WASHINGTON PSYCHIATRIC SOCIETY NEWS

JULY/AUG 2009

CHANGING THE PICTURE IN DEPRESSION:
TRANSCRANIAL MAGNETIC STIMULATION (TMS) THERAPY

By Sinan Duzyurek, MD

In the past two decades, we have seen amazing pictures tying various clinical syndromes to certain operational patterns in the brain's networks. Alas, we had no tools to improve these pictures directly by making a particular circuitry more or less active without tampering with other subsystems of the brain. That is, we could not photoshop these pictures in order to selectively correct specific patterns of dysfunction in the substrates of mood, cognition and behavior. But at last, and almost unbelievably, I have found myself doing just that: Correcting the picture in depression in a targeted way using an effective and fine-enough brush. My brush is the Transcranial Magnetic Stimulation (TMS) device and the bristles of the brush are provided in the form of rhythmically pulsed, MRI-strength magnetic fields. The paint is the minute electrical currents induced in and around cortical neurons, just enough to alter their firing patterns and underlying biology, without involving run-away electrical currents that seize the whole brain.

This historical development is coinciding with a relative saturation in other treatment paradigms. For example, the pharmaceutical industry has been struggling lately to find truly novel drugs. The low-hanging fruit, it turns out, is long gone. Moreover, any differences in efficacy between alternative treatments have remained minor. For example, older and newer types of antidepressants, antipsychotics, anxiolytics, antiepileptics, and mood stabilizers are, on the whole, equipotent. Surely, there is still more room for refinements within psychopharmacology. For example, now the focus is mostly on finding allosteric modulators of target biomolecules, rather than head-on inhibitors or stimulators (agonists). The hope is to have more nuanced effects, perhaps reducing the side effect problem. However, this approach is yet to be translated to clinical use (with the exception of benzodiazepines), and nobody is suggesting that the problem of adverse effects will be fully overcome with this approach. The pharmacotherapy paradigm bears inherent constraints, insurmountable for as long as we are inside this treatment box, limiting its efficacy and tolerability. One of these limitations stems from our long and messy evolutionary history. The human body has evolved to use a relatively limited set of biochemical molecules for numerous purposes in multiple tissues. As we attempt to manipulate one of these molecules somewhere in the body for a specific clinical purpose, we also end up affecting other processes that we would rather not meddle with. Psychopharmacological treatment is spatially non-selective. Any drug that crosses the blood brain barrier has already reached all other organs and tissues, and it will roam everywhere in the brain, not just specific cerebral subsystems we would like to target. For example, serotonin is an ancient intercellular communicator used by all animals, plants and fungi for a myriad of purposes. As central nervous systems developed, serotonin also acquired behavioral functions. However, most of what it does has nothing to do with mood or behavior. More than 80% of serotonin in the human body is made in the gut and some of this is ferried by platelets to other target tissues to be taken up by the serotonin transporter (yes, the same one interfered with by SSRIs) into various types of cells, such as osteoblasts and osteocytes in the bone. Too high intercellular concentrations of serotonin outside the bone cells (e.g., due to lurking SSRI molecules) preferentially stimulate osteoclasts, which degrade bone. Thus, patients on SSRIs and SNRIs are at increased risk for fractures, and women have double the incidence of osteoporosis. Serotonin is involved in numerous processes, including platelet aggregation, GI motility, liver repair, reproduction, endothelial function, fibrocyte stimulation (especially in the pulmonary vasculature, heart valves and the retroperitoneum), plus fetal and childhood CNS development. SRIs that perturb these processes are capable of causing clinically significant adverse outcomes. At least as importantly, serotonin-modulated processes are involved in a diverse array of brain subsystems and networks subserving numerous, and sometimes antithetical, functions. It is not possible to pick and choose the ones we want to affect among these subsystems as long as the tool is a diffusing chemical. No matter how selective a drug is for its molecular targets, as long as those targets are widely distributed in the brain and the body, it is unavoidable that all of those targets will be affected. This not only leads to untoward effects but also constrains efficacy. For example, SSRIs interact with serotonin transporters

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Washington Psychiatric Society

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THE PRESIDENT'S COLUMN

WILLIAM B. LAWSON, MD, PHD, DFAPA

Recent events have given many of us what we have always wanted: mental health parity. Over the years, many of us saw unrelenting discrimination against mental health treatment by public and private insurers. Now at last parity is law.

In the past, many of us were put on the defensive when asked about the causes of the disorders we treat. Psychodynamic models were replaced by a black hole of statistical consequences. Now at last we have imaging findings and genetic-environmental models that are making sense of the phenomenology. We have basic science research that can be translated into clinical use. In the recent past, cure was not mentioned in the same breathe as mental disorders. The recovery movement has changed that perspective and is educating our patients about the hope that we always had.

Psychiatric interventions in the recent past were considered the treatment of last resort, used only with the worried well or the hopelessly ill. September 11th changed all that. We are being appreciated as the first responders that we always had been.

We have always had an uneasy alliance with the rest of medicine. That issue now seems beyond the need for debate. With insurance recognition, a neuroscience basis, and effective treatments that can become preventive, and reconciliation with the medical community, it seems that we are where we always wanted to be.

