand Words: Using Film for Mental Health Advocacy and Activism *Alicia Salzer, M.D.*

F. Talking to the Media: Teaching Psychiatrists to Embrace the Sound Bite *Jack Drescher, M.D.*

S60. The Public Health and Clinical Interface Between HIV, STDs, and Mental Health

A. The Public Health Interface Between HIV, Sexually Transmitted Diseases, and Mental Illness *Marc Safran, M.D.*

B. The Clinical Interface Between HIV, Sexually Transmitted Diseases, and Mental Illness *Marshall Forstein, M.D.*

C. The Impact of Neuropsychiatric Syndromes on the Course of Treatment in HIV *Stephen Ferrando, M.D.*

S61. Adolescent Potential: Exploring the Developing Brain and Understanding Pathways of Addiction *National Institute on Drug Abuse*

A. The Developing Brain, Adolescence, and Alcohol/Drug Use: An Evolutionary Approach *Linda Spear, Ph.D.*

B. The Teen Brain: Insights From Neuroimaging *Jay N. Giedd, M.D.*

C. Vulnerabilities in Adolescent Decision Making: Neuroimaging Evidence of Immaturities in Cognitive Control, Reward Processing, and Brain Connectivity *Beatriz Luna, Ph.D.*

D. Brain Functioning in Adolescent Substance Using Boys and Girls *Susan F. Tapert, Ph.D.*

S62. The 2010 APA Task Force Report on the Practice of Electroconvulsive Therapy: Evidence-Based Guidelines for the Practicing Clinician *APA Council on Research and Quality Care*

A. The History of the Classification of ECT and the Challenges for the Future *Richard Weiner, M.D.*

B. The Medical Evaluation and Consent Process for Patients Undergoing ECT *Husain Mustafa, M.D.*

C. Optimal Electrode Placement in the Administration of ECT *Sarah H. Lisanby, M.D.*

D. Emerging Data on the Importance of Pulse Width in ECT *Joan Prudic, M.D.*

E. Maintenance Treatment in ECT *Charles Kellner, M.D.*

S63. *DSM-5* Examined: Nosology of Mood Disorders

A. How Do We Classify the Mood Disorders? *Michael A. Schwartz, M.D.*

B. Depression: When Sadness Is "Lost," What Is Gained? *Peter D. Kramer, M.D.*

C. Pediatric Bipolar Disorder: More Than a Social Construction, Less Than a Natural Kind *Peter Zachar, Ph.D.*

D. Major Depressive Disorder Deconstructed: Neurotic Depression and Mixed States *S. Nassir Ghaemi, M.D.*

E. An Update From the *DSM-5* Work Group on Mood Disorder: A Focus on Bipolar Symptoms *Trisha Suppes, M.D.*

S64. *DSM-5* Update Series, Part II: Reports From the Work Groups

A. Balancing Conservation and Innovation in *DSM-5:* Update on Attention-Deficit/Hyperactivity Disorder *F. Xavier Castellano, M.D.*

B. Reconsidering the Disruptive Behavior Disorders for *DSM-5 David Shaffer, M.D.*

C. Developing a New Model of Personality Disorders for *DSM-5 Andrew E. Skodol, M.D.*

S65. Revisiting Pharmacological Treatments to Prevent Suicide

A. The Evidence for and Potential Impact of Clozapine on Suicide Risk in Schizophrenia: So How Do We Get Psychiatrists to Prescribe It? *Herbert Y. Meltzer, M.D.*

B. Mortality in Schizophrenia: An 11-Year Follow-Up Study of the Total Finnish Population (Fin11 Study) *Kristian Wahlbeck, M.D.*

C. Association Between Consistent Purchase of Anticonvulsants or Lithium and Suicide Risk: A Longitudinal Cohort Study From Denmark, 1995-2001 *Eric Smith, M.D., M.P.H.*

D. Translating Suicide Endophenotypes Shared Between Humans and Mice: Novel Strategies to Understand the Mechanism Underlying Lithium's Anti-Suicidal Efficacy *Todd D. Gould, M.D.*

S66. Reward Neurocircuitry in Substance Dependence and Other Psychiatric Disorders: What Does Brain Research Tell Us? *National Institute on Drug Abuse*

A. Reward Neurocircuitry in Preclinical Models: Foundations and Alterations With Drug Use *Susan R. Sesack, Ph.D.*

B. Functional Neuroimaging of Neural Circuits Regulating Aversive Emotional Reactions and Expectations of Reward *Mauricio Delgado, Ph.D.*

C. Neuroimaging Studies of Reward Processing in Major Depressive Disorder *Wayne C. Drevets, M.D.*

D. Association of Nicotine Addiction and Nicotine's Actions With Separate Cingulate Cortex Functional Circuits *Elliot Hong, M.D.*

E. PET Evaluation of Neurocircuitry Related to Etiology and Treatment of ADHD *James M. Swanson, Ph.D.*

9 a.m.-4 p.m.

CME Courses 69-74

10 a.m.-6 p.m.

Exhibits Open
APA Member Center Open
Publishers' Bookfair Open

11 a.m.-12:30 p.m.

Advances in Medicine

AM04. Aging and Dementia: An Update on Neuroscience and Brain Imaging *Anne L. Foundas, M.D.*

Case Conference

S. Charles Schulz, M.D., on Helping Parents of a First-Episode Psychotic Patient
(Open to APA members only.)

Lectures

L13. Highlights and Lessons From 40 Years in Psychiatry *Eve C. Johnstone, M.D.*

L14. Comorbidity of Psychiatric Disorders *Ronald C. Kessler, Ph.D.*

Small Interactive Sessions

SI14. *Elissa P. Benedek M.D., on* Principles and Practice of Child and Adolescent Forensic Mental Health (Meet the Author) *National Institute on Drug Abuse*

SI15. *Nora D. Volkow, M.D., on* Addiction and the Brain

SI16. *Paul S. Sppelbaum, M.D., on* Ethical Issues in Psychiatry

SI17. *David Mrazek, M.D., on* Psychiatric Pharmacogenomics

SI18. *Elspeth C. Ritchie M.D., on* Psychiatric Issues Related to Returning Vets From Iraq and Afghanistan

Scientific and Clinical Reports
Session 15. Information Technology

SCR43. Web-Based Access to Medicaid Data to Support the Implementation of Best Practices in Pharmacotherapy in a Large-Scale Quality Improvement Initiative *Molly Finnerty, M.D.*

SCR44. PSYCKES: Web-Based Access to Medicaid Data to Support the Implementation of Best Practices in Pharmacotherapy in a Large-Scale Quality *Matthew Perkins, M.D.*

SCR45. International Telepsychiatry in Cross-Cultural Related Mental Health Care *Davor Mucic, M.D.*

Session 16. Side Effects of Psychotropic Medication

SCR46. Risk of Low Bone Mineral Density Associated With Psychotropic Medications and Mental Disorders: A Population-Based Analysis *James Bolton, B.S.C., M.D.*

SCR47. Metabolic Syndrome in Psychiatric Inpatients: The Role of Valproate and Lithium *Bonnie Szarek, R.N.*

SCR48. A Novel, Patient-Rated Scale for Side Effects: Prospective Proof of Concept Study *Rajnish Mago, M.D.*

Workshops

W93. Ethical Dilemmas in Psychiatric Practice *Ethics Committee Chair: Wade Myers, M.D.*

W94. Boundary Crossings as Boundary Accommodations: The Physician/Patient Relationship With Medically Ill Patients *Chair: James Lomax, M.D.*

W95. A Resident's Guide to Borderline Personality Disorder: From the Experts (Part II) *Chair: John Gunderson, M.D.* **(Open to residents only.)**

W96. Psychiatric Professional Liability 2009: The Year in Review *Co-Chairs: Donna Vanderpool, J.D., Martin Tracy, J.D.*

W97. The Train Has Left the Station: National Incentives and Developments in Electronic Health Records *Chair: Laura Fochtmann, M.D.*

W98. Cognitive Therapy for Psychosis in Practice: Basic Techniques for Psychiatrists *Chair: Shanaya Rathod, M.D.*

Noon-2 p.m.

New Research Poster Session 4

1 p.m.-5 p.m.

CME Courses 75-76

1:30 p.m.-3 p.m.

Advances in Medicine

AM05. Medical Mysteries and Practical Medical Psychiatric Updates: Is It Medical, Psychiatric, or a Little of Both? *Chair: Robert M. McCarron, D.O.*

Lectures

L15. Outside Lecture *Andrew T. McClellan, Ph.D., National Institute on Drug Abuse*

L16. Oskar Pfister Award Lecture *George E. Vaillant, M.D.*

Scientific and Clinical Reports
Session 17. Weight Gain and Psychiatric Illness

SCR49. Biochemical Risk Factors for Development of Obesity in First-Episode Schizophrenia *Robert Bodén, M.D.*

SCR50. Relationship Between Cholesterol Levels and Cognitive Function in Patients With Schizophrenia Randomized to Clozapine, Olanzapine, and Haloperidol *Menahem Krakowski, M.D.*

SCR51. Oatmeal v. Donuts: Treating Metabolic Syndrome/Obesity Using CBT/DBT in an Inner-City SPMI Population *Joanne Caring, M.D.*

continued on page 32

Treat your patients with the demonstrated efficacy of LEXAPRO[1-7]

In adolescents aged 12 to 17 with Major Depressive Disorder (MDD)[1]

In adults with MDD and Generalized Anxiety Disorder (GAD)[1]

In older adults with MDD and GAD[1]

Lexapro escitalopram oxalate®

WARNING: SUICIDALITY AND ANTIDEPRESSANT DRUGS

Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of Lexapro or any other antidepressant in a child, adolescent or young adult must balance this risk with the clinical need. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction in risk with antidepressants compared to placebo in adults aged 65 and older. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. Lexapro is not approved for use in pediatric patients less than 12 years of age.

Please see additional Important Safety Information on following pages.

There is no generic available for LEXAPRO

- Significantly improved MDD symptoms in adolescents[2]

Lexapro (escitalopram oxalate) is indicated for the acute and maintenance treatment of major depressive disorder (MDD) in adults and adolescents aged 12-17 years. Lexapro is also indicated for the acute treatment of generalized anxiety disorder (GAD) in adults.

IMPORTANT SAFETY INFORMATION (continued)

Contraindications

- Lexapro is contraindicated in patients taking monoamine oxidase inhibitors (MAOIs). There have been reports of serious, sometimes fatal, reactions with some cases resembling neuroleptic malignant syndrome (NMS) and serotonin syndrome. Features may include hyperthermia, rigidity, myoclonus, autonomic instability with possible rapid fluctuations of vital signs, and mental status changes that include extreme agitation progressing to delirium and coma. These reactions have also been reported in patients who have recently discontinued SSRI treatment and have been started on an MAOI. Serotonin syndrome was reported for two patients who were concomitantly receiving linezolid, an antibiotic which has MAOI activity. Lexapro should not be used in combination with an MAOI or within 14 days of discontinuing an MAOI. MAOIs should not be initiated within 14 days of discontinuing Lexapro.
- Lexapro is contraindicated in patients taking pimozide or with hypersensitivity to escitalopram or citalopram.

Warnings and Precautions

- All patients treated with antidepressants should be monitored appropriately and observed closely for clinical worsening, suicidality and unusual changes in behavior, especially within the first few months of treatment or when changing the dose. Consideration should be given to changing the therapeutic regimen, including discontinuing medication, in patients whose depression is persistently worse, who are experiencing emergent suicidality or symptoms that might be precursors to worsening depression or suicidality, especially if these symptoms are severe, abrupt in onset, or were not part of the patient's presenting symptoms. Families and caregivers of patients treated with antidepressants should be alerted about the need to monitor patients daily for the emergence of agitation, irritability, unusual changes in behavior, or the emergence of suicidality, and report such symptoms immediately. Prescriptions for Lexapro should be written for the smallest quantity of tablets, consistent with good patient management, in order to reduce the risk of overdose.

- Significantly higher rates of response and remission vs placebo in MDD and GAD in adults[4,7]
- Maintains long-term relief in MDD and demonstrated efficacy in GAD in older adults*[5,6]

- A major depressive episode may be the initial presentation of bipolar disorder. In patients at risk for bipolar disorder, treating such an episode with an antidepressant alone may increase the likelihood of precipitating a mixed/manic episode. Prior to initiating treatment with an antidepressant, patients should be adequately screened to determine if they are at risk for bipolar disorder. Lexapro should be used cautiously in patients with a history of mania or seizure disorder. Lexapro is not approved for use in treating bipolar depression.
- The concomitant use of Lexapro with other SSRIs, SNRIs, triptans, tryptophan, antipsychotics or other dopamine antagonists is not recommended due to potential development of life-threatening serotonin syndrome or neuroleptic malignant syndrome (NMS)-like reactions. Reactions have been reported with SNRIs and SSRIs alone, including Lexapro, but particularly with drugs that impair metabolism of serotonin (including MAOIs). Management of these events should include immediate discontinuation of Lexapro and the concomitant agent and continued monitoring.
- Patients should be monitored for adverse reactions when discontinuing treatment with Lexapro. During marketing of Lexapro and other SSRIs and SNRIs, there have been spontaneous reports of adverse events occurring upon discontinuation, including dysphoric mood, irritability, agitation, dizziness, sensory disturbances (e.g., paresthesias), anxiety, confusion, headache, lethargy, emotional lability, insomnia and hypomania. A gradual dose reduction rather than abrupt cessation is recommended whenever possible.

Please see Boxed Warning on first page and additional Important Safety Information on next page.

*In controlled registration trials in MDD and GAD, approximately 6% of the 1144 patients receiving escitalopram were aged 60 years or older. The number of elderly patients in these trials was insufficient to adequately assess for possible differential efficacy and safety measures on the basis of age. Nevertheless, greater sensitivity to the effects of LEXAPRO cannot be ruled out in some elderly individuals. The recommended dose for most elderly patients is 10 mg/day.

Lexapro®
escitalopram oxalate

Visit the LEXAPRO website at www.lexapro.com

LEXAPRO: Proven efficacy in MDD in adolescents aged 12 to 17, and in MDD and GAD in adults[1-7]

Warnings and Precautions (continued)

- SSRIs and SNRIs have been associated with clinically significant hyponatremia. Elderly patients and patients taking diuretics or who are otherwise volume-depleted appear to be at a greater risk. Discontinuation of Lexapro should be considered in patients with symptomatic hyponatremia and appropriate medical intervention should be instituted.
- SSRIs (including Lexapro) and SNRIs may increase the risk of bleeding. Patients should be cautioned that concomitant use of aspirin, NSAIDs, warfarin or other anticoagulants may add to the risk.
- Patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that Lexapro does not affect their ability to engage in such activities.
- Lexapro should be used with caution in patients with severe renal impairment or with diseases or conditions that alter metabolism or hemodynamic responses. In subjects with hepatic impairment, clearance of racemic citalopram was decreased and plasma concentrations were increased. The recommended dose of Lexapro in hepatically impaired patients is 10 mg/day.
- For pregnant or nursing mothers, Lexapro should be used only if the potential benefit justifies the potential risk to the fetus or child.

Adverse Reactions

- In clinical trials of MDD, the most common adverse reactions in adults treated with Lexapro (approximately 5% or greater and at least twice the incidence of placebo) were nausea (15% vs 7%), insomnia (9% vs 4%), ejaculation disorder (9% vs <1%), fatigue (5% vs 2%), somnolence (6% vs 2%), and increased sweating (5% vs 2%). In pediatric patients, the overall profile of adverse reactions was similar to that seen in adults; however, the following additional adverse reactions were reported at an incidence of at least 2% for Lexapro and greater than placebo: back pain, urinary tract infection, vomiting, and nasal congestion.
- In clinical trials of GAD, the most common adverse reactions in adults treated with Lexapro (approximately 5% or greater and at least twice the incidence of placebo) were nausea (18% vs 8%), ejaculation disorder (14% vs 2%), insomnia (12% vs 6%), fatigue (8% vs 2%), decreased libido (7% vs 2%) and anorgasmia (6% vs <1%).

Please see accompanying brief summary of prescribing information for LEXAPRO, including Boxed Warning.

References: 1. LEXAPRO [package insert]. St. Louis, Mo: Forest Pharmaceuticals, Inc.; 2009. **2.** Emslie GJ, Ventura D, Korotzer A, Tourkodimitris S. Escitalopram in the treatment of adolescent depression: a randomized placebo-controlled multisite trial. *J Am Acad Child Adolesc Psychiatry*. 2009;48:721-729. **3.** Burke WJ, Gergel I, Bose A. Fixed-dose trial of the single isomer SSRI escitalopram in depressed outpatients. *J Clin Psychiatry*. 2002;63:331-336. **4.** Davidson JRT, Bose A, Korotzer A, Zheng H. Escitalopram in the treatment of generalized anxiety disorder: double-blind, placebo controlled, flexible-dose study. *Depress Anxiety*. 2004;19:234-240. **5.** Gorwood P, Weiller E, Lemming O, Katona C. Prevention of relapse in older patients with major depressive disorder by escitalopram treatment. Poster presented at: 5th International Forum on Mood and Anxiety Disorders; November 9-11, 2005; Vienna, Austria. **6.** Lenze EJ, Rollman BL, Shear MK, et al. Escitalopram for older adults with generalized anxiety disorder: a randomized controlled trial. *JAMA*. 2009; 301:295-303. **7.** Wade A, Lemming OM, Hedegaard KB. Escitalopram 10 mg/day is effective and well tolerated in a placebo-controlled study in depression in primary care. *Int Clin Psychopharmacol*. 2002;17:95-102.

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Lexapro® escitalopram oxalate

LEXAPRO® (escitalopram oxalate) TABLETS/ORAL SOLUTION **Rx Only**

Brief Summary: For complete details, please see full Prescribing Information for Lexapro.

WARNINGS: SUICIDALITY AND ANTIDEPRESSANT DRUGS

Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of Lexapro or any other antidepressant in a child, adolescent, or young adult must balance this risk with the clinical need. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction in risk with antidepressants compared to placebo in adults aged 65 and older. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. Lexapro is not approved for use in pediatric patients less than 12 years of age. *[See Warnings and Precautions: Clinical Worsening and Suicide Risk, Patient Counseling Information: Information for Patients, and Used in Specific Populations: Pediatric Use].*

INDICATIONS AND USAGE: Major Depressive Disorder-Lexapro (escitalopram) is indicated for the acute and maintenance treatment of major depressive disorder in adults and in adolescents 12 to 17 years of age [*see Clinical Studies*]. A major depressive episode (DSM-IV) implies a prominent and relatively persistent (nearly every day for at least 2 weeks) depressed or dysphoric mood that usually interferes with daily functioning, and includes at least five of the following nine symptoms: depressed mood, loss of interest in usual activities, significant change in weight and/or appetite, insomnia or hypersomnia, psychomotor agitation or retardation, increased fatigue, feelings of guilt or worthlessness, slowed thinking or impaired concentration, a suicide attempt or suicidal ideation. **Generalized Anxiety Disorder**-Lexapro is indicated for the acute treatment of Generalized Anxiety Disorder (GAD) in adults [*see Clinical Studies*]. Generalized Anxiety Disorder (DSM-IV) is characterized by excessive anxiety and worry (apprehensive expectation) that is persistent for at least 6 months and which the person finds difficult to control. It must be associated with at least 3 of the following symptoms: restlessness or feeling keyed up or on edge, being easily fatigued, difficulty concentrating or mind going blank, irritability, muscle tension, and sleep disturbance.

CONTRAINDICATIONS: Monoamine oxidase inhibitors (MAOIs)-Concomitant use in patients taking monoamine oxidase inhibitors (MAOIs) is contraindicated [*see Warnings and Precautions*]. **Pimozide**-Concomitant use in patients taking pimozide is contraindicated [*see Drug Interactions*]. **Hypersensitivity to escitalopram or citalopram**-Lexapro is contraindicated in patients with a hypersensitivity to escitalopram or citalopram or any of the inactive ingredients in Lexapro.

WARNINGS AND PRECAUTIONS: Clinical Worsening and Suicide Risk-Patients with major depressive disorder (MDD), both adult and pediatric, may experience worsening of their depression and/or the emergence of suicidal ideation and behavior (suicidality) or unusual changes in behavior, whether or not they are taking antidepressant medications, and this risk may persist until significant remission occurs. Suicide is a known risk of depression and certain other psychiatric disorders, and these disorders themselves are the strongest predictors of suicide. There has been a long-standing concern, however, that antidepressants may have a role in inducing worsening of depression and the emergence of suicidality in certain patients during the early phases of treatment. Pooled analyses of short-term placebo-controlled trials of antidepressant drugs (SSRIs and others) showed that these drugs increase the risk of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults (ages 18-24) with major depressive disorder (MDD) and other psychiatric disorders. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction with antidepressants compared to placebo in adults aged 65 and older. The pooled analyses of placebo-controlled trials in children and adolescents with MDD, obsessive compulsive disorder (OCD), or other psychiatric disorders included a total of 24 short-term trials of 9 antidepressant drugs in over 4400 patients. The pooled analyses of placebo-controlled trials in adults with MDD or other psychiatric disorders included a total of 295 short-term trials (median duration of 2 months) of 11 antidepressant drugs in over 77,000 patients. There was considerable variation in risk of suicidality among drugs, but a tendency toward an increase in the younger patients for almost all drugs studied. There were differences in absolute risk of suicidality across the different indications, with the highest incidence in MDD. The risk differences (drug vs. placebo), however, were relatively stable within age strata and across indications. These risk differences (drug-placebo difference in the number of cases of suicidality per 1000 patients treated) are provided in Table 1.