However, in many ways, our task is just beginning. We must be at the table to insure that parity is not just a legal fiction. We must educate ourselves, the public and our colleagues about new advances in neuroscience and about new treatments. We must be available as first responders. We must continue to collaborate with our colleagues in other medical disciplines. Most importantly, as the debate intensifies about a new health care system, we must be there to remind our colleagues how psychiatry has changed. No one can do that task better than ourselves.

2009 TRANSCULTURAL PSYCHIATRY CONFERENCE

The BPA Transcultural Psychiatry Conference will be in Egypt this November, 2009. Payments must be made in full for the cruise ship portion, no later than the 15th of August.

For more information or to register: http://newton-thoth.com/_wsn/page8.html

Conference Dates
Nov. 6 - 13, 2009
Post-Conference Cruise
Nov. 13 - 16, 2009

The BPA will celebrate it's 40th Year Anniversary and 29th Transcultural Psychiatry Conference Anniversary in 2009! To commemorate this historical event, BPA, Inc. will sojourn back to Africa, Egypt (KMT) in Nubia!

Payment Plan Option Available After Deposit Received.

The 7th Annual Seminar
on the **Interface** *of* **Psychiatry and Medicine**
September 26, 2009

7:45am – 8:45am Registration\Breakfast, 8:45am-1pm Presentations • 4.0 AMA PRA Category 1 Credits™

The Annual Seminar on the Interface of Psychiatry and Medicine, coordinated by the CME Committee, is a highlight of the WPS calendar. This seminar gives psychiatrists and other mental health professionals an opportunity to explore psychiatric care in patients who are diagnosed with other medical conditions.

Two outstanding speakers will be presenting.

■ **Robert Gerwin, MD**, Fellow of the American Academy of Neurology, will speak on **Fibromyalgia: Is it Really a Functional Disorder?** Dr. Gerwin is a Diplomate of the American Board of Pain Medicine and a member of the American Academy of Pain Medicine. A graduate of the University of Chicago School of Medicine, he is the Medical Director of Pain and Rehabilitation Medicine in Bethesda, MD and is an Associate Professor in the Department of Neurology at Johns Hopkins University School of Medicine. In addition to practicing neurological medicine, his interests include Myofascial Pain and Fibromyalgia and related pain syndromes such as chronic headache, low back pain, and pelvic region pain. Dr. Gerwin will discuss fibromyalgia, its comorbidities and treatments.

■ **John L. Fleming, MD,** will present **Prolactin: the Forgotten Hormone**. Dr. Fleming is a psychiatrist who is a Distinguished Fellow of the APA. Currently in private practice in Colorado Springs, CO, Dr. Fleming was formerly on the faculties of the University of Colorado and the University of Oklahoma, Tulsa. Prolactin has at least 300 known physiologic actions, more than all other pituitary hormones combined, and binding sites on 67 tissues in the human body. This presentation will review prolactin's impact on many systems that include immune function, neurogenesis, bone density, sexual function, prostate health, obesity, emotional regulation and tumor development. Dr. Fleming will also discuss how psychoactive and other medications affect prolactin levels, and he will discuss conditions of high concern, in which any elevation of prolactin levels should be minimized.

Information on registration will be available shortly. Please check your mail for the Seminar brochure and the WPS web site for more detailed information.

SUBURBAN HOSPITAL AUDITORIUM • 8600 Old Georgetown Road • Bethesda, MD 20814

Save The Date

Resulting Trauma: Identifying the Signs, Symptoms, & Impact of Post-Traumatic Stress Disorder in African Americans

Presented by
Department of Psychiatry & Behavioral Sciences
Howard University's College of Medicine
Thursday, September 24, 2009
8:00am to 4:00pm
Howard University Hospital
Towers Auditorium
2041 Georgia Avenue, NW Washington, DC

Anticipated Topics Include:
Overrepresentation & Prevention of PTSD in Military personnel
Early abuse in urban communities leading to untreated PTSD
PTSD Gang Violence & high African American incarceration rates
Primary Care Clinics / Elder Abuse / Accidents / Suicide / Sleep / Child Psychiatry

For More Information Contact:
Guileine F. Kraft, LGSW
guikraft@yahoo.com
202.865.0097

HOWARD UNIVERSITY

For patients trapped by depression and its treatment side effects

Now you can provide them the new way back™...

NeuroStar TMS (Transcranial Magnetic Stimulation) **Therapy®**

- FDA-cleared for major depression
- Demonstrated to be effective and safe in depressed patients who have not received satisfactory improvement from prior antidepressant medication*
- In an open-label trial, 1 in 2 patients experienced significant improvement in depression symptoms
- No systemic side effects such as weight gain or sexual dysfunction
- Most commonly reported side effects were scalp pain or discomfort and headache
- Less than 5% discontinuation rate due to adverse events

NeuroStar TMS Therapy is administered by prescription only and may not be effective for everyone.