TABLE 1

Age Range	Drug-Placebo Difference in Number of Cases of Suicidality per 1000 Patients Treated
	Increases Compared to Placebo
<18	14 additional cases
18-24	5 additional cases
	Decreases Compared to Placebo
25-64	1 fewer case
≥65	6 fewer cases

No suicides occurred in any of the pediatric trials. There were suicides in the adult trials, but the number was not sufficient to reach any conclusion about drug effect on suicide. It is unknown whether the suicidality risk extends to longer-term use, i.e., beyond several months. However, there is substantial evidence from placebo-controlled maintenance trials in adults with depression that the use of antidepressants can delay the recurrence of depression. All patients being treated with antidepressants for any indication should be monitored appropriately and observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases. The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adult and pediatric patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and nonpsychiatric. Although a causal link between the emergence of such symptoms and either the worsening of depression and/or the emergence of suicidal impulses has not been established, there is concern that such symptoms may represent precursors to emerging suicidality. Consideration should be given to changing the therapeutic regimen, including possibly discontinuing the medication, in patients whose depression is persistently worse, or who are experiencing emergent suicidality or symptoms that might be precursors to worsening depression or suicidality, especially if these symptoms are severe, abrupt in onset, or were not part of the patient's presenting symptoms. If the decision has been made to discontinue treatment, medication should be tapered, as rapidly as is feasible, but with recognition that abrupt discontinuation can be associated with certain symptoms [*see Dosage and Administration*]. Families and caregivers of patients being treated with antidepressants for major depressive disorder or other indications, both psychiatric and nonpsychiatric, should be alerted about the need to monitor patients for the emergence of agitation, irritability, unusual changes in behavior, and the other symptoms described above, as well as the emergence of suicidality, and to report such symptoms immediately to health care providers. Such monitoring should include daily observation by families and caregivers [*see also Patient Counseling Information*]. Prescriptions for Lexapro should be written for the smallest quantity of tablets consistent with good patient management, in order to reduce the risk of overdose. **Screening Patients for Bipolar Disorder**-A major depressive episode may be the initial presentation of bipolar disorder. It is generally believed (though not established in controlled trials) that treating such an episode with an antidepressant alone may increase the likelihood of precipitation of a mixed/manic episode in patients at risk for bipolar disorder. Whether any of the symptoms described above represent such a conversion is unknown. However, prior to initiating treatment with an antidepressant, patients with depressive symptoms should be adequately screened to determine if they are at risk for bipolar disorder; such screening should include a detailed psychiatric history, including a family history of suicide, bipolar disorder, and depression. It should be noted that Lexapro is not approved for use in treating bipolar depression. **Serotonin Syndrome or Neuroleptic Malignant Syndrome (NMS)-like Reactions**-The development of a potentially life-threatening serotonin syndrome or Neuroleptic Malignant Syndrome (NMS)-like reactions have been reported with SNRIs and SSRIs alone, including Lexapro treatment, but particularly with concomitant use of serotonergic drugs (including triptans) with drugs which impair metabolism of serotonin (including MAOIs), or with antipsychotics or other dopamine antagonists. Serotonin syndrome symptoms may include mental status changes (e.g., agitation, hallucinations, coma), autonomic instability (e.g., tachycardia, labile blood pressure, hyperthermia), neuromuscular aberrations (e.g., hyperreflexia, incoordination) and/or gastrointestinal symptoms (e.g., nausea, vomiting, diarrhea). Serotonin syndrome, in its most severe form can resemble neuroleptic malignant syndrome, which includes hyperthermia, muscle rigidity, autonomic instability with possible rapid fluctuation of vital signs, and mental status changes. Patients should be monitored for the emergence of serotonin syndrome or NMS-like signs and symptoms. The concomitant use of Lexapro with MAOIs intended to treat depression is contraindicated. If concomitant treatment of Lexapro with a 5-hydroxytryptamine receptor agonist (triptan) is clinically warranted, careful observation of the patient is advised, particularly during treatment initiation and dose increases. The concomitant use of Lexapro with serotonin precursors (such as tryptophan) is not recommended. Treatment with Lexapro and any concomitant serotonergic or antidopaminergic agents, including antipsychotics, should be discontinued immediately if the above events occur and supportive symptomatic treatment should be initiated. **Discontinuation of Treatment with Lexapro**-During marketing of Lexapro and other SSRIs and SNRIs (serotonin and norepinephrine reuptake inhibitors), there have been spontaneous reports of adverse events occurring upon discontinuation of these drugs, particularly when abrupt, including the following: dysphoric mood, irritability, agitation, dizziness, sensory disturbances (e.g., paresthesias such as electric shock sensations), anxiety, confusion, headache, lethargy, emotional lability, insomnia, and hypomania. While these events are generally self-limiting, there have been reports of serious discontinuation symptoms. Patients should be monitored for these symptoms when discontinuing treatment with Lexapro. A gradual reduction in the dose rather than abrupt cessation is recommended whenever possible. If intolerable symptoms occur following a decrease in the dose or upon discontinuation of treatment, then resuming the previously prescribed dose may be considered. Subsequently, the physician may continue decreasing the dose but at a more gradual rate [*see Dosage and Administration*]. **Seizures**-Although anticonvulsant effects of racemic citalopram have been observed in animal studies, Lexapro has not been systematically evaluated in patients with a seizure disorder. These patients were excluded from clinical studies during the product's premarketing testing. In clinical trials of Lexapro, cases of convulsion have been reported in association with Lexapro treatment. Like other drugs effective in the treatment of major depressive disorder, Lexapro should be introduced with care in patients with a history of seizure disorder. **Activation of Mania/Hypomania**-In placebo-controlled trials of Lexapro in major depressive disorder, activation of mania/hypomania was reported in one (0.1%) of 715 patients treated with Lexapro and in none of the 592 patients treated with placebo. One additional case of hypomania has been reported in association with Lexapro treatment. Activation of mania/hypomania has also been reported in a small proportion of patients with major affective disorders treated with racemic citalopram and other marketed drugs effective in the treatment of major depressive disorder. As with all drugs effective in the treatment of major depressive disorder, Lexapro should be used cautiously in patients with a history of mania. **Hyponatremia**-Hyponatremia may occur as a result of treatment with SSRIs and SNRIs, including Lexapro. In many cases, this hyponatremia appears to be the result of the syndrome of inappropriate antidiuretic hormone secretion (SIADH), and was reversible when Lexapro was discontinued. Cases with serum sodium lower than 110 mmol/L have been reported. Elderly patients may be at greater risk of developing hyponatremia with SSRIs and SNRIs. Also, patients taking diuretics or who are otherwise volume depleted may be at greater risk [*see Geriatric Use*]. Discontinuation of Lexapro should be considered in patients with symptomatic hyponatremia and appropriate medical intervention should be instituted. Signs and symptoms of hyponatremia include headache, difficulty concentrating, memory impairment, confusion, weakness, and unsteadiness, which may lead to falls. Signs and symptoms associated with more severe and/or acute cases have included hallucination, syncope, seizure, coma, respiratory arrest, and death. **Abnormal Bleeding**-SSRIs and SNRIs, including Lexapro, may increase the risk of bleeding events. Concomitant use of aspirin, nonsteroidal anti-inflammatory drugs, warfarin, and other anticoagulants may add to the risk. Case reports and epidemiological studies (case-control and cohort design) have demonstrated an association between use of drugs that interfere with serotonin reuptake and the occurrence of gastrointestinal bleeding. Bleeding events related to SSRIs and SNRIs use have ranged from ecchymoses, hematomas, epistaxis, and petechiae to life-threatening hemorrhages. Patients should be cautioned about the risk of bleeding associated with the concomitant use of Lexapro and NSAIDs, aspirin, or other drugs that affect coagulation. **Interference with Cognitive and Motor Performance**-In a study in normal volunteers, Lexapro 10 mg/day did not produce impairment of intellectual function or psychomotor performance. Because any psychoactive drug may impair judgment, thinking, or motor skills, however, patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that Lexapro therapy does not affect their ability to engage in such activities. **Use in Patients with Concomitant Illness**-Clinical experience with Lexapro in patients with certain concomitant systemic illnesses is limited. Caution is advisable in using Lexapro in patients with diseases or conditions that produce altered metabolism or hemodynamic responses. Lexapro has not been systematically evaluated in patients with a recent history of myocardial infarction or unstable heart disease. Patients with these diagnoses were generally excluded from clinical studies during the product's premarketing testing. In subjects with hepatic impairment, clearance of racemic citalopram was decreased and plasma concentrations were increased. The recommended dose of Lexapro in hepatically impaired patients is 10 mg/day [*see Dosage and Administration*]. Because escitalopram is extensively metabolized, excretion of unchanged drug in urine is a minor route of elimination. Until adequate numbers of patients with severe renal impairment have been evaluated during chronic treatment with Lexapro, however, it should be used with caution in such patients [*see Dosage and Administration*]. **Potential for Interaction with Monoamine Oxidase Inhibitors**-In patients receiving serotonin reuptake inhibitor drugs in combination with a monoamine oxidase inhibitor (MAOI), there have been reports of serious, sometimes

fatal, reactions including hyperthermia, rigidity, myoclonus, autonomic instability with possible rapid fluctuations of vital signs, and mental status changes that include extreme agitation progressing to delirium and coma. These reactions have also been reported in patients who have recently discontinued SSRI treatment and have been started on an MAOI. Some cases presented with features resembling neuroleptic malignant syndrome. Furthermore, limited animal data on the effects of combined use of SSRIs and MAOIs suggest that these drugs may act synergistically to elevate blood pressure and evoke behavioral excitation. Therefore, it is recommended that Lexapro should not be used in combination with an MAOI, or within 14 days of discontinuing treatment with an MAOI. Similarly, at least 14 days should be allowed after stopping Lexapro before starting an MAOI. Serotonin syndrome has been reported in two patients who were concomitantly receiving linezolid, an antibiotic which is a reversible non-selective MAOI.

ADVERSE REACTIONS: Clinical Trials Experience-Because clinical studies are conducted under widely varying conditions, adverse reaction rates observed in the clinical studies of a drug cannot be directly compared to rates in the clinical studies of another drug and may not reflect the rates observed in practice. **Clinical Trial Data Sources; Pediatrics (6 -17 years)**-Adverse events were collected in 576 pediatric patients (286 Lexapro, 290 placebo) with major depressive disorder in double-blind placebo-controlled studies. Safety and effectiveness of Lexapro in pediatric patients less than 12 years of age has not been established. **Adults**-Adverse events information for Lexapro was collected from 715 patients with major depressive disorder who were exposed to escitalopram and from 592 patients who were exposed to placebo in double-blind, placebo-controlled trials. An additional 284 patients with major depressive disorder were newly exposed to escitalopram in open-label trials. The adverse event information for Lexapro in patients with GAD was collected from 429 patients exposed to escitalopram and from 427 patients exposed to placebo in double-blind, placebo-controlled trials. Adverse events during exposure were obtained primarily by general inquiry and recorded by clinical investigators using terminology of their own choosing. Consequently, it is not possible to provide a meaningful estimate of the proportion of individuals experiencing adverse events without first grouping similar types of events into a smaller number of standardized event categories. In the tables and tabulations that follow, standard World Health Organization (WHO) terminology has been used to classify reported adverse events. The stated frequencies of adverse reactions represent the proportion of individuals who experienced, at least once, a treatment-emergent adverse event of the type listed. An event was considered treatment-emergent if it occurred for the first time or worsened while receiving therapy following baseline evaluation. **Adverse Events Associated with Discontinuation of Treatment; Major Depressive Disorder; Pediatrics (6 -17 years)**-Adverse events were associated with discontinuation of 3.5% of 286 patients receiving Lexapro and 1% of 290 patients receiving placebo. The most common adverse event (incidence at least 1% for Lexapro and greater than placebo) associated with discontinuation was insomnia (1% Lexapro, 0% placebo). **Adults-**Among the 715 depressed patients who received Lexapro in placebo-controlled trials, 6% discontinued treatment due to an adverse event, as compared to 2% of 592 patients receiving placebo. In two fixed-dose studies, the rate of discontinuation for adverse events in patients receiving 10 mg/day Lexapro was not significantly different from the rate of discontinuation for adverse events in patients receiving placebo. The rate of discontinuation for adverse events in patients assigned to a fixed dose of 20 mg/day Lexapro was 10%, which was significantly different from the rate of discontinuation for adverse events in patients receiving 10 mg/day Lexapro (4%) and placebo (3%). Adverse events that were associated with the discontinuation of at least 1% of patients treated with Lexapro, and for which the rate was at least twice that of placebo, were nausea (2%) and ejaculation disorder (2% of male patients). **Generalized Anxiety Disorder; Adults**-Among the 429 GAD patients who received Lexapro 10-20 mg/day in placebo-controlled trials, 8% discontinued treatment due to an adverse event, as compared to 4% of 427 patients receiving placebo. Adverse events that were associated with the discontinuation of at least 1% of patients treated with Lexapro, and for which the rate was at least twice the placebo rate, were nausea (2%), insomnia (1%), and fatigue (1%). **Incidence of Adverse Reactions in Placebo-Controlled Clinical Trials; Major Depressive Disorder; Pediatrics (6 -17 years)**-The overall profile of adverse reactions in pediatric patients was generally similar to that seen in adult studies, as shown in Table 2. However, the following adverse reactions (excluding those which appear in Table 2 and those for which the coded terms were uninformative or misleading) were reported at an incidence of at least 2% for Lexapro and greater than placebo: back pain, urinary tract infection, vomiting, and nasal congestion. **Adults**-The most commonly observed adverse reactions in Lexapro patients (incidence of approximately 5% or greater and approximately twice the incidence in placebo patients) were insomnia, ejaculation disorder (primarily ejaculatory delay), nausea, sweating increased, fatigue, and somnolence. Table 2 enumerates the incidence, rounded to the nearest percent, of treatment-emergent adverse events that occurred among 715 depressed patients who received Lexapro at doses ranging from 10 to 20 mg/day in placebo-controlled trials. Events included are those occurring in 2% or more of patients treated with Lexapro and for which the incidence in patients treated with Lexapro was greater than the incidence in placebo-treated patients.

TABLE 2
Treatment-Emergent Adverse Reactions Observed with a Frequency of ≥ 2% and Greater Than Placebo for Major Depressive Disorder

Adverse Reaction	Lexapro (N=715)	Placebo (N=592)
Autonomic Nervous System Disorders		
Dry Mouth	6%	5%
Sweating Increased	5%	2%
Central & Peripheral Nervous System Disorders		
Dizziness	5%	3%
Gastrointestinal Disorders		
Nausea	15%	7%
Diarrhea	8%	5%
Constipation	3%	1%
Indigestion	3%	1%
Abdominal Pain	2%	1%
General		
Influenza-like Symptoms	5%	4%
Fatigue	5%	2%
Psychiatric Disorders		
Insomnia	9%	4%
Somnolence	6%	2%
Appetite Decreased	3%	1%
Libido Decreased	3%	1%
Respiratory System Disorders		
Rhinitis	5%	4%
Sinusitis	3%	2%
Urogenital		
Ejaculation Disorder[1,2]	9%	<1%
Impotence[2]	3%	<1%
Anorgasmia[3]	2%	<1%

[1]Primarily ejaculatory delay.
[2]Denominator used was for males only (N=225 Lexapro; N=188 placebo).
[3]Denominator used was for females only (N=490 Lexapro; N=404 placebo).

Generalized Anxiety Disorder; Adults-The most commonly observed adverse reactions in Lexapro patients (incidence of approximately 5% or greater and approximately twice the incidence in placebo patients) were nausea, ejaculation disorder (primarily ejaculatory delay), insomnia, fatigue, decreased libido, and anorgasmia. Table 3 enumerates the incidence, rounded to the nearest percent of treatment-emergent adverse events that occurred among 429 GAD patients who received Lexapro 10 to 20 mg/day in placebo-controlled trials. Events included are those occurring in 2% or more of patients treated with Lexapro and for which the incidence in patients treated with Lexapro was greater than the incidence in placebo-treated patients.

TABLE 3
Treatment-Emergent Adverse Reactions Observed with a Frequency of ≥ 2% and Greater Than Placebo for Generalized Anxiety Disorder

Adverse Reactions	Lexapro (N=429)	Placebo (N=427)
Autonomic Nervous System Disorders		
Dry Mouth	9%	5%
Sweating Increased	4%	1%
Central & Peripheral Nervous System Disorders		
Headache	24%	17%
Paresthesia	2%	1%
Gastrointestinal Disorders		
Nausea	18%	8%
Diarrhea	8%	6%
Constipation	5%	4%
Indigestion	3%	2%
Vomiting	3%	1%
Abdominal Pain	2%	1%
Flatulence	2%	1%
Toothache	2%	0%
General		
Fatigue	8%	2%
Influenza-like Symptoms	5%	4%
Musculoskeletal System Disorder		
Neck/Shoulder Pain	3%	1%
Psychiatric Disorders		
Somnolence	13%	7%
Insomnia	12%	6%
Libido Decreased	7%	2%
Dreaming Abnormal	3%	2%
Appetite Decreased	3%	1%
Lethargy	3%	1%
Respiratory System Disorders		
Yawning	2%	1%
Urogenital		
Ejaculation Disorder[1,2]	14%	2%
Anorgasmia[3]	6%	<1%
Menstrual Disorder	2%	1%

[1]Primarily ejaculatory delay.
[2]Denominator used was for males only (N=182 Lexapro; N=195 placebo).
[3]Denominator used was for females only (N=247 Lexapro; N=232 placebo).

Dose Dependency of Adverse Reactions-The potential dose dependency of common adverse reactions (defined as an incidence rate of ≥5% in either the 10 mg or 20 mg Lexapro groups) was examined on the basis of the combined incidence of adverse events in two fixed-dose trials. The overall incidence rates of adverse events in 10 mg Lexapro-treated patients (66%) was similar to that of the placebo-treated patients (61%), while the incidence rate in 20 mg/day Lexapro-treated patients was greater (86%). Table 4 shows common adverse reactions that occurred in the 20 mg/day Lexapro group with an incidence that was approximately twice that of the 10 mg/day Lexapro group and approximately twice that of the placebo group.

TABLE 4
Incidence of Common Adverse Reactions in Patients with Major Depressive Disorder

Adverse Reaction	Placebo (N=311)	10 mg/day Lexapro (N=310)	20 mg/day Lexapro (N=125)
Insomnia	4%	7%	14%
Diarrhea	5%	6%	14%
Dry Mouth	3%	4%	9%
Somnolence	1%	4%	9%
Dizziness	2%	4%	7%
Sweating Increased	<1%	3%	8%
Constipation	1%	3%	6%
Fatigue	2%	2%	6%
Indigestion	1%	2%	6%

Male and Female Sexual Dysfunction with SSRIs-Although changes in sexual desire, sexual performance, and sexual satisfaction often occur as manifestations of a psychiatric disorder, they may also be a consequence of pharmacologic treatment. In particular, some evidence suggests that SSRIs can cause such untoward sexual experiences. Reliable estimates of the incidence and severity of untoward experiences involving sexual desire, performance, and satisfaction are difficult to obtain, however, in part because patients and physicians may be reluctant to discuss them. Accordingly, estimates of the incidence of untoward sexual experience and performance cited in product labeling are likely to underestimate their actual incidence.

TABLE 5
Incidence of Sexual Side Effects in Placebo-Controlled Clinical Trials

Adverse Event	Lexapro	Placebo
	In Males Only	
	(N=407)	(N=383)
Ejaculation Disorder (primarily ejaculatory delay)	12%	1%
Libido Decreased	6%	2%
Impotence	2%	<1%
	In Females Only	
	(N=737)	(N=636)
Libido Decreased	3%	1%
Anorgasmia	3%	<1%

There are no adequately designed studies examining sexual dysfunction with escitalopram treatment. Priapism has been reported with all SSRIs. While it is difficult to know the precise risk of sexual dysfunction associated with the use of SSRIs, physicians should routinely inquire about such possible side effects. **Vital Sign Changes**-Lexapro and placebo groups were compared with respect to (1) mean change from baseline in vital signs (pulse, systolic blood pressure, and diastolic blood pressure) and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses did not reveal any clinically important changes in vital signs associated with Lexapro treatment. In addition, a comparison of supine and standing vital sign measures in subjects receiving Lexapro indicated that Lexapro treatment is not associated with orthostatic changes. **Weight Changes**-Patients treated with Lexapro in controlled trials did not differ from placebo-treated patients with regard to clinically important change in body weight. **Laboratory Changes**-Lexapro and placebo groups were compared with respect to (1) mean change from baseline in various serum chemistry, hematology, and urinalysis variables, and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed no clinically important changes in laboratory test parameters associated with Lexapro treatment. **ECG Changes**-Electrocardiograms from Lexapro (N=625), racemic citalopram (N=351), and placebo (N=527) groups were compared with respect to (1) mean change from baseline in various ECG parameters and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed (1) a decrease in heart rate of 2.2 bpm for Lexapro and 2.7 bpm for racemic citalopram, compared to an increase of 0.3 bpm for placebo and (2) an increase in QTc interval of 3.9 msec for Lexapro and 3.7 msec for racemic citalopram, compared to 0.5 msec for placebo. Neither Lexapro nor racemic citalopram were associated with the development of clinically significant ECG abnormalities. **Other Reactions Observed During the Premarketing Evaluation of Lexapro**-Following is a list of treatment-emergent adverse events, as defined in the introduction to the ADVERSE REACTIONS section, reported by the 1428 patients treated with Lexapro for periods of up to one year in double-blind or open-label clinical trials during its premarketing evaluation. The listing does not include those events already listed in Tables 2 & 3, those events for which a drug cause was remote and at a rate less than 1% or lower than placebo, those events which were so general as to be uninformative, and those events reported only once which did not have a substantial probability of being acutely life threatening. Events are categorized by body system. Events of major clinical importance are described in the Warnings and Precautions section. Cardiovascular - hypertension, palpitation. Central and Peripheral Nervous System Disorders - light-headed feeling, migraine. Gastrointestinal Disorders - abdominal cramp, heartburn, gastroenteritis. General - allergy, chest pain, fever, hot flushes, pain in limb. Metabolic and Nutritional Disorders - increased weight. Musculoskeletal System Disorders - arthralgia, myalgia jaw stiffness. Psychiatric Disorders - appetite increased, concentration impaired, irritability. Reproductive Disorders/Female - menstrual cramps, menstrual disorder. Respiratory System Disorders - bronchitis, coughing, nasal congestion, sinus congestion, sinus headache. Skin and Appendages Disorders - rash. Special Senses - vision blurred, tinnitus. Urinary System Disorders - urinary frequency, urinary tract infection. **Post-Marketing Experience; Adverse Reactions Reported Subsequent to the Marketing of Escitalopram**-The following additional adverse reactions have been identified from spontaneous reports of escitalopram received worldwide. These adverse reactions have been chosen for inclusion because of a combination of seriousness, frequency of reporting, or potential causal connection to escitalopram and have not been listed elsewhere in labeling. However, because these adverse reactions were reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure. These events include: Blood and Lymphatic System Disorders: anemia, agranulocytis, aplastic anemia, hemolytic anemia, idiopathic thrombocytopenia purpura, leukopenia, thrombocytopenia. Cardiac Disorders: atrial fibrillation, bradycardia, cardiac failure, myocardial infarction, tachycardia, torsade de pointes, ventricular arrhythmia, ventricular tachycardia. Ear and Labyrinth Disorders: vertigo Endocrine Disorders: diabetes mellitus, hyperprolactinemia, SIADH. Eye Disorders: diplopia, glaucoma, mydriasis, visual disturbance. Gastrointestinal Disorders: dysphagia, gastrointestinal hemorrhage, gastroesophageal reflux, pancreatitis, rectal hemorrhage. General Disorders and Administration Site Conditions: abnormal gait, asthenia, edema, fall, feeling abnormal, malaise. Hepatobiliary Disorders: fulminant hepatitis, hepatic failure, hepatic necrosis, hepatitis. Immune System Disorders: allergic reaction, anaphylaxis. Investigations: bilirubin increased, decreased weight, electrocardiogram QT prolongation, hepatic enzymes increased, hypercholesterolemia, INR increased, prothrombin decreased. Metabolism and Nutrition Disorders: hyperglycemia, hypoglycemia, hypokalemia, hyponatremia. Musculoskeletal and Connective Tissue Disorders: muscle cramp, muscle stiffness, muscle weakness, rhabdomyolysis. Nervous System Disorders: akathisia, amnesia, ataxia, choreoathetosis, cerebrovascular accident, dysarthria, dyskinesia, dystonia, extrapyramidal disorders, grand mal seizures (or convulsions), hypoaesthesia, myoclonus, nystagmus, Parkinsonism, restless legs, seizures, syncope, tardive dyskinesia, tremor. Pregnancy, Puerperium and Perinatal Conditions: spontaneous abortion. Psychiatric Disorders: acute psychosis, aggression, agitation, anger, anxiety, apathy, completed suicide, confusion, depersonalization, depression aggravated, delirium, delusion, disorientation, feeling unreal, hallucinations (visual and auditory), mood swings, nervousness, nightmare, panic reaction, paranoia, restlessness, self-harm or thoughts of self-harm, suicide attempt, suicidal ideation, suicidal tendency. Renal and Urinary Disorders: acute renal failure, dysuria, urinary retention. Reproductive System and Breast Disorders: menorrhagia, priapism. Respiratory, Thoracic and Mediastinal Disorders: dyspnea, epistaxis, pulmonary embolism, pulmonary hypertension of the newborn. Skin and Subcutaneous Tissue Disorders: alopecia, angioedema, dermatitis, ecchymosis, erythema multiforme, photosensitivity reaction, Stevens Johnson Syndrome, toxic epidermal necrolysis, urticaria. Vascular Disorders: deep vein thrombosis, flushing, hypertensive crisis, hypotension, orthostatic hypotension, phlebitis, thrombosis.

DRUG INTERACTIONS: Serotonergic Drugs-Based on the mechanism of action of SNRIs and SSRIs including Lexapro, and the potential for serotonin syndrome, caution is advised when Lexapro is coadministered with other drugs that may affect the serotonergic neurotransmitter systems, such as triptans, linezolid (an antibiotic which is a reversible non-selective MAOI), lithium, tramadol, or St. John's Wort [*see Warnings and Precautions*]. The concomitant use of Lexapro with other SSRIs, SNRIs or tryptophan is not recommended. **Triptans**-There have been rare postmarketing reports of serotonin syndrome with use of an SSRI and a triptan. If concomitant treatment of Lexapro with a triptan is clinically warranted, careful observation of the patient is advised, particularly during treatment initiation and dose increases [*see Warnings and Precautions*]. **CNS Drugs**- Given the primary CNS effects of escitalopram, caution should be used when it is taken in combination with other centrally acting drugs. **Alcohol**-Although Lexapro did not potentiate the cognitive and motor effects of alcohol in a clinical trial, as with other psychotropic medications, the use of alcohol by patients taking Lexapro is not recommended. **Monoamine Oxidase Inhibitors (MAOIs)**-[*see Contraindications and Warnings and Precautions*]. **Drugs That Interfere With Hemostasis (NSAIDs, Aspirin, Warfarin, etc.)**-Serotonin release by platelets plays an important role in hemostasis. Epidemiological studies of the case-control and cohort design that have demonstrated an association between use of psychotropic drugs that interfere with serotonin reuptake and the occurrence of upper gastrointestinal bleeding have also shown that concurrent use of an NSAID or aspirin may potentiate the risk of bleeding. Altered anticoagulant effects, including increased bleeding, have been reported when SSRIs and SNRIs are coadministered with warfarin. Patients receiving warfarin therapy should be carefully monitored when Lexapro is initiated or discontinued. **Cimetidine**-In subjects who had received 21 days of 40 mg/day racemic citalopram, combined administration of 400 mg/day cimetidine for 8 days resulted in an increase in citalopram AUC and C_{max} of 43% and 39%, respectively. The clinical significance of these findings is unknown. **Digoxin**-In subjects who had received 21 days of 40 mg/day racemic citalopram, combined administration of citalopram and digoxin (single dose of 1 mg) did not significantly affect the pharmacokinetics of either citalopram or digoxin. **Lithium**-Coadministration of racemic citalopram (40 mg/day for 10 days) and lithium (30 mmol/day for 5 days) had no significant effect on the pharmacokinetics of citalopram or lithium. Nevertheless, plasma lithium levels should be monitored with appropriate adjustment to the lithium dose in accordance with standard clinical practice. Because lithium may enhance the serotonergic effects of escitalopram, caution should be exercised when Lexapro and lithium are coadministered. **Pimozide and Celexa**-In a controlled study, a single dose of pimozide 2 mg co-administered with racemic citalopram 40 mg given once daily for 11 days was associated with a mean increase in QTc values of approximately 10 msec compared to pimozide given alone. Racemic citalopram did not alter the mean AUC or C_{max} of pimozide. The mechanism of this pharmacodynamic interaction is not known. **Sumatriptan**-There have been rare postmarketing reports describing patients with weakness, hyperreflexia, and incoordination following the use of an SSRI and sumatriptan. If concomitant treatment with sumatriptan and an SSRI (e.g., fluoxetine, fluvoxamine, paroxetine, sertraline, citalopram, escitalopram) is clinically warranted, appropriate observation of the patient is advised. **Theophylline**-Combined administration of racemic citalopram (40 mg/day for 21 days) and the CYP1A2 substrate theophylline (single dose of 300 mg) did not affect the pharmacokinetics of theophylline. The effect of theophylline on the pharmacokinetics of citalopram was not evaluated. **Warfarin**-Administration of 40 mg/day racemic citalopram for 21 days did not affect the pharmacokinetics of warfarin, a CYP3A4 substrate. Prothrombin time was increased by 5%, the clinical significance of which is unknown. **Carbamazepine**-Combined administration of racemic citalopram (40 mg/day for 14 days) and carbamazepine (titrated to 400 mg/day for 35 days) did not significantly affect the pharmacokinetics of carbamazepine, a CYP3A4 substrate. Although trough citalopram plasma levels were unaffected, given the enzyme-inducing properties of carbamazepine, the possibility that carbamazepine might increase the clearance of escitalopram should be considered if the two drugs are coadministered. **Triazolam**-Combined administration of racemic citalopram (titrated to 40 mg/day for 28 days) and the CYP3A4 substrate triazolam (single dose of 0.25 mg) did not significantly affect the pharmacokinetics of either citalopram or triazolam. **Ketoconazole**-Combined administration of racemic citalopram (40 mg) and ketoconazole (200 mg), a potent CYP3A4 inhibitor, decreased the C_{max} and AUC of ketoconazole by 21% and 10%, respectively, and did not significantly affect the pharmacokinetics of citalopram. **Ritonavir**-Combined administration of a single dose of ritonavir (600 mg), both a CYP3A4 substrate and a potent inhibitor of CYP3A4, and escitalopram (20 mg) did not affect the pharmacokinetics of either ritonavir or escitalopram. **CYP3A4 and -2C19 Inhibitors**-*In vitro* studies indicated that CYP3A4 and -2C19 are the primary enzymes involved in the metabolism of escitalopram. However, coadministration of escitalopram (20 mg) and ritonavir (600 mg), a potent inhibitor of CYP3A4, did not significantly affect the pharmacokinetics of escitalopram. Because escitalopram is metabolized by multiple enzyme systems, inhibition of a single enzyme may not appreciably decrease escitalopram clearance. **Drugs Metabolized by Cytochrome P4502D6**-*In vitro* studies did not reveal an inhibitory effect of escitalopram on CYP2D6. In addition, steady state levels of racemic citalopram were not significantly different in poor metabolizers and extensive CYP2D6 metabolizers after multiple-dose administration of citalopram, suggesting that coadministration, with escitalopram, of a drug that inhibits CYP2D6, is unlikely to have clinically significant effects on escitalopram metabolism. However, there are limited *in vivo* data suggesting a modest CYP2D6 inhibitory effect for escitalopram, i.e., coadministration of escitalopram (20 mg/day for 21 days) with the tricyclic antidepressant desipramine (single dose of 50 mg), a substrate for CYP2D6, resulted in a 40% increase in C_{max} and a 100% increase in AUC of desipramine. The clinical significance of this finding is unknown. Nevertheless, caution is indicated in the coadministration of escitalopram and drugs metabolized by CYP2D6. **Metoprolol**-Administration of 20 mg/day Lexapro for 21 days in healthy volunteers resulted in a 50% increase in C_{max} and 82% increase in AUC of the beta-adrenergic blocker metoprolol (given in a single dose of 100 mg). Increased metoprolol plasma levels have been associated with decreased cardioselectivity. Coadministration of Lexapro and metoprolol had no clinically significant effects on blood pressure or heart rate. **Electroconvulsive Therapy (ECT)**-There are no clinical studies of the combined use of ECT and escitalopram.

USE IN SPECIFIC POPULATIONS: Pregnancy; Pregnancy Category C-In a rat embryo/fetal development study, oral administration of escitalopram (56, 112, or 150 mg/kg/day) to pregnant animals during the period of organogenesis resulted in decreased fetal body weight and associated delays in ossification at the two higher doses (approximately ≥ 56 times the maximum recommended human dose [MRHD] of 20 mg/day on a body surface area [mg/m^2] basis). Maternal toxicity (clinical signs and decreased body weight gain and food consumption), mild at 56 mg/kg/day, was present at all dose levels. The developmental no-effect dose of 56 mg/kg/day is approximately 28 times the MRHD on a mg/m^2 basis. No teratogenicity was observed at any of the doses tested (as high as 75 times the MRHD on a mg/m^2 basis). When female rats were treated with escitalopram (6, 12, 24, or 48 mg/kg/day) during pregnancy and through weaning, slightly increased offspring mortality and growth retardation were noted at 48 mg/kg/day which is approximately 24 times the MRHD on a mg/m^2 basis. Slight maternal toxicity (clinical signs and decreased body weight gain and food consumption) was seen at this dose. Slightly increased offspring mortality was also seen at 24 mg/kg/day. The no-effect dose was 12 mg/kg/day which is approximately 6 times the MRHD on a mg/m^2 basis. In animal reproduction studies, racemic citalopram has been shown to have adverse effects on embryo/fetal and postnatal development, including teratogenic effects, when administered at doses greater than human therapeutic doses. In two rat embryo/fetal development studies, oral administration of racemic citalopram (32, 56, or 112 mg/kg/day) to pregnant animals during the period of organogenesis resulted in decreased embryo/fetal growth and survival and an increased incidence of fetal abnormalities (including cardiovascular and skeletal defects) at the high dose. This dose was also associated with maternal toxicity (clinical signs, decreased body weight gain). The developmental no-effect dose was 56 mg/kg/day. In a rabbit study, no adverse effects on embryo/fetal development were observed at doses of racemic citalopram of up to 16 mg/kg/day. Thus, teratogenic effects of racemic citalopram were observed at a maternally toxic dose in the rat and were not observed in the rabbit. When female rats were treated with racemic citalopram (4.8, 12.8, or 32 mg/kg/day) from late gestation through weaning, increased offspring mortality during the first 4 days after birth and persistent offspring growth retardation were observed at the highest dose. The no-effect dose was 12.8 mg/kg/day. Similar effects on offspring mortality and growth were seen when dams were treated throughout gestation and early lactation at doses ≥ 24 mg/kg/day. A no-effect dose was not determined in that study. There are no adequate and well-controlled studies in pregnant women; therefore, escitalopram should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Pregnancy-Nonteratogenic Effects-Neonates exposed to Lexapro and other SSRIs or SNRIs, late in the third trimester, have developed complications requiring prolonged hospitalization, respiratory support, and tube feeding. Such complications can arise immediately upon delivery. Reported clinical findings have included respiratory distress, cyanosis, apnea, seizures, temperature instability, feeding difficulty, vomiting, hypoglycemia, hypotonia, hypertonia, hyperreflexia, tremor, jitteriness, irritability, and constant crying. These features are consistent with either a direct toxic effect of SSRIs and SNRIs or, possibly, a drug discontinuation syndrome. It should be noted that, in some cases, the clinical picture is consistent with serotonin syndrome [*see Warnings and Precautions*]. Infants exposed to SSRIs in late pregnancy may have an increased risk for persistent pulmonary hypertension of the newborn (PPHN). PPHN occurs in 1-2 per 1000 live births in the general population and is associated with substantial neonatal morbidity and mortality. In a retrospective, case-control study of 377 women whose infants were born with PPHN and 836 women whose infants were born healthy, the risk for developing PPHN was approximately six-fold higher for infants exposed to SSRIs after the 20th week of gestation compared to infants who had not been exposed to antidepressants during pregnancy. There is currently no corroborative evidence regarding the risk for PPHN following exposure to SSRIs in pregnancy; this is the first study that has investigated the potential risk. The study did not include enough cases with exposure to individual SSRIs to determine if all SSRIs posed similar levels of PPHN risk. When treating a pregnant woman with Lexapro during the third trimester, the physician should carefully consider both the potential risks and benefits of treatment [*see Dosage and Administration*]. Physicians should note that in a prospective longitudinal study of 201 women with a history of major depression who were euthymic at the beginning of pregnancy, women who discontinued antidepressant medication during pregnancy were more likely to experience a relapse of major depression than women who continued antidepressant medication. **Labor and Delivery**-The effect of Lexapro on labor and delivery in humans is unknown. **Nursing Mothers**-Escitalopram is excreted in human breast milk. Limited data from women taking 10-20 mg escitalopram showed that exclusively breast-fed infants receive approximately 3.9% of the maternal weight-adjusted dose of escitalopram and 1.7% of the maternal weight-adjusted dose of desmethylcitalopram. There were two reports of infants experiencing excessive somnolence, decreased feeding, and weight loss in association with breastfeeding from a racemic citalopram-treated mother; in one case, the infant was reported to recover completely upon discontinuation of racemic citalopram by its mother and, in the second case, no follow-up information was available. Caution should be exercised and breastfeeding infants should be observed for adverse reactions when Lexapro is administered to a nursing woman. **Pediatric Use**-Safety and effectiveness of Lexapro has not been established in pediatric patients (less than 12 years of age) with Major Depressive Disorder. Safety and effectiveness of Lexapro has been established in adolescents (12 to 17 years of age) for the treatment of major depressive disorder [*see Clinical Studies*]. Although maintenance efficacy in adolescent patients with Major Depressive Disorder has not been systematically evaluated, maintenance efficacy can be extrapolated from adult data along with comparisons of escitalopram pharmacokinetic parameters in adults and adolescent patients. Safety and effectiveness of Lexapro has not been established in pediatric patients less than 18 years of age with Generalized Anxiety Disorder. **Geriatric Use**-Approximately 6% of the 1144 patients receiving escitalopram in controlled trials of Lexapro in major depressive disorder and GAD were 60 years of age or older; elderly patients in these trials received daily doses of Lexapro between 10 and 20 mg. The number of elderly patients in these trials was insufficient to adequately assess for possible differential efficacy and safety measures on the basis of age. Nevertheless, greater sensitivity of some elderly individuals to effects of Lexapro cannot be ruled out. SSRIs and SNRIs, including Lexapro, have been associated with cases of clinically significant hyponatremia in elderly patients, who may be at greater risk for this adverse event [*see Hyponatremia*]. In two pharmacokinetic studies, escitalopram half-life was increased by approximately 50% in elderly subjects as compared to young subjects and C_{max} was unchanged [*see Clinical Pharmacology*]. 10 mg/day is the recommended dose for elderly patients [*see Dosage and Administration*]. Of 4422 patients in clinical studies of racemic citalopram, 1357 were 60 and over, 1034 were 65 and over, and 457 were 75 and over. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but again, greater sensitivity of some elderly individuals cannot be ruled out.

DRUG ABUSE AND DEPENDENCE: Abuse and Dependence; Physical and Psychological Dependence-Animal studies suggest that the abuse liability of racemic citalopram is low. Lexapro has not been systematically studied in humans for its potential for abuse, tolerance, or physical dependence. The premarketing clinical experience with Lexapro did not reveal any drug-seeking behavior. However, these observations were not systematic and it is not possible to predict on the basis of this limited experience the extent to which a CNS-active drug will be misused, diverted, and/or abused once marketed. Consequently, physicians should carefully evaluate Lexapro patients for history of drug abuse and follow such patients closely, observing them for signs of misuse or abuse (e.g., development of tolerance, incrementations of dose, drug-seeking behavior).

OVERDOSAGE: Human Experience-In clinical trials of escitalopram, there were reports of escitalopram overdose, including overdoses of up to 600 mg, with no associated fatalities. During the postmarketing evaluation of escitalopram, Lexapro overdoses involving overdoses of over 1000 mg have been reported. As with other SSRIs, a fatal outcome in a patient who has taken an overdose of escitalopram has been rarely reported. Symptoms most often accompanying escitalopram overdose, alone or in combination with other drugs and/or alcohol, included convulsions, coma, dizziness, hypotension, insomnia, nausea, vomiting, sinus tachycardia, somnolence, and ECG changes (including QT prolongation and very rare cases of torsade de pointes). Acute renal failure has been very rarely reported accompanying overdose. **Management of Overdose**-Establish and maintain an airway to ensure adequate ventilation and oxygenation. Gastric evacuation by lavage and use of activated charcoal should be considered. Careful observation and cardiac and vital sign monitoring are recommended, along with general symptomatic and supportive care. Due to the large volume of distribution of escitalopram, forced diuresis, dialysis, hemoperfusion, and exchange transfusion are unlikely to be of benefit. There are no specific antidotes for Lexapro. In managing overdosage, consider the possibility of multiple-drug involvement. The physician should consider contacting a poison control center for additional information on the treatment of any overdose.

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Session 18. Suicide

SCR52. The Relationship Between Anxiety Disorders and Suicide Attempts: Findings From the National Epidemiologic Survey on Alcohol and Related Conditions *James Bolton, B.S.C., M.D.*

SCR53. Religion, Spirituality, and Risk of Suicidal Ideation and Attempts: An Epidemiological Perspective *Daniel Rasic, B.S., M.D.*

SCR54. A Multi-Site Review of Postdischarge Suicides *Virginia L. Susman, M.D.*

Session 19. Attention Deficits and Psychostimulants

SCR55. Double-Blind, Placebo-Controlled Efficacy and Safety Study of Lisdexamfetamine Dimesylate in Adolescents With Attention-Deficit/Hyperactivity Disorder *Ann Childress, M.D.*

SCR56. Is Deficient Emotional Self-Regulation a Comorbid or Integral Feature of Attention-Deficit/Hyperactivity Disorder in Adults? A Controlled Study *Craig Surman, M.D.*

SCR57. Adjunctive Armodafinil for Major Depression Associated With Bipolar I Disorder: A Randomized, Double-Blind, Placebo-Controlled Study *Joseph Calabrese, M.D.*

Workshop

W99. Responding to the Impact of Suicide on Clinicians *Chair: Eric M. Plakun, M.D.*

2 p.m.-5 p.m.

Advances in Series

A07. Advances in Substance Abuse Treatment *Co-Chairs: Marc Galanter, M.D., Herbert D. Kleber, M.D.*

A08. Advances in Personality Disorders *Co-Chairs: John M. Oldham, M.D., Andrew E. Skodol, M.D.*

Media Workshop

MW5. Novel Programs to Promote Mental Wellness in Medical Students *American Foundation for Suicide Prevention Co-Chairs: Julie Chilton, M.D., Leah Dickstein, M.D.*

Presidential Symposium

PS07. To Be Announced *Chair: Harold A. Pincus, M.D.*

Symposia

S67. Implementing the STEPPS* Program for Borderline Personality Disorder (*Systems Training for Emotional Predictability and Problem Solving)

A. Implementing the STEPPS Program in Iowa Prisons *Nancee Blum, M.S.W.*

B. VERS: a Randomized, Controlled Trial of a Dutch Version of STEPPS for Borderline Personality Disorder *Bas van Wel, M.D.*

C. Implementing STEPPS in the United Kingdom *Renee Harvey, M.A.*

D. Emotion Regulation Training (An Adaptation of STEPPS) for Adolescents With Borderline Personality Symptoms *Marieke Schuppert, M.D.*

S68. Evidence-Based Treatments (EBT) for Borderline Personality Disorder: Empirical Clarity Meets Clinical Reality

A. Integrating Metallization-Based Treatment With Other Evidence-Based Treatment With Other Treatments for Borderline Personality Disorder: Lethal Cocktail or Super Therapy? *Anthony Bateman, M.D.*

B. Development and Implantation of Transference-Focused Psychotherapy (TFP) *Otto Kernberg, M.D.*

C. Dialectical Behavioral Therapy and Metallization-Based Treatment: An Integration of Two Empirically Validated Treatments for BPD *Lois Choi-Kain, M.D.*

D. The Trials and Tribulations of Implementing Dialectical Behavior Therapy *Joan Whellis, M.D.*

S69. The Nuts and Bolts of the Perinatal Psychiatric Consultation

A. Evaluation of Mood and Anxiety Disorders During Pregnancy and the Postpartum Period *Ruta M. Nonacs, M.D.*

B. Staying Informed and Afloat: How to Approach Evidence-Based Practice in the Psychiatric Treatment of Pregnant and Postpartum Patients *Elizabeth M. Fitelson, M.D.*

C. Psychotherapy Treatments *Margaret Spinelli, M.D.*

D. The Perinatal Psychiatric Consultation: Medication Treatment *Adele Viguera, M.D.*

E. Putting It All Together: The Last Movement of the Perinatal Psychiatric Consultation *Kristin Leight, M.D.*

S70. The Potential and Pitfalls of Creating a Bipolar Genomic Biobank

A. Mayo Clinic Individualized Medicine Biobank for Bipolar Disorder: Overview *Joachim Benitez, M.D.*

B. Antidepressant-Induced Mania: The Need for Rigorous Phenotypic Assessment *Mark Frye, M.D.*

C. Retrospective Pharmacogenomic Treatment Response *Susan McElroy, M.D.*

D. Advocacy Collaboration Into Biobanks *Allen Daniels, Ed.D.*

E. Biobanking: New Ethical Challenges? *Barbara A. Koenig, Ph.D.*

S71. The Treatment of Psychiatric Disorders With rTMS: New Research and Clinical Findings

A. Repetitive Transcranial Magnetic Stimulation for Auditory Hallucinations in SCZ *Zafiris J. Daskalakis, M.D.*

B. Transcranial Magnetic Stimulation (TMS) for Major Depression: Past, Present, and Future Challenges *Yechiel Y.L. Levkovitz, M.D.*

C. Can rTMS Help Obsessive Compulsive Disorder? *Peggy Richter, M.D.*

D. A Meta-Analytic Study Evaluating Brain Activation and Response to rTMS in Anorexia Nervosa *Allan S. Kaplan, M.D., Kate Strasburg, M.D.*

S72. The Tattered Safety Net: The Public Mental Health Crisis in an Economic Recession *APA Council on Minority Mental Health and Health Disparities*

A. Who Cares? Can We Afford to Reduce Expenditures for Mental Health Services in Times of Need? *Anita S. Everett, M.D.*

B. The Economic Downturn, Mental Health, Mental Illness: Prospects for Recovery *Kenneth Thompson, M.D.*

C. Mental Health Consequences of the U.S. Economic Downturn: What Do We Know and What Can Be Done? *Lisa M. Bates, S.M.*

D. Sacramento County, Calif., Budget Cuts, Work Arounds, and Unintended Consequences *Russell F. Lim, M.D.*

E. Adding Insult to Injury: The Public Mental Health Crisis in Regions of Long-Term Economic Stagnation *Patrick S. Runnels, M.D.*

F. An Action Plan for Public Mental Health During an Economic Recession *David A. Pollack, M.D.*

S73. Lessons From Hurricane Katrina: Response, Recovery, and Rebuilding

A. Charting the Course of Recovery From Mental Disorders in Hurricane Katrina *Ronald C. Kessler, Ph.D.*

B. The Federal Crisis Counseling Program: Lessons From New Orleans *Kenneth Thompson, M.D.*

C. Louisiana Spirit: Catastrophic Impact and Psychological Recovery *Anthony Speier, Ph.D.*

D. Mental Health and Recovery Following Hurricane Katrina *Howard J. Osofsky, M.D.*

E. Mental Health and Recovery Following Hurricane Katrina *Joy D. Osofsky, Ph.D.*

S74. Toward a New Model for Mental Health Services in the University Community *APA Council on Children, Adolescents, and Their Families*

A. The Need for a Community Mental Health Model *Paul J. Barreira, M.D.*

B. Contributions From the Public Health Orientation *Laurie Davidson, M.A.*

C. Integrating the Student's Family Into College Mental Health *Kristine A. Girard, M.D.*

D. The Campus as Community: Working With Administration *Lorraine D. Siggins, M.D.*

E. Psychiatry Residents in the College Mental Health Service *Jerald Kay, M.D.*

S75. *DSM-5* Update Series, Part III: Reports From the Work Groups

A. *DSM-5* Update on Anxiety Disorders and Obsessive-Compulsive Spectrum Disorders *Katharine A. Phillips, M.D.*

B. Major Issues Concerning Mood Disorders in *DSM-5 Jan Fawcett, M.D.*

C. Anticipating *DSM-5:* Schizophrenia and Related Psychoses *William T. Carpenter, M.D.*

D. Looking Toward *DSM-5:* PTSD and Dissociative Disorders *Matthew J. Friedman, M.D.*

E. Update From the Mood Disorders Work Group, Bipolar Disorder Subcommittee *Trisha Suppes, M.D.*

S76. The Challenge of Cognitive Enhancers in Medicine *National Institute on Drug Abuse*

A. 5 HT Receptors as Targets for Cognitive Enhancement in Schizophrenia *Herbert Y. Meltzer, M.D.*

B. ADHD Treatment, Comorbidity With SUDs, and COGS-Related Diversion *Nora D. Volkow, M.D.*

C. Modafinil's Abuse Potential and Possible Role in Cocaine Dependence *Charles Dackis, M.D.*

D. Nonimpaired Elders, Cognitive Enhancers, and the Boundaries of Usual and Customary Practice *James M. Ellison, M.D.*

E. Pharmacological Cognitive Enhancement in Neuropsychiatric Disorders and in Healthy People *Barbara Sahakian, M.D.*

S77. Sex and Psychodynamics: Contemporary Approaches to Clinical Issues Through the Lifecycle *American Academy of Psychoanalysis and Dynamic Psychiatry*

A. Breaking the Silence: Discussing Sex With Teens in Psychotherapy *Eugene Beresin, M.D.*

B. Psychodynamics of Hypersexuality in Children and Adolescents With Bipolar Disorder *Stewart L. Adelson, M.D.*

C. Driven Sexual Behavior in Adults With "Soft Bipolarity": A Psychodynamic Perspective *Jennifer I. Downey, M.D.*

E. The Role of Sexual History Taking in Improving Psychotherapeutic Treatment *Matthew Neltner, M.D.*

F. Menopause, Depression, and Decreased Sexual Desire: A Psychodynamic Contribution *Sherry P. Katz Bearnot, M.D.*

What's Up With *DSM-5*?

With eight sessions on *DSM-5,* APA's 2010 annual meeting will feature highlights from each of the diagnostic work groups and broad updates about potential changes to the manual. Of particular interest is an interactive workshop that will allow attendees to provide feedback about possible revisions to criteria, terminology, and diagnostic labels.

The meeting will offer five *DSM-5* symposia, including a three-session series with updates from each of the *DSM-5* work groups and two diagnostic-specific sessions from the Neurodevelopmental Disorders Work Group and the Substance-Related Disorders Work Group. A full schedule of sessions will appear in a future issue of *Psychiatric News.*

Monday morning, May 24, will feature the annual *DSM* research forum, "*DSM-5*: Progress in Research and Development," which will introduce the three-part work group series and feature brief presentations from the *DSM-5* study groups on impairment and disability, assessment, and instrumentation, and the interface between psychiatry and general medicine. Additionally, William Narrow, M.D., M.P.H., *DSM-5* research director and associate director of APA's Division of Research, will discuss the purpose and impact of integrating dimensional assessments into *DSM-5* .

Treat today with NAMENDA

Proven efficacy and tolerability

- Improves function, delays onset of behavioral symptoms, and provides benefits in cognition[1-3]
- Proven safety and tolerability with low risk of gastrointestinal side effects may lead to therapy persistence[4,5]
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- Effective first-line and in combination with an acetylcholinesterase inhibitor[1,2]

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Namenda® memantine HCl

Extending memory and function

NAMENDA® (memantine HCl) is indicated for the treatment of moderate to severe Alzheimer's disease.

NAMENDA is contraindicated in patients with known hypersensitivity to memantine HCl or any excipients used in the formulation. The most common adverse events reported with NAMENDA vs placebo (≥5% and higher than placebo) were dizziness, confusion, headache, and constipation. In patients with severe renal impairment, the dosage should be reduced.

References: 1. Reisberg B, Doody R, Stöffler A, Schmitt F, Ferris S, Möbius HJ, for the Memantine Study Group. Memantine in moderate-to-severe Alzheimer's disease. *N Engl J Med.* 2003;348:1333-1341. **2.** Tariot PN, Farlow MR, Grossberg GT, Graham SM, McDonald S, Gergel I, for the Memantine Study Group. Memantine treatment in patients with moderate to severe Alzheimer disease already receiving donepezil: a randomized controlled trial. *JAMA.* 2004;291:317-324. **3.** Cummings JL, Schneider E, Tariot PN, Graham SM, for the Memantine MEM-MD-02 Study Group. Behavioral effects of memantine in Alzheimer disease patients receiving donepezil treatment. *Neurology.* 2006;67:57-63. **4.** Data on file. Forest Laboratories, Inc. **5.** NAMENDA® (memantine HCl) Prescribing Information. Forest Pharmaceuticals, Inc., St Louis, Mo. **6.** Wimo A, Winblad B, Stöffler A, Wirth Y, Möbius HJ. Resource utilisation and cost analysis of memantine in patients with moderate to severe Alzheimer's disease. *Pharmacoeconomics.* 2003;21:327-340. **7.** Winblad B, Poritis N. Memantine in severe dementia: results of the ³M-BEST Study (Benefit and efficacy in severely demented patients during treatment with memantine). *Int J Geriatr Psychiatry.* 1999;14:135-146.

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For more details, please visit **www.namenda.com**.

Please see brief summary of Prescribing Information on the adjacent page.

62-1014307R R2 03/09

Namenda
memantine HCl ®

Tablets/Oral Solution
Rx Only

Brief Summary of Prescribing Information.

For complete details, please see full Prescribing Information for Namenda.

INDICATIONS AND USAGE
Namenda (memantine hydrochloride) is indicated for the treatment of moderate to severe dementia of the Alzheimer's type.

CONTRAINDICATIONS
Namenda (memantine hydrochloride) is contraindicated in patients with known hypersensitivity to memantine hydrochloride or to any excipients used in the formulation.

PRECAUTIONS
Information for Patients and Caregivers: Caregivers should be instructed in the recommended administration (twice per day for doses above 5 mg) and dose escalation (minimum interval of one week between dose increases).

Neurological Conditions
Seizures: Namenda has not been systematically evaluated in patients with a seizure disorder. In clinical trials of Namenda, seizures occurred in 0.2% of patients treated with Namenda and 0.5% of patients treated with placebo.

Genitourinary Conditions
Conditions that raise urine pH may decrease the urinary elimination of memantine resulting in increased plasma levels of memantine.

Special Populations
Hepatic Impairment
Namenda undergoes partial hepatic metabolism, with about 48% of administered dose excreted in urine as unchanged drug or as the sum of parent drug and the N-glucuronide conjugate (74%). No dosage adjustment is needed in patients with mild or moderate hepatic impairment. Namenda should be administered with caution to patients with severe hepatic impairment.

Renal Impairment
No dosage adjustment is needed in patients with mild or moderate renal impairment. A dosage reduction is recommended in patients with severe renal impairment (see CLINICAL PHARMACOLOGY and DOSAGE AND ADMINISTRATION in Full Prescribing Information).

Drug-Drug Interactions
N-methyl-D-aspartate (NMDA) antagonists: The combined use of Namenda with other NMDA antagonists (amantadine, ketamine, and dextromethorphan) has not been systematically evaluated and such use should be approached with caution.

Effects of Namenda on substrates of microsomal enzymes: In vitro studies conducted with marker substrates of CYP450 enzymes (CYP1A2, -2A6, -2C9, -2D6, -2E1, -3A4) showed minimal inhibition of these enzymes by memantine. In addition, *in vitro* studies indicate that at concentrations exceeding those associated with efficacy, memantine does not induce the cytochrome P450 isoenzymes CYP1A2, CYP2C9, CYP2E1, and CYP3A4/5. No pharmacokinetic interactions with drugs metabolized by these enzymes are expected.

Effects of inhibitors and/or substrates of microsomal enzymes on Namenda: Memantine is predominantly renally eliminated, and drugs that are substrates and/or inhibitors of the CYP450 system are not expected to alter the metabolism of memantine.

Acetylcholinesterase (AChE) inhibitors: Coadministration of Namenda with the AChE inhibitor donepezil HCl did not affect the pharmacokinetics of either compound. In a 24-week controlled clinical study in patients with moderate to severe Alzheimer's disease, the adverse event profile observed with a combination of memantine and donepezil was similar to that of donepezil alone.

Drugs eliminated via renal mechanisms: Because memantine is eliminated in part by tubular secretion, coadministration of drugs that use the same renal cationic system including hydrochlorothiazide (HCTZ), triamterene (TA), metformin, cimetidine, ranitidine, quinidine, and nicotine, could potentially result in altered plasma levels of both agents. However, coadministration of Namenda and HCTZ/TA did not affect the bioavailability of either memantine or TA, and the bioavailability of HCTZ decreased by 20%. In addition, coadministration of memantine with the antihyperglycemic drug Glucovance® (glyburide and metformin HCl) did not affect the pharmacokinetics of memantine, metformin, and glyburide. Furthermore, memantine did not modify the serum glucose lowering effect of Glucovance®.

Drugs that make the urine alkaline: The clearance of memantine was reduced by about 80% under alkaline urine conditions at pH 8. Therefore, alterations of urine pH towards the alkaline condition may lead to an accumulation of the drug with a possible increase in adverse effects. Urine pH is altered by diet, drugs (e.g. carbonic anhydrase inhibitors, sodium bicarbonate), and clinical state of the patient (e.g. renal tubular acidosis or severe infections of the urinary tract). Hence, memantine should be used with caution under these conditions.

Carcinogenesis, Mutagenesis and Impairment of Fertility
There was no evidence of carcinogenicity in a 113-week oral study in mice at doses up to 40 mg/kg/day (10 times the maximum recommended human dose [MRHD] on a mg/m² basis). There was also no evidence of carcinogenicity in rats orally dosed at up to 40 mg/kg/day for 71 weeks followed by 20 mg/kg/day (20 and 10 times the MRHD on a mg/m² basis, respectively) through 128 weeks.

Memantine produced no evidence of genotoxic potential when evaluated in the *in vitro S. typhimurium* or *E. coli* reverse mutation assay, an *in vitro* chromosomal aberration test in human lymphocytes, an *in vivo* cytogenetics assay for chromosome damage in rats, and the *in vivo* mouse micronucleus assay. The results were equivocal in an *in vitro* gene mutation assay using Chinese hamster V79 cells.

No impairment of fertility or reproductive performance was seen in rats administered up to 18 mg/kg/day (9 times the MRHD on a mg/m² basis) orally from 14 days prior to mating through gestation and lactation in females, or for 60 days prior to mating in males.

Pregnancy
Pregnancy Category B: Memantine given orally to pregnant rats and pregnant rabbits during the period of organogenesis was not teratogenic up to the highest doses tested (18 mg/kg/day in rats and 30 mg/kg/day in rabbits, which are 9 and 30 times, respectively, the maximum recommended human dose [MRHD] on a mg/m² basis).

Slight maternal toxicity, decreased pup weights and an increased incidence of non-ossified cervical vertebrae were seen at an oral dose of 18 mg/kg/day in a study in which rats were given oral memantine beginning pre-mating and continuing through the postpartum period. Slight maternal toxicity and decreased pup weights were also seen at this dose in a study in which rats were treated from day 15 of gestation through the post-partum period. The no-effect dose for these effects was 6 mg/kg, which is 3 times the MRHD on a mg/m² basis.

There are no adequate and well-controlled studies of memantine in pregnant women. Memantine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers
It is not known whether memantine is excreted in human breast milk. Because many drugs are excreted in human milk, caution should be exercised when memantine is administered to a nursing mother.

Pediatric Use
There are no adequate and well-controlled trials documenting the safety and efficacy of memantine in any illness occurring in children.

ADVERSE REACTIONS
The experience described in this section derives from studies in patients with Alzheimer's disease and vascular dementia.

Adverse Events Leading to Discontinuation: In placebo-controlled trials in which dementia patients received doses of Namenda up to 20 mg/day, the likelihood of discontinuation because of an adverse event was the same in the Namenda group as in the placebo group. No individual adverse event was associated with the discontinuation of treatment in 1% or more of Namenda-treated patients and at a rate greater than placebo.

Adverse Events Reported in Controlled Trials: The reported adverse events in Namenda (memantine hydrochloride) trials reflect experience gained under closely monitored conditions in a highly selected patient population. In actual practice or in other clinical trials, these frequency estimates may not apply, as the conditions of use, reporting behavior and the types of patients treated may differ. Table 1 lists treatment-emergent signs and symptoms that were reported in at least 2% of patients in placebo-controlled dementia trials and for which the rate of occurrence was greater for patients treated with Namenda than for those treated with placebo. No adverse event occurred at a frequency of at least 5% and twice the placebo rate.

Table 1: Adverse Events Reported in Controlled Clinical Trials in at Least 2% of Patients Receiving Namenda and at a Higher Frequency than Placebo-treated Patients

Body System Adverse Event	Placebo (N = 922) %	Namenda (N = 940) %
Body as a Whole		
Fatigue	1	2
Pain	1	3
Cardiovascular System		
Hypertension	2	4
Central and Peripheral Nervous System		
Dizziness	5	7
Headache	3	6
Gastrointestinal System		
Constipation	3	5
Vomiting	2	3
Musculoskeletal System		
Back pain	2	3
Psychiatric Disorders		
Confusion	5	6
Somnolence	2	3
Hallucination	2	3
Respiratory System		
Coughing	3	4
Dyspnea	1	2

Other adverse events occurring with an incidence of at least 2% in Namenda-treated patients but at a greater or equal rate on placebo were agitation, fall, inflicted injury, urinary incontinence, diarrhea, bronchitis, insomnia, urinary tract infection, influenza-like symptoms, abnormal gait, depression, upper respiratory tract infection, anxiety, peripheral edema, nausea, anorexia, and arthralgia.

The overall profile of adverse events and the incidence rates for individual adverse events in the subpopulation of patients with moderate to severe Alzheimer's disease were not different from the profile and incidence rates described above for the overall dementia population.

Vital Sign Changes: Namenda and placebo groups were compared with respect to (1) mean change from baseline in vital signs (pulse, systolic blood pressure, diastolic blood pressure and weight) and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. There were no clinically important changes in vital signs in patients treated with Namenda. A comparison of supine and standing vital sign measures for Namenda and placebo in elderly normal subjects indicated that Namenda treatment is not associated with orthostatic changes.

Laboratory Changes: Namenda and placebo groups were compared with respect to (1) mean change from baseline in various serum chemistry, hematology, and urinalysis variables and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed no clinically important changes in laboratory test parameters associated with Namenda treatment.

ECG Changes: Namenda and placebo groups were compared with respect to (1) mean change from baseline in various ECG parameters and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed no clinically important changes in ECG parameters associated with Namenda treatment.

Other Adverse Events Observed During Clinical Trials
Namenda has been administered to approximately 1350 patients with dementia, of whom more than 1200 received the maximum recommended dose of 20 mg/day. Patients received Namenda treatment for periods of up to 884 days, with 862 patients receiving at least 24 weeks of treatment and 387 patients receiving 48 weeks or more of treatment.

Treatment emergent signs and symptoms that occurred during 8 controlled clinical trials and 4 open-label trials were recorded as adverse events by the clinical investigators using terminology of their own choosing. To provide an overall estimate of the proportion of individuals having similar types of events, the events were grouped into a smaller number of standardized categories using WHO terminology, and event frequencies were calculated across all studies.

All adverse events occurring in at least two patients are included, except for those already listed in Table 1, WHO terms too general to be informative, minor symptoms or events unlikely to be drug-caused, e.g., because they are common in the study population. Events are classified by body system and listed using the following definitions: frequent adverse events - those occurring in at least 1/100 patients; infrequent adverse events - those occurring in 1/100 to 1/1000 patients. These adverse events are not necessarily related to Namenda treatment and in most cases were observed at a similar frequency in placebo-treated patients in the controlled studies.

Body as a Whole: *Frequent:* syncope. *Infrequent:* hypothermia, allergic reaction.

Cardiovascular System: *Frequent:* cardiac failure. *Infrequent:* angina pectoris, bradycardia, myocardial infarction, thrombophlebitis, atrial fibrillation, hypotension, cardiac arrest, postural hypotension, pulmonary embolism, pulmonary edema.

Central and Peripheral Nervous System: *Frequent:* transient ischemic attack, cerebrovascular accident, vertigo, ataxia, hypokinesia. *Infrequent:* paresthesia, convulsions, extrapyramidal disorder, hypertonia, tremor, aphasia, hypoesthesia, abnormal coordination, hemiplegia, hyperkinesia, involuntary muscle contractions, stupor, cerebral hemorrhage, neuralgia, ptosis, neuropathy.

Gastrointestinal System: *Infrequent:* gastroenteritis, diverticulitis, gastrointestinal hemorrhage, melena, esophageal ulceration.

Hemic and Lymphatic Disorders: *Frequent:* anemia. *Infrequent:* leukopenia.

Metabolic and Nutritional Disorders: *Frequent:* increased alkaline phosphatase, decreased weight. *Infrequent:* dehydration, hyponatremia, aggravated diabetes mellitus.

Psychiatric Disorders: *Frequent:* aggressive reaction. *Infrequent:* delusion, personality disorder, emotional lability, nervousness, sleep disorder, libido increased, psychosis, amnesia, apathy, paranoic reaction, thinking abnormal, crying abnormal, appetite increased, paronia, delirium, depersonalization, necrosis, suicide attempt.

Respiratory System: *Frequent:* pneumonia. *Infrequent:* apnea, asthma, hemoptysis.

Skin and Appendages: *Frequent:* rash. *Infrequent:* skin ulceration, pruritus, cellulitis, eczema, dermatitis, erythematous rash, alopecia, urticaria.

Special Senses: *Frequent:* cataract, conjunctivitis. *Infrequent:* macula lutea degeneration, decreased visual acuity, decreased hearing, tinnitus, blepharitis, blurred vision, corneal opacity, glaucoma, conjunctival hemorrhage, eye pain, retinal hemorrhage, xerophthalmia, diplopia, abnormal lacrimation, myopia, retina detachment.

Urinary System: *Frequent:* frequent micturition. *Infrequent:* dysuria, hematuria, urinary retention.

Events Reported Subsequent to the Marketing of Namenda, both US and Ex-US
Although no causal relationship to memantine treatment has been found, the following adverse events have been reported to be temporally associated with memantine treatment and are not described elsewhere in labeling: aspiration pneumonia, asthenia, atrioventricular block, bone fracture, carpal tunnel syndrome, cerebral infarction, chest pain, cholelithiasis, claudication, colitis, deep venous thrombosis, depressed level of consciousness (including loss of consciousness and rare reports of coma), dyskinesia, dysphagia, encephalopathy, gastritis, gastroesophageal reflux, grand mal convulsions, intracranial hemorrhage, hepatitis (including increased ALT and AST and hepatic failure), hyperglycemia, hyperlipidemia, hypoglycemia, ileus, increased INR, impotence, lethargy, malaise, myoclonus, neuroleptic malignant syndrome, acute pancreatitis, Parkinsonism, acute renal failure (including increased creatinine and renal insufficiency), prolonged QT interval, restlessness, sepsis, Stevens-Johnson syndrome, suicidal ideation, sudden death, supraventricular tachycardia, tachycardia, tardive dyskinesia, thrombocytopenia, and hallucinations (both visual and auditory).

ANIMAL TOXICOLOGY
Memantine induced neuronal lesions (vacuolation and necrosis) in the multipolar and pyramidal cells in cortical layers III and IV of the posterior cingulate and retrosplenial neocortices in rats similar to those which are known to occur in rodents administered other NMDA receptor antagonists. Lesions were seen after a single dose of memantine, in a study in which rats were given daily oral doses of memantine for 14 days, the no-effect dose for neuronal necrosis was 6 times the maximum recommended human dose on a mg/m² basis. The potential for induction of central neuronal vacuolation and necrosis by NMDA receptor antagonists in humans is unknown.

DRUG ABUSE AND DEPENDENCE
Controlled Substance Class: Memantine HCl is not a controlled substance.

Physical and Psychological Dependence: Memantine HCl is a low to moderate affinity uncompetitive NMDA antagonist that did not produce any evidence of drug-seeking behavior or withdrawal symptoms upon discontinuation in 2,504 patients who participated in clinical trials at therapeutic doses. Post marketing data, outside the U.S., retrospectively collected, has provided no evidence of drug abuse or dependence.

OVERDOSAGE
Signs and symptoms associated with memantine overdosage in clinical trials and from worldwide marketing experience include agitation, confusion, ECG changes, loss of consciousness, psychosis, restlessness, slowed movement, somnolence, stupor, unsteady gait, visual hallucinations, vertigo, vomiting, and weakness. The largest known ingestion of memantine worldwide was 2.0 grams in a patient who took memantine in conjunction with unspecified antidiabetic medications. The patient experienced coma, diplopia, and agitation, but subsequently recovered.

Because strategies for the management of overdose are continually evolving, it is advisable to contact a poison control center to determine the latest recommendations for the management of an overdose of any drug. As in any cases of overdose, general supportive measures should be utilized, and treatment should be symptomatic. Elimination of memantine can be enhanced by acidification of urine.

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Rev. 04/07

S78. Progress and Promise: Preventing the First Episode of Psychosis

A. Cognitive and fMRI Studies in Clinical High Risk and Early Psychosis: Understanding Mechanisms and Predicting Risk *Carter S. Cameron, M.D.*

B. Pattern of Neurocognitive Deficits in Individuals at Clinical High Risk for Psychosis *Barbara Cornblatt, Ph.D.*

C. Transitioning From First Episode to Prodrome: Learning From the EAsT Program *Robert Wolf, M.D.*

D. Portland Identification and Early Referral (PIER): Conversion and Incidence Outcomes in a Catchment Area-Wide Psychosis Prevention Program *William R. McFarlane, M.D.*

S79. Reproductive Issues and Women's Mental Health: How to Untie the Gordien Knot?

A. Why Psychiatry and Abortion? *Nada L. Stotland, M.D.*

B. Dilemmas Concerning Miscarriage and Genetic Terminations *Gail E. Robinson, M.D.*

C. The Right to Health: The Need to Uphold Sexual and Reproductive Health to Promote Mental Health in Latin America *Marta B. Rondon, M.D.*

D. What If Motherhood Cannot Chase All the Blues Away? *Gisèle Apter, M.D.*

S80. Treatment of Depression With TMS: An Overview of Findings From the Optimization of TMS for the Treatment of Depression Trial (Opt TMS)

A. Introduction and State of the Current Practice and Knowledge *Mark S. George, M.D.*

B. Clinical Results From the Randomized OPT TMS Trial *Paul Holtzheimer, M.D.*

C. How Do These Results Relate to Clinical Practice and How Do We Decide Who to Treat and for How Long? *William M. McDonald, M.D.*

D. How Do You Create a TMS Sham? *Sarah H. Lisanby, M.D.*

E. How Long Do the TMS Clinical Effects Last? *Antonio Montavani, M.D.*

F. How Does Prefrontal TMS Work to Treat Depression? *Ziad H. Nahas, M.D.*

S81. Mood, Memory, and Myths: What Really Happens at Menopause?

A. Depression and Other Symptoms: Risks in the Transition to Menopause *Ellen Freeman, Ph.D.*

B. Hot Flashes and Sleep Disturbances During Menopause Transition: Exploring Effective Treatment Strategies *Claudio N. Soares, M.D.*

C. Sexuality in Transition: Menopause and Aging *Anita H. Clayton, M.D.*

D. Where Did I Put My Keys? The Ongoing Saga of Estrogen, Serotonin, Mood, and Memory at Menopause *C. Neill Epperson, M.D.*

3 p.m.-5 p.m.

New Research Poster Session 5

3:30 p.m.-5 p.m.

Scientific and Clinical Reports

Session 20. Inpatient Psychiatry: Admissions and Readmissions

SCR 58. The Association Between Preadmission Suicidality and Readmission Is Modified by Patient Experiences, Feelings, and Characteristics *Stephen Woolley, D.Sc., M.P.H.*

SCR 59. Effectiveness of Peer Support in Reducing Readmissions Among People With Multiple Psychiatric Hospitalizations *William Sledge, M.D.*

SCR 60. Inpatients With Psychotic Versus Nonpsychotic MDD: Prevalence and Clinical Characteristics *John Goethe, M.D.*

Session 21.Scales and Screening Measures

SCR 61. Feasibility and Effectiveness of Using E-mail to Screen College Students for Depression *Irene Shyu, B.A.*

SCR 62. The Valuation of Impairment: Relative Values on the Psychiatric Impairment Rating (PIRS) Subscales *Gordon Davies, M.B., B.S.*

SCR 63. Are Screening Scales for Bipolar Disorder Good Enough to Be Used in Clinical Practice? *Mark Zimmerman, M.D.*

Workshop

W100. Ethical Challenges in End-of-Life Care in the Hospitalized Elderly *Chair: Maria Lapid, M.D.*

Lecture

L17. Simon Bolivar Award Lecture *American Society of Hispanic Psychiatry; Maria Oquendo, M.D.*

7 p.m.-10 p.m.

Media Workshop

MW6. "Boy Interrupted" *Co-Chairs: Nancy Rappaport, M.D., Joanne Harpel, J.D.* ■

Music and the Mind: Frederic Chopin

In 1830, at the age of 20, Frederic Chopin left Warsaw for Italy. Shortly afterward an uprising in his homeland was brutally suppressed by the Russians, and Chopin became one of countless expatriates, exiled for the duration of his life from his beloved homeland.

The longing for home, combined with a series of ill-fated love affairs and chronic respiratory illness that killed him at the age of 39, made for a short life of much suffering. Moreover, Chopin also experienced a variety of psychiatric symptoms including panic attacks, phobias, mood swings, and hallucinations.

Yet Chopin is remembered today not for his suffering, but as one of the great musical masters of the Romantic period. His compositions, mainly for the piano, were groundbreaking for the way they grafted a new expressiveness and passion onto older musical forms.

Psychiatrist and master concert pianist Richard Kogan, M.D., will explore the mind and music of Chopin and the connection between his suffering and his art at APA's 2010 annual meeting in New Orleans. The session will be held on Monday, May 24, from 11 a.m. to 12:30 p.m. in room 220-222 at the Morial Convention Center.

For several years now, Kogan has been bringing keen insights into the relationship between the interior lives of great composers and the music they created, and his lectures have become an annual meeting favorite.

Kogan's lecture will help attendees recognize the psychological factors that influenced Chopin's artistic development; appreciate the challenges of retrospective, posthumous psychiatric diagnosis; and understand some fundamental concepts about creativity. The discussion will be illuminated by performances of some of the composer's best music, including his mazurkas, polonaises, preludes, and ballades.

Recovery

continued from page 4

streetcar line, has bounced back to normal. The grand Victorian mansions of the Garden District and Uptown look as impressive as ever. New shops and restaurants along Magazine Street have become trendy haunts for 20-somethings from nearby Tulane University and elsewhere, said Foulks, the medical director of the East Jefferson Parish Human Services Agency.

Reconstruction has varied in other parts of the city, such as residential areas along Lake Ponchartrain, depending on residents' private resources.

However, neighborhoods like the Lower Ninth Ward remain devastated, said Foulks.

> **"Even to speak of 'the city' is misleading. Different social and economic groups give you different answers."**

Actor Brad Pitt created the Make It Right Foundation, which invited top architects to design 150 affordable houses for flood victims in the Lower Ninth Ward. Many are built on stilts to keep them above any future high water.

"This is an interesting experiment, but it is not affecting large numbers of people," said Foulks.

Medical Facilities Still in Recovery Mode

Of more interest to APA members may be the transformation of the region's medical infrastructure.

"The Tulane and Louisiana State University systems are alive and present in New Orleans," said Foulks. "But Katrina destroyed the public Charity Hospital and the Veterans Administration Hospital across the street."

Charity Hospital is still closed, and the VA is open only as a clinic. Patients and clinicians are now scattered around the city and the region.

"We have moved from a centralized, downtown health care system to a de facto community one," said Foulks.

VA patients are sent to community hospitals for inpatient care. Many residents and students at the city's two medical schools who would have trained at Charity or the VA hospital now rotate through scattered sites elsewhere in New Orleans or 20, 30, 50, or more miles away.

Almost five years after the storm, city, state, and federal officials are still debating whether to refurbish the developed hospitals or start from scratch on a tract of land in the Mid-City area north of downtown ruined by Katrina.

Inpatient services in the city are minimal now. Closure of the New Orleans Adolescent Hospital last summer meant transfer of patients to state mental hospitals in Mandeville and Jackson, both extended drives away for patients' families (*Psychiatric News*, September 18, 2009).

"Many people have major scars from Katrina and its aftermath," said Foulks. "People with preexisting schizophrenia, bipolar disorder, or depression often developed PTSD. Some could not take [the hardships] and presented a clinical challenge to the system, but many people came out of the experience with a new role in life. It brought out the best in them."

"There is a resilience, a spiritual toughness here," agreed Piazza.

"In New Orleans, especially among African Americans, there are deep, ritualized strategies for dealing with mortality and entropy," he said. "The traditional New Orleans jazz funeral includes both ritual grieving and also an acknowledgement of the continuity of life. Where else in America do you have exuberant dance music played at a funeral? It encourages a disposition that adjusts to the hard facts of life in an explosion of grace." ■

7:30 a.m.-Noon
Registration/Course Enrollment Open

8 a.m.-Noon
Master Course
MC05. Neuropsychiatry for Veterans *Chair: Stuart C. Yudofsky, M.D.*

9 a.m.-10:30 a.m.
Case Conference 4
Glen O. Gabbard, M.D., on The Self-Defeating Patient
(Open to APA members only.)

Lectures
L19. Administrative Psychiatry Award Lecture *Arthur L. Lazarus, M.D., M.B.A.,*
L20. Seek and Treat for Optimal Prevention of HIV/AIDS STOP HIV/AIDS *Julio Montaner, M.D.*

Scientific and Clinical Reports
Session 22. Genetics
SCR64. Longer Hospitalization Associated With Combinatorial CYP450 Drug Metabolism Deficiencies *Gualberto Ruano, M.D.*
SCR65. Psychiatric Phenotype in Fragile X-Associated Tremor/Ataxia Syndrome (FXTAs) *Andreea Seritan, M.D.*
SCR66. Association of Seropositivity for Influenza and Coronaviruses With History of Mood Disorders and Suicide Attempts *Olaoluwa Okusaga, M.D.*

Session 23. Issues in Child and Adolescent Psychiatry
SCR67. Childhood and Adolescence Predictors of Psychosis in General Population in the Northern Finland 1986 Birth Cohort *Pirjo H. Maki, M.D.*
SCR68. The Use of Video Feedback to Improve the Mother-Infant Relationship in Women With Postnatal Depression *Anne Buist, M.D.*
SCR69. Medical Comorbidity in Bipolar Children With Rapid Cycles: Is It Different Relative to Non-Rapid-Cycling Children? *Ruby Castilla-Puentes, M.D.*

Session 24. Antidepressant Response and Augmentation
SCR70. Quetiapine Augmentation of Antidepressant Treatment in Elderly Depressed Patients *Yoram Barak, M.D.*
SCR71. Do Adjunctive Stimulants Destabilize Mood in Patients With Bipolar Disorders? Findings From the STEP-BD *Joseph Goldberg, M.D.*
SCR72. Difference Between Morning and Evening TRH Tests Could Predict Antidepressant Response *Fabrice Duval, M.D.*

Session 25. (Psycho)pharmacology
SCR73. Tolerability of High-Dose Venlafaxine XL in Depressed Patients *Faouzi Alam, M.D.*
SCR74. Twelve-Month Herbal Medicine Use for Mental Health From the National Comorbidity Survey: Replication (NCS-R) *Simha Ravven, M.D.*
SCR75. Relationship Between Serum Venlafaxine, Its Metabolite Levels (O-Desmethylvenlafaxine), and Treatment Response in Patients With Refractory Depression *Qaiser Javed, M.B.B.S.*

Small Interactive Session
SI20. Alternative Treatments in Psychiatry *David Mischoulon, M.D.*

Workshops
W102. Fighting Stigma: When Psychiatrists Who Have Been in Treatment Speak Out *Co-Chairs: Michael Myers, M.D., Leah Dickstein, M.D.*
W103. Assessment of Capacity: Developments, Documentation, and Defendability *Chair: Michael Wise, M.B.B.S.*

9 a.m.-Noon
Media Workshop
MW7. Building Bridges: The Intersection Between Faith and Mental Health *Co-Chairs: Asghar Ali, M.D., Cecil Webster M.D.*

Symposia
S82. Women's Mental Health in Latin America: Present and Future Research
A. Depression Among Women With Cancer in Ecuador *Carlos León Andrade, M.D.*
B. Childhood Sexual and Physical Abuse History in a Gynecology Outpatient Clinic in Colombia: How Abuse Impacts Menopausal Symptoms *Ruby C. Castilla Puentes, M.D.*
C. Improving the Treatment of Depression in Chilean Women *Enrique Jadresic, M.D.*
D. Clinical Presentation and Treatment of Girls With Attention-Deficit/Hyperactivity Disorder in Chile and Argentina *Arturo P. Grau, M.D.*
E. Women's Mental Health in Latin America: Present and Future *Elvia Velásquez, M.D.*
F. Differences and Similarities in Mental Health Issues Between Men and Women in Latin America *Jorge Forero, M.D.*
G. Suicidal Behavior and Substance Abuse Among Sexually Abused Girls in Ecuador *Emma Saad, M.D.*

S83. How Dysfunction of Learning and Memory Circuits Contribute to Substance Abuse and Other Psychiatric Disorders *National Institute on Drug Abuse*
A. Selective Impairments in Reward vs. Punishment Learning in Psychiatric Disorders *Mark A. Gluck, Ph.D.*
B. Addiction as Dysfunction in Learning- and Memory-Based Decision Systems: Multiple Potential Failure Points Leading to Multiple Addiction Endophenotypes *A. David Redish, Ph.D.*
C. Impaired Modulation of Learned Motivational Responses to Cues: Common Core Dysfunctions in Addiction—and in PTSD *Anna Rose Childress, Ph.D.*
D. Neuroplasticity in Prefrontal Regulation of the Basal Ganglia Underlies Vulnerability to Relapse *Peter W. Kalivas, Ph.D.*
E. Emotional Influences on Memory Circuits in Posttraumatic Stress Disorder and Healthy Adults *Kevin S. LaBar, Ph.D.*

S84. Advances in Psychiatric Ethics: New Approaches That Inform Psychiatric Practice
A. Neuroethics: An Introduction for the Clinical Psychiatrist *Jinger G. Hoop, M.D.*
B. Ethical Considerations From Military Psychiatry *Christopher H. Warner, M.D.*
C. What Do Forensic Ethics Mean for General Psychiatry? *Philip J. Candilis, M.D.*
D. Research Ethics and the Practicing Psychiatrist—The Brave New World of Research in One's Private Practice *Donna T. Chen, M.D.*
E. Psychiatric Ethics Through the Prism of Geriatric Research *Sahana Misra, M.D.*

S86. Autonomy in the Prolongation and Curtailment of Life
A. The Balance Between Suicide and Autonomous End-of-Life Decisions: A Model Based on Chronic Kidney Disease and Dialysis *Lewis M. Cohen, M.D.*
B. Existential Resilience in Metastatic Breast Cancer: Choosing Life While Facing Death *David Spiegel, M.D.*
C. Ethics and Judao-Christian Views of Suicide and Life Extension *Norman B. Levy, M.D.*
D. Ethics in Suicide Not Associated With Psychiatric Illness *James J. Strain, M.D.*

S87. New Perspectives on Intergenerational Transmission of BPD
A. Genetic and Environmental Contributions to Borderline Personality Disorder *John Livesley, M.D.*
B. Familial Aggregation and Heritability of Borderline Personality Disorder and Its Component Traits *Mary C. Zanarini, Ed.D.*
C. Rejection Sensitivity as a Core Trait of Borderline Personality Disorder *Lois W. Choi-Kain, M.D.*
D. Familiality of Candidate Phenotypes *John G. Gunderson, M.D.*
E. Infantile Hypersensitivity to the Social Environment and Potential Developmental Failure in Affect Regulation, Effortful Control, and Mentalization *Peter Fonagy, Ph.D.*

S88. New CANMAT Guidelines for Depression and Bipolar Disorder: Combining Evidence With Clinical Practice
A. CANMAT Clinical Guidelines for Mood and Anxiety Disorders —History and Development *Sidney H. Kennedy, M.D.*
B. CANMAT Clinical Guidelines for Management of Adults With Major Depressive Disorder *Raymond W. Lam, M.D.*
C. CANMAT Guidelines for Management of Bipolar Depression *Lakshmi N. Yatham, M.B.B.S.*
D. Combining Evidence-Based Psychiatry With Clinical Practice—CANMAT and Other Recent Guidelines *Sagar Parikh, M.D.*

S89. Psychiatry Across Borders: Working for the U.S. Government in the Department of State as a Psychiatrist
A. Managing a World of Trouble: Psychiatrists at the State Department 1978-2008 *Samuel Thielman, M.A.*
B. Mental Health Response to a Terrorist Attack, Sana'a, Yemen *Joseph N. Rawlings, M.D.*
C. Psychiatry Across Borders: Working for the U.S. Government in the Department of State as a Psychiatrist *Paul S. Beigbley, M.D.*
D. Managing a Psychiatric Medical Evacuation From Overseas *Kenneth Dekleva, M.D.*
E. Managing a Psychiatric Medical Evacuation From Overseas *Christopher F. Flynn, M.D.*

S90. Update on Cannabis Use Disorders *National Institute on Drug Abuse*
A. Marijuana Abuse and Dependence in the General Population: Risk Factors, Symptom Structure, and Axis I and Axis II Comorbidity Effects on Persistence *Deborah S. Hasin, Ph.D.*
B. Neurobiology and Brain Imaging of Cannabis Dependence *Aviv Weinstein, B.S.C.*
C. Advances in the Development of Behavioral Treatments for Cannabis Use Disorders *Alan Budney, Ph.D.*
D. Advances in the Development of Pharmacological Treatments for Cannabis Use Disorders *Margaret Haney, Ph.D.*
E. Medical and Psychiatric Effects

DB Nominations Sought For Disaster Psychiatry Award

APA's district branches are invited to nominate up to two of their members for the 2011 Bruno Lima Award for Excellence in Disaster Psychiatry. The award recognizes outstanding contributions of members who have demonstrated care of and understanding to disaster victims. Contributions include designing disaster response plans, providing direct service delivery in time of disaster, providing disaster consultation and education, and/or doing research.

Submissions must include a nomination letter signed by the district branch president with a description of the district branch's selection process, a one-page description of the activities for which the individual is being nominated and the disaster events, a letter summarizing the nominee's contributions, a one-page biographical sketch, and any other supporting documentation.

The deadline is March 1 for consideration for next year's award.

More information is available from Elizabeth Stickman of APA's Office of International Activities at estickman@psych.org. ■

Associated With Cannabis Use *David A. Gorelick, M.D.*

S91. Cultural Adaptation of Cognitive-Behavior Therapy for Ethnic and Minority Patients

A. Implementing CBT for Psychosis in the Treatment of Ethnic Minorities in the United States *Michael Garrett, M.D.*

B. Cognitive-Behavior Therapy Across Cultures *David G. Kingdon, M.D.*

C. Developing Culturally Sensitive Cognitive-Behavior Therapy for Psychosis: A United Kingdom–Based Study *Shanaya Rathod, M.D.*

D. Developing Culturally Sensitive CBT Project Southampton: Adaptation of CBT for Depression in Pakistan *Farooq Naeem, M.R.C.*

S92. Nonpsychotic Issues of Schizophrenic Patients

A. Cognitive Rehabilitation of Schizophrenia: Treatment and Research *Raquel Gur, M.D.*

B. Smoking and Schizophrenia: Efficacy of New Treatments *S. Hossein Fatemi, M.D.*

C. Schizophrenia and Substance Abuse *Alan I. Green, M.D.*

D. Approaches to Suicide in Schizophrenia *Lawrence Adler, M.D.*

S93. Should 'Risk Syndrome of Psychosis' Be Included in *DSM-5* as a Diagnosis? A Road Toward Preventive Psychiatry

A. Risk Syndrome of Psychosis as a Diagnosis in *DSM-5:* Is the Question Legitimate? *Amresh Shrivastava, M.D.*

B. The Psychosis Risk Syndrome: On the Right Track but Not Quite There *Patrick McGorry, M.D.*

C. An Overview of the Current Status of Risk Syndrome for Psychosis *Ming Tsuang, M.D.*

D. Risk Syndrome for Psychosis: A Reliable and Valid Diagnosis *Scott Woods, M.D.*

E. Inclusion of the Psychosis At-Risk Category in *DSM-5:* Is It Premature? *Barbara Cornblatt, Ph.D.*

S94. Basic Science in Psychiatry: A Move Toward Translational Medicine

A. Synaptic Biology of Depression: G Proteins, Lipid Rafts, and the Search for a Biomarker *Mark Rasenick, Ph.D.*

B. Animal Models: Cell Cycle Regulators and Neurobehavioral Disorders *Robert Pechnick, Ph.D.*

C. Altered Brain Bioenergetics: A Reflection of Mitochondrial Dysfunction During the Treatment of Major Depressive Disorder *Dan Iosifescu, M.D.*

D. Neurogenesis Assays Prospectively Identify a Novel, Clinically Efficacious Combination for the Treatment of Major Depressive Disorder *Carrolee Barlow, M.D.*

S95. The Supreme Court and Psychiatry in the 21st Century

A. *Atkins v. Virginia:* Mental Retardation and the Death Penalty *Paul S. Appelbaum, M.D.*

B. *Clark v. Arizona:* The Supreme Court Considers the Insanity Defense and Psychiatric Testimony *Steven K. Hoge, M.D.*

D. *Panetti v. Quarterman* (2007) Competence to Be Executed: An Ethical Challenge for Psychiatrists and the Evolution of the Legal Standard *Howard V. Zonana, M.D.*

E. *Indiana v. Edwards:* Competence to Represent Oneself *Debra Pinals, M.D.*

S96. Novel Tools for Preventing and Treating Substance Use and Comorbidities in the Military and Returning Veterans *National Institute on Drug Abuse*

A. Understanding Long-Term Tobacco and Alcohol Use and Comorbid Mental Health Symptoms in Military Service Members and Veterans: The Millennium Cohort Study *Tyler C. Smith, Ph.D.*

B. Automated Interactive Voice Response as a Therapeutic Tool for Chronic Pain Reduction and Opioid Medication Use Decrease *Magdalena R. Naylor, M.D.*

C. Virtual Reality and D-Cycloserine for Exposure-Based Therapy *Barbara Rothbaum, Ph.D.*

D. The Video Doctor Approach: Potential Applications to Psychiatric Practices Serving Patients Impacted By War *Barbara Gerbert, Ph.D.*

E. Computer-Based Training in Cognitive-Behavioral Therapy: New Findings and Applications for Military Personnel *Kathleen M. Carroll, Ph.D.*

9 a.m.-4 p.m.

CME Course 77

11 a.m.-12:30 p.m.

Advances in Medicine

AM06. Update on Gastroenterology and Hepatology for Psychiatrists and Mental Health Practitioners *Nathaniel S. Winstead, M.D.*

Lecture

L21. Seek and Treat for Optimal Prevention of HIV/AIDS: STOP HIV/AIDS *Julio Montaner, M.D., Frontiers of Science Lecture*

Scientific and Clinical Reports

Session 26. Psychosis

SCR76. Catatonia: A "Frozen Condition"? New Treatment Options Based on Case Reports and Literature Review *Cristinel Coconcea, M.D.*

SCR77. Racial Differences in Major Depressive Disorder With Psychotic Features *Karen Bullock, Ph.D.*

SCR78. Toward a Better Understanding of the Interaction Between Religious Delusions and the Clinical and Religious Background of Patients With Schizophrenia *Philippe Huguelet, M.D.*

Session 27. Issues in Mood Disorders

SCR79. Minor Mixed Depression, Formerly Mixed Affective State: A Treatable Condition in Violent, Court-Ordered Detention Patients With a Personality Disorder *Carel De Blécourt, M.D.*

SCR80. Psychosocial Impairment Associated With Dysthymic Disorder in the NESARC Study *David Hellerstein, M.D.*

SCR81. Increased Mortality and Hospital Readmissions in Patients Depressed at the Time of Discharge From Medical Wards *Antonio Campayo, M.D.*

Session 28. Epidemiology, Sleep, and Medical Screening

SCR82. Laboratory Evaluation of Psychiatric Patients in the Emergency Room *Leslie Zun, M.D.*

SCR83. STOP-BANG Sleep Apnea Screening Evinces a High Risk Among Patients Admitted to Psychiatric Units *Sam Al-Saadi, M.D., M.S.*

SCR84. Schizotypal Personality Disorder in the United States: Prevalence and Correlates in a Representative General Population Sample *Vanessa Lentz, M.S.*

Session 29. Important but Infrequently Addressed Topics

SCR85. Overdiagnosis of Bipolar Disorder and Disability Payments *Mark Zimmerman, M.D.*

SCR86. The Economic Impact of Medication-Access Problems Among Medicaid Psychiatric Patients in 10 States *Joyce West, Ph.D., M.P.P.*

SCR87. Can We Talk? Do Psychotherapists and Prescribing Psychiatrists Communicate With Each Other About Their Mutual Patients? *Thomas Kalman, M.D., M.S.*

Small Interactive Sessions

SI21. *Marc E. Agronin, M.D., on* Borderline Personality Spectrum Disorders

SI22. *Deborah Spitz, M.D., on* Balancing Work and Family **(Open to APA resident members only.)**

SI23. *Ranga Krishnan, M.D., on* How to Research Clinical Questions

Workshops

W104. Tai Chi Exercise: A Controllable Physical Intervention to Enhance Mindfulness and Behavioral Activation in CBT Group Treatment for Depressed Patients *Co-Chairs: Jun Yang, M.D., Jennice Vilhauer, Ph.D.*

W105. Children of Psychiatrists *Co-Chairs: Michelle Riba, M.D., Leah Dickstein M.D.*

Noon-2 p.m.

New Research Poster Session 6

continued on page 36

Another Round of MindGames Planned For Annual Meeting

APA's exciting final round of the MindGames competition for psychiatry residents will once again be a highlight of the annual meeting—not only for residents but for psychiatrists in the audience who want to see how they measure up to their younger colleagues. This fun and educational competition pits residents against each other in a test of knowledge about medicine and patient care. The final round will be held on Sunday, May 23, from 6 p.m. to 7 p.m. in room 343/344/345 at the Morial Convention Center.

MindGames is open to all residency programs in the United States and Canada. The competition begins during the last two weeks of February, when residency teams of three residents each take a 60-minute online examination consisting of 100 multiple-choice questions. The questions follow the ABPN Part I content outline. The three top-scoring teams with the fastest posted times will receive a $5,000 grant from APA to send their teams to the MindGames final round at the annual meeting. The names of the three finalist teams will be announced in March at the meeting of the American Association of Directors of Psychiatric Residency Training.

At APA's annual meeting, the teams will compete in a "Jeopardy"-style game, emceed by Glen Gabbard, M.D. The winner takes home a trophy.

Last year the teams from the University of Pennsylvania, Albert Einstein Healthcare Network in New York, and the University of Texas at Houston competed in the final competition, with Albert Einstein emerging as the victor.

MindGames is a collaboration between APA and the American College of Psychiatrists and supported by an unrestricted educational grant from AstraZeneca.

Credit: David Hathcox

Glen Gabbard, M.D., waits to hear an answer at last year's MindGames competition.

26 WEDNESDAY MAY

1 p.m.-5 p.m.
Seminar

SM07. Practical Guide to the Performance of the Mental Status Examination *Chair: Steven Deutsch, M.D.*

1:30 p.m.-3 p.m.
Workshops

W106. Making Your Presentation More Interactive: The Better Way! *Chair: Jon Davine, M.D.*

W107. Games People Play: What Every Psychiatrist Needs to Know About Video Games *Co-Chairs: Deidre Williams, M.D., Faye Chao, M.D.*

W108. How to Implement Cardiometabolic Monitoring Across Large Public Health Systems *Co-Chairs: Laura Kent M.D., Christina Mangurian, M.D.*

W112. Feedback on Criteria and Terminology in *DSM-5* *Co-Chairs: David Kupfer, M.D., Darrel A. Regier, M.D.*

2 p.m.-5 p.m.
Media Workshop

MW8. Rachel Is Getting Married, Kym Is Getting Sober, Everyone Is Losing It *American Academy of Addiction Psychiatry Chair: Petros Levounis, M.D.*

Symposia

S97. Hot Topics in Afro-American Mental Health; Impact of Past and Current Prejudices; Womens' Mental Health; HIV; Unique Psychopharmacological Findings

A. History of Racism in Mental Health: Seeds of Distrust *Harriet A. Washington, B.S.*

B. Pseudoscientific Literature Promotes Racial Prejudice Among Physicians *Zack Z. Cernovsky, Ph.D.*

C. Black Women and Depression: The Role of Stigma as a Barrier to Treatment *Janet E. Taylor, M.D.*

D. HIV and Afro-American Mental Health *David W. Smith, M.D.*

E. Response and Tolerability of Psychotropics in African Americans *William B. Lawson, M.D.*

S98. Dysfunctions in Mentalization or Metacognition in Personality Disorders: Empirical Evidence and Implications for Pathology, Treatment, and Research

A. Impaired Metacognition and Correlations With Symptoms, Social Functioning, and Overall Personality Disorder Severity *Giuseppe Nicolo, M.D.*

B. Improving Mentalization in Borderline Patients in Transference-Focused Psychotherapy (TFP) *John Clarkin, Ph.D.*

C. Verbal Elaboration of Distinct Affect Categories in Borderline Personality Disorder *Serge Lecours, Ph.D.*

S99. Understanding Comorbidity of Heart Disease With Depression and Anxiety Disorders

A. Depression-Anxiety Comorbidity: Clinical Aspects *Jose Luis Ayuso, M.D.*

B. Treatment of Anxiety Disorders Is Associated With a Significantly Lower Prevalence of Secondary Depression *Leo Russo, Ph.D.*

C. Neurobiological Mechanisms in Anxiety/Depression and the Impact on Coronary Heart Disease *Jorge Tellez-Vargas, M.D.*

D. Understanding Comorbidity of Heart Disease With Depression and Anxiety Disorders *Ricardo Secin, M.D.*

E. Depression and Panic Disorders Significantly Increase the Risk for Heart Disease: One More Piece of Evidence *Ruby C. Castilla-Puentes, M.D.*

F. Association Study Between Blood Pressure and Personality, Anxiety, and Depression *Jorge Ospina, M.D.*

G. Strategies for Optimizing Treatment of Depression and Panic Disorder: What to Do When SSRIs Fail? *Carolina Remedi, M.D.*

S100. Treating Borderline Personality Disorder: Current Psychodynamic Perspectives

A. Key Clinical Interventions of Mentalization-Based Treatment *Anthony W. Bateman, M.D.*

B. Transference-Focused Psychotherapy in Theory and in Practice *Frank E. Yeomans, M.D.*

C. Overview of Expressive Supportive Psychotherapy (ESP) *John G. Gunderson, M.D.*

D. An Overview of Integrated Psychotherapy for BPD *Glen O. Gabbard, M.D.*

E. Discussion *Peter Fonagy, Ph.D.*

S101. Comprehensive HIV Psychiatry Update

A. HIV/AIDS Medical Update *David Mushatt, M.D.*

B. Neuropsychiatric Overview *Mordecai Potash, M.D.*

C. Neurocognitive Decline *Karl Goodkin, M.D.*

D. Psychopharmacology *Francisco Fernandez, M.D.*

S103. The Ethics of Innovative Interventions in Psychiatry

A. Ethical Issues in DBS Research for Psychiatric Disorders *Laura B. Dunn, M.D.*

B. The Ethics of Genetic Screening for Psychiatric Disorders *Paul S. Appelbaum, M.D.*

C. Ethical Issues Related to the Use of Transcranial Magnetic Stimulation and Vagus Nerve Stimulation in Psychiatry *Paul Holtzheimer, M.D.*

D. Ethical Issues in Pharmacologic Enhancement *Jinger G. Hoop, M.D.*

3 p.m.-5 p.m.
New Research Poster Session 7

3:30 p.m.-5 p.m.
Workshop

W113. Feedback on Criteria and Terminology in *DSM-5* *Co-Chairs: David Kupfer, M.D., Darrel A. Regier, M.D.* ■

Don't Forget! APA's 2010 annual meeting will begin with a full schedule of sessions on Saturday, May 22, and end a day earlier than in the past—Wednesday, May 26.

Psychiatry on the World Stage

APA's Office of International Activities (OIA) and the Council on Research and Quality Care and its components are pleased to announce that numerous scientific presentations dealing with international psychiatric issues are slated for APA's 2010 annual meeting in New Orleans. Here's a sampling. Check your program book for location.

MAY 22 — SATURDAY

2 p.m.-5 p.m. **Symposium: Recent Changes to Acute Psychiatric Care: An International Perspective on Prevention of PTSD: Recent Israeli Practices**

Symposium: Women's Mental Health in Latin America: Present and Future Research

MAY 23 — SUNDAY

11 a.m.-12:30 p.m. **Workshop: Psychiatric Care in Latin America: Current Challenges and Future Perspectives**

1:30 p.m.-3 p.m. **Workshop: Promoting International Medical Graduates: Psychosocial Support During Residency Training**

1:30 p.m.-4:30 p.m. **Culture and Psychiatric Diagnosis: Implications for the International Impact of *DSM-5***

MAY 24 — MONDAY

9 a.m.-10:30 a.m. **Workshop: Core Competencies in Europe and the U.S.: An Educational Model**

MAY 25 — TUESDAY

9 a.m.-Noon **Symposium: Psychiatrists in the World: Advocating for LGBT Mental Health**

MAY 26 — WEDNESDAY

9 a.m.-Noon **Symposium: Psychiatry Across Borders: Working for the U.S. Government in the Department of State as a Psychiatrist**

Other international activities hosted by the OIA and the Council on Research and Quality Care include six international discussion groups or forums. These groups will focus on current issues in psychiatry on these topics: Europe, South Asia, Africa, Pacific Rim and the Middle East, and international lesbian, gay, and transgender groups and are open to all meeting attendees.

- **Middle East Discussion Group**
  Sunday, May 23, 10 a.m.-noon
  Ascot Room, Third Floor, Hilton New Orleans Riverside
- **International Lesbian, Gay, Bisexual, and Transgender Discussion Group**
  Sunday, May 23, 1 p.m.-3 p.m.
  Norwich Room, Third Floor, Hilton New Orleans Riverside
- **Africa Discussion Group**
  Sunday, May 23, 3 p.m.-5 p.m.
  Elmwood Room, Third Floor, Hilton New Orleans Riverside
- **Pacific Rim Discussion Group**
  Monday, May 24, 1 p.m.-3 p.m.
  Grand Salon C, Section 15, First Level, Hilton New Orleans Riverside
- **South Asia Discussion Group**
  Monday, May 24, 2 p.m.-4 p.m.
  Grand Salon C, Section 16, First Level, Hilton New Orleans Riverside
- **European Discussion Group**
  Tuesday, May 25, 12:30 p.m.-2:30 p.m.
  Prince of Wales Room, Second Floor, Hilton New Orleans Riverside

In addition to the many international activities being held at the annual meeting, OIA and the Disaster Work Group encourage participants to attend the following sessions dealing with trauma and disaster psychiatry:

SATURDAY, MAY 22

11 a.m.-12:30 p.m. **Workshop: The Behavioral Health Action Network: Reorganizing the Behavioral Health Delivery System in Post-Katrina New Orleans**

1:30 p.m.-3 p.m. **Workshop: Vulnerability and Resilience: Katrina's Widespread Impact on First Responders, Clinicians, Youth, and Relocated Survivors**

MONDAY, MAY 24

9 a.m.-10:30 a.m. **Workshop: Disaster Preparedness, Evacuation, and Rebuilding: Lessons Learned from Katrina Applied to Gustav and Ike**

9 a.m.-10:30 a.m. **Case Conference: Posttraumatic Stress Disorder**
Robert Ursano, M.D.

7 p.m.-10 p.m. **Media Workshop: National Disasters: Developing a Road Map for Preparedness and Interventions**
World Psychiatric Association

WEDNESDAY, MAY 26

9 a.m.-Noon **Symposium: Lessons from Hurricane Katrina: Response, Recovery, and Rebuilding**

More information about the Office of International Activities and its components can be accessed at APA's Web site at <www.psych.org/MainMenu/Research/InternationalPrograms.aspx> or obtained by e-mailing the office at internationaloffice@psych.org.

Discoveries

continued from page 6

Two additional sessions will explore the mechanisms of reward neurocircuitry and the learning and memory system and offer explanations for impairment in addiction, posttraumatic stress disorder, and other psychiatric disorders. The symposium "Reward Neurocircuitry in Substance Dependence and Other Psychiatric Disorders: What Does Brain Research Tell Us?" will be held on Tuesday, May 25. The symposium "How Dysfunction of Learning and Memory Circuits Contributes to Substance Abuse and Other Psychiatric Disorders" will take place on Wednesday, May 26.

Ample Clinical Advice Presented

In addition to new discoveries from the laboratory, the NIDA track also features numerous sessions with clinical advice immediately useful in practice. A symposium on Saturday, May 22, titled "Smoking in Psychiatric Disorders: Clues About Causal Pathways and Innovative Treatment Approaches," will highlight research into the mechanisms of and effective treatments for smoking cessation in patients with schizophrenia and other psychiatric disorders. On Sunday, May 23, attendees can learn about women-specific issues in drug-abuse treatment at a symposium in the morning titled "Sex/Gender Differences and Women-Specific Issues in Drug Abuse: Predicting and Improving Treatment Outcomes" and strategies for managing long-term treatment for opiate dependence at the afternoon workshop "Maintenance Treatment for Opiate Dependence: Terminable or Interminable."

The symposium "Update on Medication Development: Promising New Treatment for Drug Addiction" will report research findings on modafinil in treating cocaine addiction, D-cycloserine for cocaine and nicotine dependence, bupropion for methamphetamine addiction, dronabinol for cannabis addiction, and a nicotine vaccine for nicotine addiction. The symposium will be held on Monday, May 24.

Federal Drug Official to Speak

In addition to symposia and workshops, several lectures will be given on key topics. A. Thomas McLellan, Ph.D., will give a lecture on federal policies and strategies addressing addiction and substance abuse on Tuesday, May 25. McLellan is deputy director of the White House Office of National Drug Control Policy.

Karl Deisseroth, M.D., Ph.D., an associate professor of bioengineering and of psychiatry and behavioral sciences at Stanford University, will give an overview of the development and application of optogenetics on Monday, May 24. Optogenetics is a new field of research that combines genetic engineering with light to probe and illuminate the activities of neurons.

In addition, Julio Montaner, M.D., a professor of medicine, chair of AIDS Research, and head of the Division of AIDS at the University of British Columbia, will provide an update on treatment and prevention strategies for HIV illness on Wednesday, May 26.

The entire NIDA track is "filled with outstanding science," Volkow emphasized. She is encouraging annual meeting attendees to take a close look at all the addiction-related presentations offered. The basic and applied addiction research is very relevant to other psychiatric practice areas, she noted.

"NIDA is excited and pleased to work with APA to address ways to advance the practice of psychiatry through the science of addiction," said Volkow. "Scientific advances give hope to clinicians and patients for better prevention and treatment of addiction and related mental illnesses. Recognizing the overlap at descriptive, clinical, and neurophysiologic levels of addictions with many other psychiatric disorders is an essential part of this advancing science."

The complete schedule of programs in the NIDA track will be published in a future issue and distributed on site at the annual meeting. ■

French Quarter

continued from page 4

the new residents during the 1830s was a nephew of Napoleon Bonaparte.

By 1840, the city was the fourth largest in the United States. The nearby Mississippi was congested with river boats, steamers, and ocean-sailing craft. At this juncture, the city had much of the wildness of a frontier town about it. But in 1849, New Orleans experienced a disastrous flood, the worst ever until that caused by Hurricane Katrina in 2005.

The city's unique architecture mostly survived the American Civil War of 1861-1865 intact, but it was in 1905 that a major disaster hit in the form of a yellow-fever epidemic. President Teddy Roosevelt paid the city a visit against the advice of many who feared that he would contract the disease.

In 1934, simmering hatred between Louisiana Governor Huey Long and New Orleans Mayor T. Semmes Walmsley came to a head. State troopers and armed city police faced off. Armed conflict was narrowly avoided.

In 1965, the French Quarter was designated a National Historic Landmark, and marking another landmark, in 1978 Ernest Morial became the first African-American mayor of New Orleans. Regarded as one of New Orleans' most accomplished politicians, he served two terms as mayor.

By 2000, the French Quarter still contained many of the buildings constructed under the Spanish or in the Spanish style. Although a number were used as hotels, bars, shops, or tourist attractions, others were private homes and occupied by people whose families had lived in the Quarter for generations. The temperament of the Quarter was still somewhat Gallic, the climate still alluringly sultry.

Because the Quarter is located on higher ground than much of New Orleans, it experienced far less damage by Hurricane Katrina's floods in 2005. So today, as in years gone by, it represents the heart of New Orleans for natives and visitors alike—impudent, raffish, yet at the same time, restrained and cultivated. Or as the French would say, "*Ah, c'est formidable!*" ■

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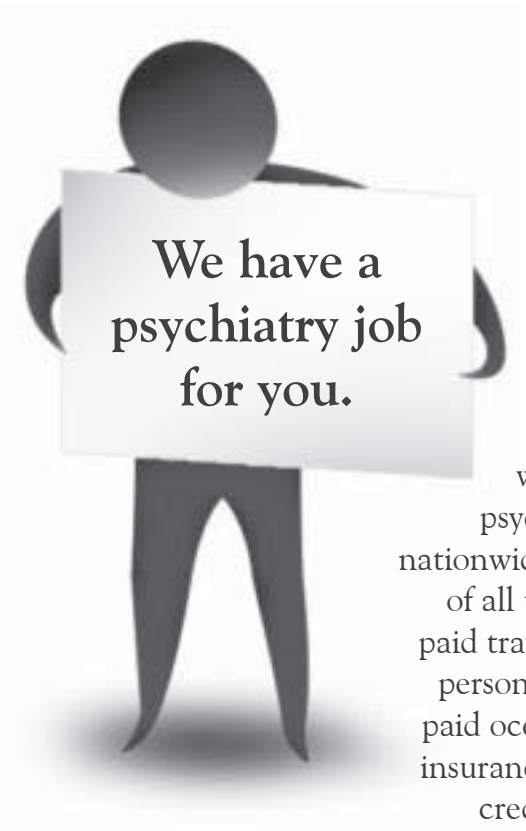

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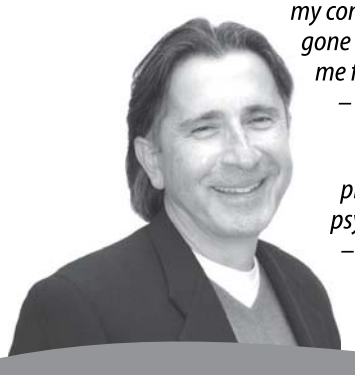

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Send cover letter, resume and 3 letters of recommendation to Search #R38181, University of Massachusetts, Norma Fisher, Human Resources, 150 Infirmary Way, Amherst, MA 01003. Review of resumes will begin on February 16, 2010, and will continue until position is filled.

The University of Massachusetts is an Affirmative Action/Equal Opportunity Employer. Women and members of minority groups are encouraged to apply.

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PSYCHIATRIST

Saint Francis Hospital's Department of Psychiatry, a respected leader providing mental health care, has a unique opportunity for a full time Staff Psychiatrist to support Emergency Psychiatric Services.

Requires NYS license, BC/BE in psychiatry.

The Hospital offers a competitive salary and incentive package and an excellent benefits program.

Saint Francis Hospital is located in New York's scenic Hudson Valley, with easy access to New York City.

The Staff Psychiatrist will practice in a brand-new, state-of-the-art Emergency Psychiatric Center surrounded by a newly-renovated and expanded Emergency Department as part of a close team of practitioners from the Behavioral Health and Emergency Medicine teams.

Please send CV and letter of interest to:

Human Resources, Saint Francis Hospital,
241 North Road, Poughkeepsie, NY 12601
Or, e-mail to jobs@sfhhc.org

You may also contact
Dr. Michael C. Susco MD,
Director, Department of Behavioral Medicine at (845) 431-8743.

EOE M/F/D/V

Saint Francis Hospital and Health Centers

SHEPPARD PRATT PHYSICIANS, P.A.

Community Hospital Contract Management Division
Central Maryland

Sheppard Pratt Physicians, P.A. manages the psychiatric services for several community hospitals in Central Maryland and employs the psychiatry staff to provide those services. Sheppard Pratt is seeking psychiatrists with experience and expertise in inpatient and consultation liaison psychiatry, sensitivity to the needs of hospital medical staff and community physicians and an ability to focus on both quality care and continuity of care. Depending on the hospital, the psychiatrist may elect to provide a combination of inpatient, partial hospital, consultation liaison and outpatient services. Both leadership and staff positions are available.

Qualified candidates must possess a current license to practice in Maryland at the time of appointment. All positions are full time employment positions with benefits. Leadership positions combine the administrative roles of Chair of the Department of Psychiatry and Medical Director of the Psychiatric Services Unit with clinical services anchoring the consultation liaison and inpatient services and reports to the Vice President of Medical Affairs, Sheppard Pratt Health System. Board certification is required for leadership positions; subspecialty training is highly desired.

Sheppard Pratt offers a generous compensation package and comprehensive benefits and is an equal opportunity employer.

If you would like to explore these options, please contact our Director for Professional Services, Ms. Barbara Magid at 410 938-3460, email bmagid@sheppardpratt.org,

Chair, Department of Psychiatry

School of Medicine
University of California,
San Francisco

The School of Medicine at UC San Francisco seeks an outstanding individual to lead its Department of Psychiatry. This position also serves as the Director of the Langley Porter Psychiatric Institute. The successful candidate will have exceptional administrative and organizational skills and a national reputation as a leader in academic medicine in the areas of medical education, clinical care and research. The individual chosen will have major responsibilities in the overall direction of this distinguished department. Applicants must be qualified for appointment as a tenured professor.

Please send your curriculum vitae no later than March 31, 2010, to:

Deborah Taylor
School of Medicine, UCSF
Office of the Dean
513 Parnassus Ave., Room S-224
San Francisco, CA 94143-0410

Or submit via e-mail
deborah.taylor@ucsf.edu

University of California
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School of Medicine

UCSF seeks candidates whose experience, teaching, research, or community service has prepared them to contribute to our commitment to diversity and excellence. UCSF is an Affirmative Action/Equal Opportunity Employer. The University undertakes affirmative action to assure equal employment opportunity for underutilized minorities and women, for person with disabilities, and for covered veterans.

Psychiatry Opportunities in Beautiful Duluth, MN

SMDC Health System, a member of Essentia Health, serves a regional population of 460,000 in Northeastern Minnesota, Northwestern Wisconsin and Michigan's Upper Peninsula. The integrated health system includes five hospitals, as well as the Duluth Clinic, a nationally recognized 450+ physician multispecialty group providing care at 17 locations.

Located along Lake Superior's rugged hillside, Duluth's spectacular scenery, abundant recreational opportunities and vibrant arts community earned it inclusions on best small cities lists from Outside and Money magazines. Two hours from Minneapolis/St. Paul metro area. EOE/AA

CHILD/ADOLESCENT AND ADULT PSYCHIATRISTS

- Join a group of 4 adult and 1 child/adolescent psychiatrists as part of a Behavioral Health Care Team to also include doctoral level psychologists, advanced practice nurses, nurse clinicians and psychotherapists
- Full range of psychiatric problems and diagnoses
- Opportunity to evaluate and treat chemically dependent adolescent patients
- 37-bed adult and 16-bed child/adolescent unit
- 3 partial hospital programs for adults, children and adolescents
- 24/7 referral center for triage and assessment services
- Consultation/liaison service available
- Competitive benefit package and salary with first-year guarantee
- J1-waiver opportunity

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Sandra Kramer, Physician Recruiter
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skramer@smdc.org

Duluth Clinic
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MIDWEST PHYSICIAN OPPORTUNITY
WITH PARTNERSHIP

Medical Associates Clinic, located in Dubuque, Iowa, is seeking a BE/BC General Psychiatrist or Child/Adolescent Psychiatrist to join the Psychiatry and Behavioral Medicine Department. The department currently consists of two Psychiatrists, three Psychologists, two Psychiatric Certified Nurse Practitioners and one Physician Assistant.

Medical Associates Clinic, established in 1924, is the oldest multispecialty group practice in Iowa with over 150 providers. The Clinic is both physician owned and directed and is also the sole owner of highly successful and NCQA Excellent accredited Medical Associates Health Plans. An AMGA "Best Practice" for physician satisfaction clinic, Medical Associates offers a truly outstanding practice opportunity.

Located along the scenic bluffs overlooking the wooded banks of the Mississippi River, Dubuque is a beautiful city with one of the finest school systems in the country. The area offers something for everyone: a talented local symphony, the Smithsonian-affiliated National Mississippi River Museum and Aquarium, excellent community theatre, miles of hiking, biking and cross country skiing trails, boating, and extensive programs and events for children. With a population of 65,000 and a drawing base area of over 250,000, Dubuque is a city where the simple pleasures and modern conveniences of life are balanced. Dubuque is a little over a one hour drive from both Madison and Iowa City and is only three hours from Chicago.

FOR CONSIDERATION, PLEASE CALL:
Cathy Boyd at (800) 528-8286, X4113 or
email your CV to cathy.boyd@stratummed.com

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Issue	Deadline (Friday, 2 p.m. E.T.)
March 19	March 5
April 2	March 19

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ALABAMA

Busy solo practice in Huntsville, AL looking for psychiatrist interested in adult, child & adolescent, and addiction treatment. Competitive salary/benefit package. Partnership opportunity with higher than average income potential. Graduating residents welcome. Email CV dwdopa@comcast.net or fax 256-883-7032

ARIZONA

Sierra Tucson - Adult Psychiatrists. Our internationally renowned dual-disorder behavioral health treatment facility, will be adding two (2) adult psychiatrists to join our dynamic staff. Applicants must be board-certified or board-eligible in psychiatry. Prefer applicants with experience in addiction medicine, but experience in mood, anxiety, eating disorders, chronic pain, or trauma is also valued. Learn more about Sierra Tucson and this exceptional treatment opportunity at www.sierratucson.com.

Send a cover letter & resume to HR Manager:
Fax: (520) 818-5889
Email: careers@sierratucson.com
Mail: 39580 S. Lago del Oro Pkwy, Tucson, AZ 85739.

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SCENIC NORTHERN ARIZONA
WORK, PLAY, RETIRE HERE

EXPANDING PRACTICE

Highly desirable Inpatient/Outpatient Community Mental Health opportunities for BE/BC Psychiatrist available in Northern Arizona's beautiful White Mountain vacation area. Be part of a family friendly community with southwestern charm. Step into a hassle-free practice, where you see patients and we take care of the rest. Experience professional, supportive staff, a collegial environment, as well as comfortable work hours and life style. Modern, newly constructed inpatient psychiatric hospital offers a state of the art treatment environment. Arizona's White Mountain area is renowned for mild summers and beautiful, snow-capped mountain winters, perfect for hiking, hunting, fishing, camping, skiing, snowboarding, and bird watching.

Excellent salary with full benefits package, malpractice coverage, and CME. 35 days per year paid time off. **NHSC Loan Repayment Program participant/ J-1 applicants welcome.** Arizona Medical License required.

Interested applicants, please contact Jennifer Foran, M.D., Medical Director at (928)241-2461 for more information, or submit your CV by e-mail to: jforan@ccc-az.org or FAX to Human Resources @ (928) 524-3068.

ARKANSAS

LITTLE ROCK & FAYETTEVILLE- General & Child Psychiatrists. Admin/Clinical & Staff positions. Inpatient & partial programs. Fulltime or part-time positions offering highly competitive salary, benefits & bonus. **Student loan assistance.** Contact Joy Lankswert, In-house recruiter @ 866-227-5415 or email joy.lankswert@uhsinc.com

CALIFORNIA

Intuitive Health Services, Inc.
CA Corrections $170 an hour and $42 on call. Atascadero St. Hosp. $185. 4-10's and weekends available. www.intuitivehealthservices.com intuitivehealthservices@intuitivehealthservices.com, (805) 703-3729, FAX (925)462-2583

PSYCHIATRIST
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APPROXIMATE ANNUAL SALARY: $146,910 - $178,568
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EEO/ADA Employer and a Drug Free Workplace

SOUTHERN CALIFORNIA PRACTICE OPPORTUNITY

Mission Hospital is looking to recruit a Board Certified/Board Eligible Psychiatrist. The successful candidate must have a California License. Mission Hospital currently has two campuses located in Mission Viejo and Laguna Beach. Mission Hospital Laguna Beach has a Behavioral Health Unit providing inpatient and outpatient treatment programs. The newly recruited physician would be establishing a private practice on the Mission Viejo campus, and share office space with an established Psychiatric Group. In addition to establishing an Outpatient practice, the candidate will be required to be available for consultation of inpatient and emergency room patients with psychiatric and medical co-dispositions.
A Recruitment package is available commensurate with Fair Market Value for the area. If you are interested please send CV to Martha.Montgomery@stjoe.org or call at (949) 422-1510.

Mental Health

PATTON STATE HOSPITAL — CARE AND TREATMENT WITH RESPECT AND DIGNITY

CALIFORNIA
BC/BE STAFF PSYCHIATRIST

Patton State Hospital is recruiting board certified/eligible psychiatrists. Patton is a Joint Commission accredited, 1500 bed, adult forensic psychiatric hospital, with an extremely interesting and challenging patient population. The hospital is nestled below Arrowhead and the San Bernardino Mountains, 65 miles east of Los Angeles; an hour's drive to beaches, Palm Springs, or mountain lakes and skiing. Salary with Board Certification starts at **$18,622 and goes to $21,311 monthly.** Salary for Board Eligible starts at **$18,146 and goes to $20,711 monthly.** In addition, Patton offers excellent benefits (health, dental, and vision; license renewal; malpractice insurance; tax-deferred compensation; paid annual leave and 12 holidays (plus one personal holiday), as well as seven days per fiscal year of Continuing Medical Education leave). Voluntary on call duty is compensated on an hourly basis over and above base salary. We provide civil service security and retirement plans (including safety retirement). For confidential consideration, send CV to George Christison, M.D., (A) Medical Director, 3102 East Highland Avenue, Patton, California 92369, (909) 425-7326 or Fax (909) 425-6635.

Contract psychiatrists needed at Coalinga State Hospital, CA. Schedules - Five 8 hrs; Four 10 hrs & Three 12 hrs weekly. Rate $180/hr & we offer malpractice when you contact us directly. Call 800-758-7012; fax 800-758-7013 & e-mail hahacorp@gmail.com. We work with recruiters for fee

View the classifieds online at
pn.psychiatryonline.org

LICENSED CA. PSYCHIATRIST wanted for part-time PRIVATE PRACTICE POSITION. Flexible hours. Already on insurance panels a plus. No inpatient work. Very little on call. AVERAGE $200 PER HOUR. Fax CV to 760-946-1215 or email DesertBehavioralHlth@msn.com

San Diego County needs psychiatrist for hospital, possible ER and telepsychiatry. Salary extremely competitive for San Diego - up to 170K plus 10% Boards and extra 5% second Boards. CV to Marshall Lewis, MD, Clinical Dir, County Behavioral Health Div, Marshall.Lewis@sdcounty.ca.gov. Apply now at www.sdcounty.ca.gov/hr.

COLORADO

Horizon Health, the nation's leader in psychiatric contract management seeks an **Attending Psychiatrist** for a **10-bed Gero-psych** unit at **Colorado Plains Medical Center (CPMC),** a 50-bed acute-care hospital located in **Fort Morgan, CO,** serving a two-county area of 35,000. The opportunity includes the development of a community based outpatient practice. **CPMC** is fully accredited by JCAHO, and has a Level III Trauma Center, a 24-hour Emergency Room and many other services.
Fort Morgan, located 80 miles northeast of Denver on U.S. Interstate 76, less than an hour's drive to Denver International Airport, is big enough to have it all, and small enough to be a delightful home town. Contact: Mark Blakeney, Horizon Health, 972-420-7473, fax CV: 972-420-8233, or email mark.blakeney@horizonhealth.com. EOE.

BOULDER: General or Child Psychiatrist. Staff and Admin/Clinical positions. Inpatient & Partial programs. Salary, benefits & incentive plan. Contact: Joy Lankswert, In-house recruiter @ 866-227-5415 or email joy.lankswert@uhsinc.com

CONNECTICUT

Psychiatrist/Child Psychiatrist to work in Stamford, CT in a private practice, part time, seeing quality patients of all age groups and better than average rate of pay ($90+). Fax resume to 203-930-3655 or email at childpsychny@aol.com.

BEAUTIFUL SUBURBAN CT/
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CT licensed BC/BE Psychiatrist to join a 30 year well established multi-disciplinary practice providing adult psychiatric services. Excellent Compensation. Send CV/cover letter by fax 203-797-0877 or Email: afrymd@yahoo.com.

DELAWARE

DOVER: Child or General Psychiatrists. Inpatient/partial programs for adolescents & adults. Very competitive salary, benefits & incentive plans. **J1 eligibility.** Contact Joy Lankswert In-house recruiter @ 866-227-5415; OR email joy.lankswert@uhsinc.com

FLORIDA

DAYTONA - MELBOURNE - ORLANDO - MIAMI - FORT LAUDERDALE - PALM BEACH - OCALA - GAINESVILLE - FORT MYERS - SARASOTA - PENSECOLA - JACKSONVILLE - Psychiatrists needed for rapidly expanding Nursing Home Service. Great support. No call. Average Salary 210K + benefits. Part-time available. Some travel required. Must have FL Medicare & FL Medicaid individual provider #s. No Restrictions (H1B Candidates Considered). Call our administrator, Christy, at 866-936-5250.

Child & Adolescent Psychiatrists

Lee Mental Health Center, Inc. (LMH) is the primary provider of mental health services in Lee County, in Southwest Florida. A private non-profit company, the Center provides a continuum of mental health and substance abuse services for adults and children. We are committed to the recovery model of service delivery. We are currently seeking dynamic Child & Adolescent Psychiatrist candidates for **PT (20+ hrs/wk) or FT positions in our Crisis Stabilization and Outpatient departments.** Will be responsible for diagnostic interviews, medication management, consults, second opinions, rotating on-call duty and rounds. Will interface/collaborate with other treatment professionals, as appropriate. Successful candidates will possess an active/clear Florida medical license and a valid DEA. Must be Board certified or eligible in General/Adult or Child psychiatry. Must be eligible to serve as a provider in Medicaid and Medicare programs. Experience in community mental health and substance use disorders a plus.
Compensation/Benefits: Competitive salary and a benefits package for FT employees that includes: Malpractice Insurance, generous paid time off (includes vacation, sick and personal leave); 10 paid holidays per year, Health, dental and life insurance, Short Term & Long Term Disability (and other supplemental insurance options) 403b retirement plan and more!
Nearby: LMH is located on the vibrant Gulf Coast of southern Florida. Residents enjoy a variety of communities with excellent schools, easy access to year round recreational and cultural activities and unlimited sunshine. You are encouraged to come and enjoy the diversity and beauty of SW Florida!
Submit both an employment application and CV to: Lee Mental Health Center, Inc. (Attention: HUMAN RESOURCES), 2789 Ortiz Avenue, Fort Myers, FL 33905; or fax: 239-418-0094; or email: apply@leementalhealth.org Please visit www.leementalhealth.org to access an employment application and for additional information.
EOE/DFWP

Great Opportunity for Psychiatrist in Practice in or near Cocoa Beach Area - Position nicely compliments already existing private practice by incorporating inpatient work into your practice; we'll market your practice as well. Increase income/Capture new market.Inpatient unit in general hospital - adult and geriatric patients. Please **call Terry B. Good at 1-804-684-5661**, Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

ORLANDO - Medical Director & Staff Physician positions. Inpatient & partial programs for child - adult ages. Fulltime - salary & benefits. Contact Joy Lankswert In-house recruiter @ 866-227-5415 or email joy.lankswert@uhsinc.com

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BRADENTON - General Psychiatrist. Full-time position for inpatient & partial programs. Competitive salary, benefits & bonus plan. Contact Joy Lankswert In-house recruiter @ 866-227-5415 or email joy.lankswert@uhsinc.com

GEORGIA

THOMASVILLE: JC accredited state hospital with modern facilities, congenial staff, and up-to-date programs desires BE/BC PSYCHIATRIST to join medical staff of board-certified psychiatrists and generalists. No primary care duties; back-up call by phone. Adult and forensic programs. Excellent salary and benefits. Send CV or contact Joseph B. LeRoy, M.D., Clinical Director, Southwestern State Hospital, POB 1378, Thomasville, GA 31799. 229.227.2990; Fax 229.225.4052; email jbleroy@dhr.state.ga.us.

Private Practice seeking FT BC Adult Psychiatrist to take over established Psychiatrists' practice in NE GA. The practice also has a team comprised of 2 Ph.D. Psychologists, an LCSW and an LPC. E-mail CV to mkingphd@gmail.com

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Metro Atlanta - Outpatient Adult Psychiatrists sought by progressive comprehensive mental health system. Part time. Flex schedules. Supportive staff. Contract at competitive pay. Fax CV to Gretchen Collins MD at 770-339-5382 or email crissie@northsidepsychiatric.com

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ATLANTA: Medical Director & Staff Position - Inpatient & partial psych programs. **Staff Position** - premier Addiction Program - must be fellowship trained or have addiction interest/experience. Weekend moonlighting also available. Contact Joy Lankswert, In-house recruiter @ 866-227-5415 or email joy.lankswert@uhsinc.com

ILLINOIS

Psychiatry Opportunity - Chicago- MacNeal Hospital
Employed position which would be primarily inpatient and medical surgical consults. Outpatient practice to grow with referrals from other employed physicians. 48 bed BHS unit currently covered by private physicians. Please send CV in confidence to: Nicole Chamberlain, nicole@vhschicago.com, 708-783-3955.

Psychiatrist
Addiction & Pain Program

Advocate Christ Medical Center, Department of Psychiatry seeks a qualified and experienced Liaison Psychiatrist for our addiction and pain program. Candidates must be Fellowship trained in addiction psychiatry, hold a current Illinois license and be board certified or board eligible.

Advocate Christ Medical Center (ACMC) is a 695-bed, not-for-profit teaching, research and referral medical center located in the southwest suburbs of Chicago. ACMC is part of Advocate Health Care, Chicago's largest provider of care and one of the nation's leading integrated health systems.

The selected candidate for this highly visible position will lead the addictions detox and medical psych unit which is joined with an active pain program and cooperate with a multidisciplinary consultation liaison service for hospital based medical and surgical services. There further exists the opportunity to teach and supervise medical students and residents.

This exciting part time salaried position includes health and retirement benefits.

The incumbent may also enjoy an opportunity to perform out patient work seeing substance abuse patients and general psychiatry as part of a progressive multi specialty psychiatric group practice located in Orland Park, Illinois.

To apply directly, please submit a CV and cover letter to: donna.kutka@advocatehealth.com or for more information contact Donna C. Kutka, RN, MS, Director, Physician Recruitment, at 708.684.5009.

KANSAS

Full-time Child/Adolescent and Adult Psychiatrist for Community Mental Health Center

Johnson County Mental Health Center (located in a suburb of Kansas City) has an opening effective 2-1-10 for a full-time Child, Adolescent and Adult Psychiatrist for outpatient and corrections work. Req. a medical degree; (M.D. or D.O.); successful completion of ACGME accredited General Psychiatry and Child and Adolescent Psychiatry Residency Programs; must be eligible for licensure to practice in KS. Must have board eligibility or certification through the ABPN; compensation commensurate with experience. This position has been posted as open until filled. For the current recruitment status, please visit our website. Interested applicants should apply online at http://hr.jocogov.org/ or contact: Dr. Jane Lauchland. Johnson County Mental Health Center, 6000 Lamar, Suite 130, Mission, KS 66202; 913-831-2550; FAX to 913-826-1594; Jane.Lauchland@jocogov.org EOE M/F/D.

LOUISIANA

The Department of Psychiatry and Neurology at Tulane University School of Medicine is recruiting a geriatric psychiatrist for a full-time faculty position. The candidate will spend part of their time at the Southeast Louisiana Veterans Health Care System (SLVHCS) and will also be involved in the new initiatives in both clinical geriatric care and special geriatric education programs at Tulane. Responsibilities include patient care as well as contributing to the various teaching and training programs of Tulane University's Department of Psychiatry and Neurology at the SLVHCS. He/she will be provided the opportunity to pursue their research interests. The person selected for this position must be professionally competent and be board eligible/certified in general psychiatry and in geriatric psychiatry. She/he must be eligible for medical licensure in the State of Louisiana and have a current state and federal narcotics number. In addition, candidates must be eligible for clinical privileges at Tulane University Hospital and Clinic under the appropriate staff category and must agree to abide by those privileges as outlined by the current bylaws of the institution. Salary will be competitive and commensurate with the level of the candidate's academic appointment. Applications will be accepted until a suitable qualified candidate is found. Applicants should send letter of interest, updated CV and list of references to Daniel K. Winstead, MD, Heath Professor and Chair, Department of Psychiatry and Neurology, Tulane University School of Medicine, 1440 Canal Street TB48, New Orleans, LA 70112. Interested and eligible candidates may obtain further information by contacting Daniel K. Winstead, MD at 504-988-5246 or winstead@tulane.edu. Tulane is strongly committed to policies of non-discrimination and affirmative action in student admissions and in employment.

CHILD PSYCHIATRISTS - DEPARTMENT OF PSYCHIATRY AND NEUROLOGY, TULANE UNIVERSITY SCHOOL OF MEDICINE in New Orleans, LA, is recruiting for BE/BC child psychiatrists at the instructor or assistant professor level, salary commensurate with experience. Clinical responsibilities available in the areas of inpatient psychiatry, community based child and adolescent psychiatry, and early childhood mental health. Teaching responsibilities include the supervision of residents, clinical psychology fellows and interns, and medical students rotating through the clinical facilities serviced by this position as well as the presentation of grand rounds and participation in the didactic series in child psychiatry. Clinical research is strongly encouraged. The persons selected must be professionally competent and be board eligible/certified in general psychiatry. She/he must be eligible for medical licensure in the State of Louisiana and have a current state and federal narcotics number. In addition, candidates must be eligible for clinical privileges at Tulane University Hospital and Clinic under the appropriate staff category and must agree to abide by those privileges as outlined by the current bylaws of the institution. Applications will be accepted until a suitable qualified candidate is found. Send CV and list of professional/academic references to Charley Zeanah, Jr, MD, Professor and Vice Chair, Child and Adolescent Psychiatry, Tulane University School of Medicine, Department of Psychiatry and Neurology, 1440 Canal Street TB52, New Orleans, LA 70112 (czeanah@tulane.edu). Tulane is strongly committed to policies of non-discrimination and affirmative action in student admission and in employment.

DEPARTMENT OF PSYCHIATRY AND NEUROLOGY, TULANE UNIVERSITY SCHOOL OF MEDICINE in New Orleans, LA, is recruiting for several general and forensic psychiatrists (clinical track) for our growing department, at the Assistant/Associate Professor level. Candidates must have completed an approved general psychiatry residency and be board certified/eligible in general psychiatry and forensic psychiatry, respectively. Responsibilities will include direct patient care, teaching of medical students and house officers, and research (clinical and basic science) at various state hospitals, state correctional institutions, and at Tulane University Health Sciences Center. Time allocations will be based upon individual situations. Applicants must be eligible to obtain a Louisiana medical license. In addition, candidates must be eligible for clinical privileges at Tulane University Hospital and Clinic under the appropriate staff category and must agree to abide by those privileges as outlined by the current bylaws of the institution. Applications will be accepted until suitable qualified candidates are found. Send CV and list of references to Daniel K. Winstead, MD, Heath Professor and Chair, Department of Psychiatry and Neurology, Tulane University School of Medicine, 1440 Canal Street TB48, New Orleans, LA 70112. For further information, you may contact Dr. Winstead, at 504-988-5246 or winstead@tulane.edu. Tulane is strongly committed to policies of non-discrimination and affirmative action in student admission and in employment.

MAINE

MAINE COAST - CHILD PSYCHIATRIST Penobscot Bay Medical Center has an opportunity for a full-time BS/BA outpatient Child/Adolescent Psychiatrist to join our hospital-employed and community-based team of professionals. Work with fascinating and complex psychopathology with a diverse client base and provide a wide array of services. Generous salary and benefit package including medical school loan repayment program. Mid-Coast Maine offers spectacular natural beauty, incredible outdoor recreation, rich cultural opportunities and great schools all in a safe environment. Contact John Bragg at (207) 596 8214 or e-mail CV to jbragg@penbayhealthcare.org. No recruitment firms.

MAINE COAST - OUTPATIENT PSYCHIATRY Penobscot Bay Medical Center has an opportunity for a full-time BS/BA adult psychiatrist to join our hospital-employed and community-based team of professionals. Participate in a multi-disciplinary team approach to serve a diverse client base. Generous salary and benefit package including medical school loan repayment program. Mid-Coast Maine offers spectacular natural beauty, incredible outdoor recreation, rich cultural opportunities and great schools all in a safe environment. Contact John Bragg at (207) 596 8214 or e-mail CV to jbragg@penbayhealthcare.org. No recruitment firms.

MARYLAND

EHP® BEHAVIORAL SERVICES, LLC

Union Memorial Hospital
Department of Psychiatry
Associate Chief

We are seeking a board-certified psychiatrist with the ambition and skills to assume a leadership role and advance to the chief position within a 5-year period. Qualified candidates must be able to demonstrate the following:

- Comprehensive, efficient and quality clinical care
- Excellent interpersonal skills with:
  - Executive hospital management
  - Behavioral health professionals in our group
  - Community and hospital-based physicians
  - Hospital administrative and clinical support staff
  - Group administrative and management staff
- Practice management knowledge
- Leadership ability
- Medical administrative management knowledge
- Professional staff recruitment and retention skills

EHP is a multi-discipline behavioral health group that provides consultation, crisis intervention, inpatient, PHP and outpatient services at Union Memorial Hospital in Baltimore, Maryland. The selected individual will be expected to gain experience in all phases of our operation. Initial focus will be on consultation service management and inpatient support.

For consideration, please forward your cover letter and CV to: EHP at 3333 N. Calvert Street, Suite 670, Baltimore, MD 21218 via mail, 410-933-9085 via fax or sar@psychbillinc.com via e-mail. Should you have any questions, please feel free to contact Steven A. Rose, RN at 410-933-9000, extension 210.

Inpatient, Special Unit for Deaf Patients. Springfield Hospital Center is seeking a BC/BE **general psychiatrist** for the state of Maryland's special inpatient psychiatric unit for deaf patients. ASL interpreters are available 24/7. Salary is negotiable, within MHA guidelines. For other descriptive information, please see our accompanying ad for a general psychiatrist. Please send CV to **Jonathan Book, M.D., Clinical Director, SHC, 6655 Sykesville Road, Sykesville, MD 21784. For questions, call (410)970-7006 or e-mail JBook@dhmh.state.md.us.** EOE

MASSACHUSETTS

Medical Director, Crisis Services—Exceptional Opportunity in the Beautiful Berkshires, Western Massachusetts

The Brien Center for Mental Health and Substance Abuse Services in collaboration with Berkshire Health Systems is seeking a BC/BE Adult Psychiatrist to lead an innovative, integrated community crisis team. Teaching/supervision opportunities and academic appointment possible through affiliations with UMASS Medical School. The Brien Center is Berkshire County's largest community mental health agency, and is recognized in Massachusetts as a leader in providing outpatient mental health services.

Competitive salary and benefits package, including relocation costs and sign-on bonus. The Berkshires is a 4-season resort community with endless cultural and recreational opportunities. Excellent public and private schools make this an ideal family location, just 2 ½ hours from both Boston and New York City. ID#30577PY.

Contact Ashley McNeil at 800-678-7858 x64465; amcneil@cejkasearch.com; or visit www.cejkasearch.com.

Massachusetts. Lifestyle practice. Top notch colleagues.

Berkshire Medical Center's Department of Psychiatry and Behavioral Science provides you the opportunity to become part of a stable, highly integrated clinical collaboration between BMC and the Brien Center for Mental Health and Substance Abuse Services that treats nearly 12,000 patients per year. The majority of acute services are based at BMC, with the Brien Center providing most long-term outpatient care. Services include inpatient psychiatry, chemical dependency, partial hospital, child crisis stabilization, adult crisis and half-way houses, rehabilitation, outpatient clinics, memory disorders and a crisis team. Alex Sabo, MD, Chairman, seeks a full-time general adult acute care hospital psychiatrist. Flexibility in designing a position exists if your interest also lies in acute primary care outreach services, inpatient chemical dependency services, community crisis services, or community outpatient mental health psychiatry. Positions available are: adult inpatient psychiatry, adult outpatient psychiatry, consult liaison psychiatry, and Medical Director, Crisis Services Program. Our newly established psychiatry residency program allows you to contribute to the education of the next generation of mental health specialists. Signing bonus/loan assistance available. Temporary to permanent options considered. Berkshire Medical Center is a recipient of HealthGrades Distinguished Hospital Award for Clinical Excellence for 2009. A Monday-Friday, 8:00 am - 5:00 pm schedule with no required call provides you and your family a lifestyle conducive to enjoying the Berkshires! ID#30577PY.

Contact Ashley McNeil at 800-678-7858 x64465; amcneil@cejkasearch.com; or visit www.cejkasearch.com.

Starr Psychiatric Center seeks a 20-40 hr psychiatrist for dynamic established psychiatric practice On Boston's South Shore. Medical model, multi-disciplinary staff. Stimulating environment, good pay. Clinic has a reputation for successful care, where others have failed. Email davidzstarr@juno.com or call 508.580.2211.

BOSTON - Central & Suburb locations. NO CALL. Medical Director (S. Attleboro) & Staff Positions (varied locations). Inpatient & Partial. Salary, benefits & incentive plans. Moonlighting also available. Contact Joy Lankswert, In-house recruiter @ 866-227-5415; OR email joy.lankswert@uhsinc.com

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Mount Auburn Hospital, affiliated with Harvard Medical School, is recruiting for a half-time consultation-liaison psychiatrist to join our existing consultation service. Responsibilities include consultation to medical and surgical inpatient units and to the emergency department, and participation in the teaching activities of the Department. Fellowship training in psychosomatic medicine preferred. Appointment to the clinical faculty at Harvard Medical School is anticipated. Please send a letter of interest and cv to: Joseph D'Afflitti, M.D., Chair, Department of Psychiatry, Mount Auburn Hospital, 330 Mount Auburn Street, Cambridge, MA 02138; Tel: 617-499-5008; email: jdafflit@mah.harvard.edu.

MICHIGAN

Medical Director - An Easy Income of $220k to $240k (Or More) - No long workdays necessary to make a great income. Seeking Psychiatrist for clinical and part-time administrative responsibilities on Psychiatric Services in a hospital in Saginaw, MI.Adult and C/A psychiatric services. Salary w/benefits is also an option.Very close to Bay City on Lake Huron and Flint. Only an hour and a half to Detroit and Ann Arbor. Please call **Terry B. Good at 1-804-684-5661**, Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

OUTPATIENT PSYCHIATRY OPPORTUNITY

- Multidisciplinary community mental health setting
- Join staff with two existing Psychiatrists
- Outpatient services only
- No on-call responsibilities

- Located on beautiful Lake Superior
- Outstanding year-round recreation
- Picturesque small college town setting
- Live where you would want to vacation

- Excellent compensation and benefit package
- Send C.V. to

Lora A. Bulleit, Human Resources Director
Copper Country Mental Health Services
901 W. Memorial Drive
Houghton, MI 49931
EOE

GRAND RAPIDS - Staff Psychiatrist. Inpatient & Outpatient practice position. Collegial clinical care & work environment. Highly competitive salary & benefits & bonus offered. Contact Joy Lankswert In-house recruiter @ 866-227-5415 or email joy.lankswert@uhsinc.com Will consider H1 sponsorship.

MINNESOTA

Clinical/Scholar Opportunities!

The **Minnesota** Department of Human Services is seeking several **BE/BC Adult Psychiatrists and Psych Mental Health APRN's** to work for our innovative healthcare system serving adults with multiple behavioral health disorders at select locations throughout the state. We are also looking for a **BC Medical/Clinical Director** to work with the Minnesota Neurocognitive Services. Our benefits include liability insurance, overhead costs, no 3rd party billing and much more. We also offer a unique **clinical scholar opportunity** with the **University of Minnesota**. Contact Trace Kinley at 651-431-3724 or tracekinley@state.mn.us.

MISSOURI

Medical Director - Base Salary $220k to $240k - Can easily make well over base with Very Generous Bonus Plan - Close to Springfield - Extremely lucrative opportunity. Can be inpatient and nursing homes or inpatient and outpatient work. Unit is a 10-bed geropsychiatric program; outpatient primarily adult. Strong hospital support for behavioral health with plans for expansion.Please **call Terry B. Good at 1-804-684-5661**, Fax #: 804-684-5663; Email:terry.good@horizonhealth.com.

MONTANA

Helena, MT
Queen City of the Rockies

Horizon Health invites you to consider an exciting new **Medical Director** opportunities for two NEW distinct **Adult** and **Geriatric** Inpatient Psychiatric Units, comprised of **26** total beds in **Helena, MT.** Nestled beneath the foothills of the Montana Rockies, **Helena,** the Capital of Montana, is alive with history and culture. This charming and beautiful Victorian city of 70,000 people provides a diverse attraction with many street festivals, theater, museums, symphonies, fairs and rodeos. There is truly something for everyone here! Excellent practice opportunity with great income ($200K+) and unparalleled quality of life! For more information contact: Mark Blakeney, Voice: 972-420-7473, Fax: 972-420-8233; email: mark.blakeney@horizonhealth.com EOE.

NEW JERSEY

Behavioral Health office in Old Bridge, NJ is seeking FT or PT Psychiatrists to join a diverse practice and work with experienced Psychiatrists and LCSW's. Excellent income is guaranteed. Benefits available. Fax CV to 732-679-4549 or email to stressmg@optonline.net.

PSYCHIATRISTS
Earn up to $200K plus benefits

Get inside the criminal mind and make a difference. University Correctional HealthCare (UCHC), a branch of the University and Medicine and Dentistry of New Jersey (UMDNJ), currently has regular (full-time and part-time) and per diem openings for psychiatrists throughout the state. We are dedicated to providing excellent mental health and rehabilitative services to our patients.

As a psychiatrist, you will have the unique opportunity to work with interesting patients and stimulating colleagues within the New Jersey Department of Corrections' prisons. We offer a comprehensive benefits package and a salary of up to $200,000 depending upon location, board certification, and experience. You will work with a multidisciplinary team and a state-of-the-art medical record. With minimal call, flexible hours, no managed care, no insurance forms, and an emphasis upon treatment rather than paperwork, isn't it time you discovered the difference you can make with University Correctional HealthCare.

Please apply via our website at www.umdnj.edu/hrweb or e-mail our Director of Psychiatry, Rusty Reeves, M.D., at reevesdo@umdnj.edu. UMDNJ is an affirmative action/equal employment opportunity M/F/H/V and is a member of the University Health System of New Jersey.

Child/Adol. Psychiatrist

Child/Adol. Psychiatrist - needed for multidisciplinary group in affluent communities in North/Central N.J. Expertise in pychopharmacology required. NO Managed Care! Please fax CV to (908) 598-2408.

CHILD & ADOLESCENT PSYCHIATRIST WESTFIELD & PRINCETON

Child/Adolescent Psychiatrist to join Westfield or Princeton office of successful private fee for service comprehensive child, adolescent and adult therapy Center with locations in Westfield, Princeton, Cedar Knolls and Ridgewood. Candidate will be part of a multi-disciplinary team and will provide psychiatric evaluation, medication management and, if desired, psychotherapy. He/She will also clinically oversee treatment at the Center. Salary and benefit package is generous and includes medical/dental insurance, retirement plan, professional liability coverage and substantial continuing education and vacation. Supportive collegial atmosphere. Candidate must be board certified or board eligible in child/adolescent psychiatry. E-mail CV to abbazn@aol.com.

Westampton - East of Philadelphia. 2 positions. General/Addiction Psychiatrist for dual diagnoses program and Adult O/P services. Salary & Benefits. No on site weekend call. Contact Joy Lankswert, In-house recruiter @ 866-227-5415 or email joy.lankswert@uhsinc.com

NEW MEXICO

Presbyterian Healthcare Services (PHS) in New Mexico has openings in general adult and child/adolescent psychiatry. PHS is New Mexico's largest private, non-profit integrated healthcare system. The Behavioral Medicine Program is a full-service psychiatry department covering inpatient and outpatient care, intensive outpatient treatment, emergency and consultative psychiatry and mental health services embedded in primary care. These are full-time employed positions with the 500+ provider Presbyterian Medical Group. PHS provides competitive salary and benefits including malpractice insurance and relocation allowance. Additional information about PHS can be found at www.phs.org.

Contact: Susan Camenisch, Physician Recruiter, PHS
E-mail: scamenisc@phs.org
Phone: 1-866-742-7053

NEW YORK CITY & AREA

Creedmoor Psychiatric Center, a 390 bed state hospital in Queens, NY seeks a full-time supervisor for 4 psychiatrists on 4 wards (MICA, DBT, Secure Care). Teaching opportunities & possible faculty appt. NY License, Board Cert., > 1 year experience with SMI pts. MICA or DBT knowledge a plus. Salary: $150K plus generous fringe. Contact Dr. Caterina Grandi at CRACCGG@omh.state.ny.us 718-264-3663. CPC is an Equal Opportunity Employer

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Psychiatrist - Outpatient

The highly regarded **Pederson-Krag Center** offers a 20-22.5 hour position in our **Smithtown** Mental Health Clinic providing evaluation, consultation and medication services.
Flexible schedule. Excellent benefits. Competitive Salary.
Mail CV to **Roger Kallhovd, M.D., Pederson-Krag Center, 55 Horizon Drive, Huntingdon, N.Y. 11743 or fax 631-920-8165 EOE/AA www.pedersonkrag.org**

Child and Adolescent Psychiatrist
P/T - 10-15 hours per week (evenings and/or weekends) in a Child and Family Mental Health Center in Brooklyn. Excellent compensation. No call. Fax resume to (718) 553-6769, or email to clinicaldirector@nypcc.org

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BC/BE Psychiatrists to provide Consultation services in Long Term Care (NH, SNF), and Hospital settings. Facilities Located in NYC Metro area, Dutchess, Rockland, Orange, Westchester counties and Long Island.
Priority positions: Dutchess & Rockland
Outpatient opportunities available in the Bronx. PT/FT Well above average salaries/benefits, flexible hours. Recent graduates encouraged to apply. Spanish speaking a plus.

Please contact: Zoila Solano at Tel: 718-239-0030
E-mail: zsolano@neuropsych-services.com

PSYCHIATRIST

Downtown Bronx Medical P.C. Associates, the Faculty Practice of Lincoln Medical and Mental Health Center, a major teaching facility in NYC and part of the Health and Hospital Corporation is seeking FT/PT/sessional BC/BE Psychiatrists for: Outpatient/Inpatient/ER Services. Responsible for teaching and supervising residents, and direct patient care. Spanish speaking pref. Academic Appt. with Weill-Cornell Med. College. Send CV to Amy S. Hoffman, MD: Fax: 718-579-4910 or Email: somwarub@dbmapc.org. AA/EOE M/F.

NEW YORK STATE

OTSEGO COUNTY COMMUNITY SERVICES
Community Mental Health Psychiatrist

If you are interested in providing leadership and making a difference in a community clinic, we would like to talk to you.

Otsego County Community Services has an opening for an adult psychiatrist in our community based mental health and addiction services. The clinic is open from 8:30 A.M. to 5 P.M. Monday- Friday. There is no evening or weekend coverage required. Current NYS license to practice medicine required at the time of employment. Must have or be eligible for board certification in psychiatry.

This position is eligible for J-1 and loan forgiveness HPSA designation.

Resumes to: Susan Dalesandro, DCS, Otsego County Community Services, 242 Main St., Oneonta, NY 13820, dalesandros@otsegocounty.com

Otsego County is a beautiful rural county that includes Cooperstown, NY, home of the Baseball Hall of Fame, Glimmerglass Opera, the City of Oneonta, Hartwick College, and SUNY Oneonta.
http://www.thisiscooperstown.com

Western New York-Chautauqua Region: Jamestown Psychiatric PC is seeking a Psychiatrist to join our rapidly growing Adult and Child Psychiatric team. Competitive salary and flexible growth opportunities are offered. We will offer a starting bonus to eligible candidates. Loan repayment, J1 or H1 assistance available. Please contact Mrs. Linda Jones, office manager @ lj@psychwebmd.com or Phone 716-483-2603. Fax CV and qualifications to 716-483-2828.

Central New York Psychiatric Center, a state-operated, JCAHO Accredited facility, is seeking Psychiatrists for full-time positions at its main Inpatient Facility in Marcy, NY, and at its Forensic Outpatient Units throughout New York State.

Job Description: Central New York Psychiatric Center, a state-operated, JCAHO Accredited facility, is seeking Psychiatrists for full-time positions at its main Inpatient Facility in Marcy, NY, and at its Forensic Outpatient Units throughout New York State, including: Albion, Arthurkill, Auburn, Downstate, Elmira, 5 Points (Romulus), Great Meadow, Groveland, Mid-State (Marcy) and Wende (Alden).

- Comprehensive NY State Benefits package available
- Outstanding NY State Pension Plan
- Opportunity for Loan Forgiveness Program
- Opportunities exist for additional compensation

Assistant Psychiatrist: $107,318-$119,449 (general salary increases of 4% in 2010 is scheduled)

Qualifications: Possession of a NY State Limited Permit AND completion of a training program in psychiatry approved by the American Board of Psychiatry and Neurology for entrance into their certifying examination AND eligibility for full and unconditional participation in Medicaid and Medicare programs.

Psychiatrist 1: $161,751 (general salary increase of 4% in 2010 is scheduled)

Qualifications: Possession of a License to practice medicine in NY State OR possession of a Limited Permit and licensure in another state or by written examination in Canada; AND completion of a training program in psychiatry approved by the American Board of Psychiatry and Neurology for entrance into their certifying examination; AND eligibility for full and unconditional participation in Medicaid and Medicare programs.

Psychiatrist 2: $174,798 (general salary increase 4% in 2010 is scheduled)

Qualifications: Possession of a license to practice medicine in NY State OR possession of a Limited Permit and licensure in another state or by written examination in Canada; AND certified in psychiatry by the American Board of Psychiatry and Neurology; AND eligibility for full and unconditional participation in Medicaid and Medicare programs.

Direct Contact Information:
Dr. Jonathan Kaplan, Clinical Director
Central New York Psychiatric Center
Box 300 Marcy, NY 13403
Phone: (315) 765-3624 Fax: (315) 765-3629
E-mail: CN00025@OMH.STATE.NY.US

PSYCHIATRY POSITION IN CENTRAL NEW YORK

Faxton-St. Luke's Healthcare is seeking an Adult Psychiatrist for a hospital employed position in Utica, New York. 26-bed inpatient unit; consultation liaison; emergency department coverage. Excellent compensation and full benefits package. Wonderful four-season community with excellent schools and an array of recreational activities. For more information, please contact Susan Richter, Director, Physician Support Services Office, 1676 Sunset Avenue, Utica, NY 13502; phone: 800-809-4380; fax: 315-624-5473; e-mail: srichter@mvnhealth.com

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ELMIRA PSYCHIATRIC CENTER
Adult and Adolescent Psychiatrists

Board Certified - $172,269 - $176,903
Licensed Physician - $141,751
Limited Permit - $107, 318 - $115,905

- All positions M-F 8-4:30 with no managed care insurance demands
- Optional participation in a low stress on-call program with potential to earn up to an extra $74,000/year
- Student loan repayment available
- Excellent NYS benefits package
- Inpatient, Outpatient and Day Treatment services
- Our location offers: quality housing prices; little traffic; regional airport; Cornell University; 4hr drive to NYC, Toronto & Philadelphia; 5 ½ hr drive to Boston & DC; less than 1hr to Finger Lakes

For further info contact: Patricia Santulli, Director of Human Resources at: Elmira Psychiatric Center, 100 Washington Street, Elmira, NY 14901 or
e-mail: elpopms@omh.state.ny.us
or call: (607) 737-4726
or fax: (607) 737-4722
An AA//EOE Employer

Weill Cornell Medical College and the New York-Presbyterian Hospital is recruiting an academic Child and Adolescent Psychiatrist at the Associate or Professor level to serve as Clinical Director for the Child and Adolescent Psychiatry clinical and research programs at the Payne Whitney Clinic's Westchester Division located in White Plains, New York. Duties will include administrative responsibility for child and adolescent inpatient and outpatients services, and development of new specialty programs that integrate Payne Whitney Clinic's exceptional clinical programs with clinical research. Experience in administration and clinical research is required.

Founded in 1898, and affiliated with what is now New York-Presbyterian Hospital since 1927, Weill Cornell Medical College (WCMC) is among the top-ranked clinical and medical research centers in the country. The Westchester Division of the Payne Whitney Clinic is renowned for the range and quality of its inpatient and outpatient specialty programs, as well as its general psychiatric services.

Weill Cornell Medical College is an equal opportunity, affirmative action educator and employer.

NORTH CAROLINA

WINSTON-SALEM: Child Psychiatrist. Fulltime position for residential, inpatient & partial programs. Very competitive salary, benefits & bonus plan. Contact Joy Lankswert In-house recruiter @ 866-227-5415 or email joy.lankswert@uhsinc.com

NORTH DAKOTA

North Dakota - MeritCare Medical Group of Fargo, ND is seeking an Adult Psychiatrist to join its multi-disciplinary Psychiatry Department. Opportunity to teach psychiatry residents. MeritCare is an integrated 450-physician, multi-specialty group practice, 30-bed inpatient psychiatric unit and 8-bed eating disorder unit. Excellent referral base with 27 regional primary care clinics Fargo-Moorhead metropolitan area is a tri-college community of 190,000 offers excellent educational systems, recreation and sports activity as well as a variety of entertainment and cultural events. Market competitive compensation and benefits package. To learn more about this excellent practice opportunity visit our website at www.meritcare.com or contact:

Jean Keller, Physician Recruiter
Phone: 701-280-4853
Fax: 701-280-4136
Email: Jean.Keller@meritcare.com

AA/EOE - Not subject to H1B caps

OHIO

Psychiatrist, The Ohio State University, Columbus, Ohio. Counseling and Consultation Service at the Ohio State University is seeking a board eligible/ board certified psychiatrist for a 1.0 FTE Senior Staff position. The psychiatrist will provide outpatient services to the student population, collaborate with a multidisciplinary staff, supervise trainees and consult with other campus units. State of Ohio benefits with no call or weekend duties. To assure consideration, please apply by **March 15, 2010** by visiting our web site at www.jobsatosu.com and searching by requisition **#348687.** Candidates should submit a cover letter and curriculum vitae when they apply. To build a diverse workforce Ohio State encourages applications from individuals with disabilities, minorities, veterans, and women. EEO/AA employer.

Cincinnati - expanding our private practice. Come join 2 other psychiatrists in a mixed hospital-office practice. We see adult & geriatric but are flexible if you want to see children, work in nursing home or any other type of work you choose. Will pay salary or a percentage arrangement. Future ownership potential.

Check out our website at www.galemd.com. Email to mgalemd@fuse.net or call Melvin Gale at 513-241-1811.

OKLAHOMA

OKLAHOMA CITY: Child Psychiatrist. Fulltime position for inpatient & partial programs. Competitive salary, benefits & bonus plan. Contact Joy Lankswert In-house recruiter @ 866-227-5415 or email joy.lankswert@uhsinc.com

OREGON

Oregon State Hospital (OSH)
Salem, Oregon

Oregon Department of Human Services (DHS), OSH is looking for Oregon BC/BE Psychiatrists. OSH offers FT, PT and flexible opportunities in our general adult, geriatric, and forensic programs. A generous and comprehensive benefit package is included; as well as a new hospital in 2011 which will incorporate state-of-the-art architecture, treatment space and technology. Salary is very competitive and includes psychiatric differential, certification pay and opportunities for additional on-call work. Dr. Mark Diamond, CMO and Roy Orr, Superintendent invite you to call and/or send your CV to us today! Phone: (503) 945-2887 Email: lila.m.lokey@state.or.us; Fax: (503) 945-9910; Mail: Human Resources, 2600 Center Street NE, Salem, OR 97301-2682. Visit our website: www.oregon.gov/DHS/mentalhealth/osh. EOE.

PENNSYLVANIA

CBHNP/PerformCare, An AmeriHealth Mercy Company, is offering the following growth opportunity in the Harrisburg, PA area:

MEDICAL DIRECTOR/PHYSICIAN ADVISOR
(Req #324)
Part Time-36 hours/week

CBHNP/PerformCare is an innovative, consumer-focused, Behavioral Health Managed Care Company (BH-MCO) that supports almost 4 million Members through specialized behavioral health and human service programs in the public and private sector.

We are currently searching for a Medical Director/Physician Advisor (Child Psychiatrist) for our Clinical department. This position will provide clinical medical necessity reviews, conduct peer to peer reviews, attend committee meetings and participate in quality improvement projects. Qualified candidates will be a PA licensed, board certified Child psychiatrist. Excellent clinical skills in an inpatient setting a must and an interest in improving the system can make this an interesting part-time experience. Previous managed care experience essential.

CBHNP/PeformCare offers a competitive salary and a comprehensive benefit package. ***In order to be considered you must*** **submit your expression of interest as asked.** Your cover letter and resume **must reference** a Req #/Job Title **and indicate** how you meet the basic qualifications for the vacant position; and **must state** your specific salary req. Please mail in confidence to: CBHNP, PO Box 6600, Harrisburg, PA 17112 **OR email HRAdministrator@cbhnp.org OR** Fax (717) 909-2108 EOE/AA Employer

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Great Opportunity for Psychiatrist in Practice in or near Montgomery County, PA near Bucks Cty line - Increase income/Capture new market. Geropsychiatric Unit in general hospital.Associate Medical Director position with annual stipend.Position nicely compliments already existing private practice and we'll market your practice as well.Please **call Terry B. Good at 1-804-684-5661**, Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

PHILADELPHIA (Bucks County) - Child Psychiatrist for Partial Program. **CLARION (Western PA) and SHIPPENSBURG (near Harrisburg).** General Psychiatrist for inpatient & partial programs. Admin/Clinical position available. Very competitive compensation plans. **Student loan assistance negotiable in Clarion.** Contact Joy Lankswert @ 866-227-5415; OR email joy.lankswert@uhsinc.com

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Psychiatrists:

Currently we have exciting full- and part-time positions in a rapidly expanding department. Opportunities include responsibilities in and outside our five-hospital health system. There are immediate openings for child/adolescent, adult and addictions psychiatrists.

There are also practice options in a traditional psychotherapy model. Evening and weekend positions also available. Excellent salaries, no on-call nor rounding responsibilities ever and exceptional benefits package offered. Send CV to Kevin Caputo, M.D., Vice President and Chairman, Department of Psychiatry, Crozer-Keystone Health System, One Medical Center Blvd., Upland, PA 19013 or contact the department manager, Kathy Waring at 610-619-7413

New Geropsychiatric Unit - Eastern PA - Seeking a Psychiatrist to work on new 10-bed inpatient geropsychiatric unit in an impressive med/surg hospital. Adult unit here as well. Offering attractive salary/benefits, relo pkg, and bonus plan. Easy drive to Philadelphia and Baltimore. Please call T**erry B. Good at 1-804-684-5661**, Fax #: 804-684-5663; Email: terry.good@horizonhealth.com.

Greater Philadelphia Area

Horizon Health, in partnership with **Lower Bucks Hospital** in **Bristol, PA,** has an exciting opportunity for an **Associate Medical Director** for a **24-bed** Adult Inpatient Psychiatric Program. Excellent practice opportunity and income potential for local physician. Call coverage shared - 1:3 weekends, or less, and 1-2 nights per week.
For more information contact: Mark Blakeney, Voice: 972-420-7473, Fax: 972-420-8233; email: mark.blakeney@horizonhealth.com EOE.

RHODE ISLAND

Psychiatry

Rhode Island Hospital and
The Miriam Hospital

Affiliated Hospitals of the Warren Alpert Medical School of Brown University

Psychiatrist Opportunities
Emergency: The largest emergency psychiatry facility in the region is seeking to augment staffing with scheduled rotations from 5 PM to 1 AM seven days a week and weekends from 9 am to 2 pm.
Geriatric: Extensive multidisciplinary program seeking psychiatrist with Geriatric Board certification; interests including nursing home and/or inpatient coverage.
Outpatient: Areas of interest include: mood and anxiety disorders; liaison with medical programs and behavioral medicine.
Adult Partial Hospital: Position to augment multidisciplinary team, including two other full-time psychiatrists. Program integrates psychopharmacologic, psychosocial, and existential group therapies.

Positions eligible to be considered for Faculty appointment at Brown University. Opportunities for research for applicants with appropriate background and interests. Applicants must be Board Certified or eligible (within three years of training completion). Salary and benefits competitive and commensurate with level of training and experience.

Please send CV's along with a letter of interest to Richard J. Goldberg, M.D., Psychiatrist-in-Chief, APC-9, Rhode Island Hospital, 593 Eddy Street, Providence, RI 02903 and/or email: rj-goldberg@lifespan.org.

The Center for Women's Behavioral Health at Women & Infants Hospital in Providence, RI is seeking a full time psychiatrist for clinical work with perinatal patients in a mother-baby partial hospital setting. Clinical opportunities available with inpatient consultation-liaison and an outpatient perinatal psychiatry clinic. Clinical faculty position and resident teaching opportunities possible through Alpert Medical School of Brown University. Experience with perinatal psychiatry required.

Send letter of interest and CV to Teri Pearlstein, MD, Director of Women's Behavioral Health, 101 Dudley Street, Providence, RI 02905.

SOUTH CAROLINA

Fantastic Practice Opportunity for Psychiatrist who wants to establish a very lucrative inpatient/outpatient practice in a small town in a warmer climate where there is little competition and **lots of opportunity**. Medical Director position on geropsychiatry unit in northeast SC-an easy drive to Florence, SC and Fayetteville, NC; 2 hours from Columbia and Raleigh. Offering administrative stipend, income guarantee and relocation package. Please **call Terry B. Good at 1-804-684-5661**,Fax:804-684-5663; Email:terry.good@horizonhealth.com.

TENNESSEE

Horizon Health, in partnership with **Jamestown Regional Medical Center** in **Jamestown, TN,** has an exciting opportunity for a **Medical Director** for a **10-bed** Geriatric Inpatient Psychiatric Program. Excellent practice opportunity and income potential with attractive Medical Director's Stipend.

For more information contact: Mark Blakeney, Voice: 972-420-7473, Fax: 972-420-8233; email: mark.blakeney@horizonhealth.com EOE.

TEXAS

PSYCHIATRISTS: Mental Health Mental Retardation Authority of Harris County (MHMRA) in Houston, Texas is one of the largest mental health centers in the United States. Demands have created the need for additional BC/BE Psychiatrists throughout the Agency.

Outpatient Clinic
Part-time Adult position available
Perform psychiatric evaluations & treatment in clinic setting
Flexible day hours
No on call

Psychiatric Emergency Center
24/7 Mental Health Crisis Unit
Full & Part-time positions available

Harris County Jail
Second & third shifts available
Perform psychiatric evaluations & medication management
Some on call at 24/7 facility

Texas licensure is required for all positions

MHMRA offers competitive salary plus a generous benefit package. Houston offers excellent quality of life, lower than average cost of living, no state sales tax and exciting cultural, entertainment, sporting and tourists venues.

Contact Charlotte Simmons at (713) 970-7397, or submit your C.V. to charlotte.simmons@mhmraharris.org or fax: 713-970-3386

Salaried Opportunities for Adult Psychiatrists - San Antonio, TX

Vericare (www.vericare.com) is the leader in providing mental health services to residents of long term care. We have immediate, salaried positions for Adult or Geriatric Psychiatrists in San Antonio. We offer flexible scheduling, 100% paid malpractice, administrative support, no on call/weekend requirement and a complete benefits package. Board Certified preferred. **Call Sanel Lekic at 800-257-8715 x1166 or email your resume/inquiry to slekic@vericare.com.**

The Texas Department of Aging and Disability Services is looking for psychiatrists to fill vacancies at our state supported living centers in **El Paso, Mexia, Abilene, Brenham,Lufkin, San Angelo, San Antonio,Corpus Christi**, and **Austin**.

We offer a competitive salary, health/dental insurance, paid vacations,up to 15 paid holidays per year, an excellent retirement program, and the opportunity to make a difference.

For additional information, visit **www.career-satdads.com** or contact Judy Garner at **512-438-3268** or **judy.garner@dads.state.tx.us**.

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EXCITING LEADERSHIP OPPORTUNITY FOR CREATIVE MENTAL HEALTH PROFESSIONAL in a nationally recognized psychiatric hospital for children and adolescents located in an urban academic medical center. The Department of Psychiatry and the Virginia Commonwealth University Health System (VCUHS) currently seek an individual with interests and strengths in child mental health to serve as Director of the Virginia Treatment Center for Children (VTCC). The Director is responsible to VCUHS and to the Chair, Department of Psychiatry for the effective management of multiple integrated functions of VTCC. These functions include the clinical care of inpatients and outpatients, multi-disciplinary teaching of students from various disciplines, and development and implementation of meaningful research. Statewide outreach to improve children's mental health is essential, as is maintaining integrative teaching and clinical research relationships with the University, the School of Medicine, VCU Psychiatry, and MCV Hospitals. Specific VTCC duties include responsibilities for the following:

- Supervision and coordination of the Executive Committee and its members which include directors of Clinical Services Operations, Medical Services, Support Services, Utilization Management and Quality Improvement, Education and the Business Office.
- Planning and budgeting for the Treatment Center including establishing, monitoring, and maintaining annual service and financial goals and objectives.
- Ensuring that services meet standards of accrediting entities and that continuous quality improvement processes are in place.
- Working collaboratively with community agencies/organizations to ensure children referred to the Treatment Center receive appropriate care and to promote the development and delivery of comprehensive, quality services for children/adolescents in Virginia with mental health needs.
- As a faculty member in Psychiatry, the Director is expected to perform usual faculty duties, including teaching, research, and clinical care, where relevant.

QUALIFICATIONS: Doctoral degree in a mental health discipline, experience in the provision of clinical services to children/adolescents/families, strong administrative experience, including personnel and budget management, experience in teaching and research. Send CV to Joel Silverman, MD, Chair, VCU, Box 980710, Richmond, VA 23298. Virginia Commonwealth University is an Equal Opportunity/Affirmative Action employer. Women, persons with disabilities, and minorities are encouraged to apply.

WASHINGTON

The University of Washington and Harborview Medical Center (HMC) in Seattle, WA is accepting applications for a hospital-based psychiatrist at the rank of Acting Instructor, Acting Assistant Professor, or Assistant Professor (WOT). An MD and graduation from an accredited psychiatry residency program is required. This position is 1.0 FTE and will work doing a combination of inpatient psychiatry and hospital psychiatry consultation work with a large team consisting of another psychiatrist, psychologist, nurse and social worker. Two half-days a week will be spent in an ambulatory outpatient setting seeing patients. The position will also be responsible for teaching residents and medical students. Application deadline is March 1, 2010. Start date July 1, 2010. Please send application and CV to Peter Roy-Byrne MD, Chief Psychiatry, Harborview Medical Center 325 9th Ave. Box 359911, Seattle, WA 98104. University of Washington faculty engage in teaching, research, and service. The UW is building a culturally diverse faculty and strongly encourages applications from females and minority candidates. The UW is and EOE/AA employer.

The University of Washington and Harborview Medical Center (HMC) in Seattle, WA is accepting applications for a geriatric psychiatrist at the rank of Instructor or Assistant Professor. An MD and experience as a geriatric psychiatrist are required. This position is 1.0 FTE and will work providing services as part of a team with case managers and nurse practitioners in settings that include nursing home, primary care clinic, and a community mental health center geriatric specialty program. The position will also be responsible for teaching geriatric psychiatry fellows, residents and medical students. Application deadline is March 1, 2010. Start date July 1, 2010. Please send application and CV to Peter Roy-Byrne MD, Chief Psychiatry, Harborview Medical Center 325 9th Ave. Box 359911, Seattle, WA 98104. University of Washington faculty engage in teaching, research, and service. The UW is building a culturally diverse faculty and strongly encourages applications from females and minority candidates. The UW is and EOE/AA employer.

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If interested email CV / Resume to erik_sams01@yahoo.com or fax (304)485-5185 Attn Erik Sams. After you send a CV / resume please call to confirm that I received it. **If interested or have questions call - Erik Sams at (304) 991-2158.**

PSYCHIATRIST-West Virginia University School of Medicine, The Department of Behavioral Medicine and Psychiatry, has ongoing opportunities and faculty positions for full-time, part-time or per diem BE/BC adult and child psychiatrists in various locations throughout the state of West Virginia, including its primary clinical, educational and research location in Morgantown, WV, as well as William R. Sharpe Jr. Hospital, a 150-bed, JCAHO-accredited, state psychiatric hospital in Weston, WV. Responsibilities include patient care and teaching, with opportunities for research. Positions will remain open until filled. Contact Susan Clayton at sclayton@hsc.wvu.edu. WVU is an AA/EO employer.

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Fellowships

Psychosomatic Medicine Fellowship Positions Available

The Departments of Psychiatry at **Jamaica Hospital Medical Center** and **Flushing Hospital Medical Center** in Queens, NY, have two positions available for Psychosomatic Medicine Fellows starting July 2010. 70K.

The Fellowship is a one-year, ACGME-accredited program. Fellows work closely with Board Certified, Psychosomatic Fellowship-trained Psychiatrists. They learn in culturally diverse, general hospitals and have opportunities to work in subspecialty areas, including: child psychosomatics, chemical dependency, pain management, and traumatic brain injury units. Fellows have clinical and teaching experience in various settings, such as: Primary Care Clinics, Community Hospitals and a Tertiary Care Center. Opportunities for independent research abound. This program meets all ABPN requirements for candidates to sit for the Psychosomatic Medicine Boards.

Interested applicants should contact Adam Chester, D.O., Fellowship Director at 718-670-4414 or achester.flushing@jhmc.org

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Addiction Psychiatry Fellowship

The University of Wisconsin School of Medicine and Public Health is seeking candidates for a PGY-5 fellowship in Addiction Psychiatry. The ACGME-accredited fellowship is one year in length, but it is possible to arrange a 2-year fellowship for candidates with appropriate research interests. The fellowship provides rotations in VA, private, and university sites and emphasizes not only clinical skills, but also skills in performance improvement needed for future clinical leaders. Experiences include 12-step, motivational enhancement, and relapse prevention efforts, as well as psychopharmacologic interventions of all types. Exposure to settings focused on adolescents, women, and students are included. Competitive salary and full benefits are available. If interested, call or e-mail Dean Krahn, MD, Fellowship Director, at 608-280-7015 or Dean.Krahn@va.gov. EOE/Random Drug Screen.

Columbia University
College of Physicians and Surgeons
Department of Psychiatry

Position available as Postdoctoral Clinical Fellow in the Department of Psychiatry of Columbia University and part time Attending Psychiatrist, as part of a Psychiatric Emergency Room Fellowship at the New York Presbyterian Hospital. Candidate must be Board Eligible in Psychiatry. Opportunities for professional development in an academic medical center. Direct patient care, team leader, teaching Columbia Medical Residents and Students. Must have NYS license and DEA certificate. Equal Opportunity, Affirmative Action Employer.

Please forward resumes to:
bb181@columbia.edu or fax to (212) 305-9730

Meetings & Conferences

The NADD 2010 International Congress (ID/MH), Innovations and Interventions, April 14 - 16, in Toronto, ON, Canada. Information: www.thenadd.org

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References: 1. Robinson D, Woerner MG, Alvir JMJ, et al. Predictors of relapse following response from a first episode of schizophrenia or Schizoaffective Disorder. *Arch Gen Psychiatry*. 1999;56:241-247. **2.** Mahmoud RA, Engelhart LM, Janagap CC, Oster G, Ollendorf D. Risperidone versus conventional antipsychotics for schizophrenia and schizoaffective disorder: Symptoms, quality of life and resource use under customary clinical care. *Clin Drug Invest*. 2004;24:275-286.

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