Description of Indicated Population*

DSM-IV Diagnosis	Unipolar, non-psychotic Major Depressive Disorder (MDD)
Patients with Previous MDD Episodes	97%
Treatment History in Current Episode	# of median treatments attempted: 4 Range of treatments attempted (#): 1 - 23 # of treatments at adequate dose and duration: 1
Patients Unemployed due to MDD	48%
Patients with Co-morbid Anxiety Disorder	35%
Symptom Severity	Baseline MADRS=33, HAMD24=30 (moderate to severe)

*NeuroStar TMS Therapy is indicated for the treatment of Major Depressive Disorder (MDD) in adult patients who have failed to achieve satisfactory improvement from one prior antidepressant medication at or above the minimal effective dose and duration in the current episode.

NeuroStar TMS Therapy is now available in the Washington, DC metro area. To learn more:

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ASSOCIATION FOR ACADEMIC PSYCHIATRY

AAP 2009 Annual Meeting

Detailed Meeting & Registration Information Available Online at www.academicpsychiatry.org

SEPT 30—OCT 3, 2009 LOCATION: HAMILTON CROWNE PLAZA WASHINGTON, DC

IMPORTANT DATES TO REMEMBER

- **August 24, 2009 deadline for discounted hotel rate at Hamilton Crowne Plaza Washington, DC**
- **August 26, 2009 deadline for discounted meeting registration**
- **Meeting Dates: September 30—October 3, 2009**

ANNUAL MEETING EXTRAS

Master Educator Program

Consultations with an AAP Distinguished Life Fellow

Resident Career Consultations

Cultural Competence Consultations

Academic Program Consultations

Box Lunches for Section/Workgroup Meetings

The Innovator's Dilemma: Finding Solutions and Managing Change

AAP's Annual Meeting is designed for psychiatrists who are interested in learning about academic development, teaching psychiatry and researching about teaching psychiatry. The meeting is filled with interactive workshops designed to teach a wide array of academic topics including "How to's" for different levels of personal academic and leadership development to using technology in teaching, and teaching to teach, as well as all required and relevant aspects of resident and medical student education in psychiatry. The meeting is a wonderful and casual way to network with academic psychiatrists and psychiatry leaders who have similar interests to you. Informal sharing and mentoring is a frequent occurrence. Come and check it out!

This year's meeting will have a special focus on:

- including CME in the educational mission of academic psychiatrists- how to improve lifelong learning for those who have graduated from medical school and residency;
- how educators can use technology to explore innovation in teaching, manage information and develop new collaborations;
- changing the face of our faculty: continuing the initiative to support a more diverse group of psychiatric educators; and
- strengthening faculty evaluation skills [and preparing faculty for the American Board of Psychiatry and Neurology (ABPN) Clinical Skills Exam].

Accreditation

The Association for Academic Psychiatry 2009 Annual Meeting is a CME activity of the Medical College of Wisconsin.

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education (ACCME) through joint sponsorship of the Medical College of Wisconsin (MCW) and the Association for Academic Psychiatry. MCW is accredited by ACCME to provide continuing medical education for physicians.

MEDICAL COLLEGE OF WISCONSIN CME program

MCW designates this educational activity for a maximum of 19 *AMA PRA Category 1 Credit(s)* ™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

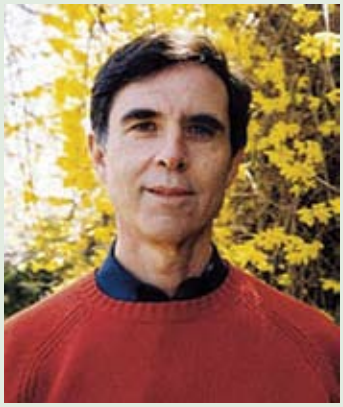
MCW designates this activity for up to 19 contact hours of continuing education for allied health professionals.

Register online at www.academicpsychiatry.org
Questions: Dawn Levreau at dlevreauaap@gmail.com or 770-222-2265

Obituary

Dr. KENNETH PAUL GORELICK (Age 67)

"Looking back I feel my life has been right."



Dr. Ken Gorelick of Washington, DC, died on June 8, 2009 after a two year struggle with brain cancer. Born and raised in Paterson, New Jersey, the son of Russian Jewish immigrant parents, Dr. Gorelick wanted, early on, to become a doctor—inspired and affected by the visits of his father's doctor after his father suffered a heart attack when Ken was a small child. "How May I Help You?"—the phrase he used to greet customers in Gorelick's Bakery—became his favorite way of starting patient interviews in medical school.

He was a fervent student who graduated first in his class at Montclair Academy and Rutger's College, where he was elected to Phi Beta Kappa and won scholarships from General Electric, the Robert Wood Johnson Foundation, and the Henry Rutgers Scholarship Fund. He turned down admission to Columbia, Yale and Harvard Medical Schools in order to take a Fulbright Scholarship to Bordeaux to study French Literature and Language.

He reapplied to Harvard which had the very good sense to accept him; and he graduated in 1967 after a distinguished record. Dr. Gorelick served his medical internship at Mount Zion Hospital and Medical Center in San Francisco and attended his Residency Training at the Massachusetts Mental Health Center, where he also served as a Clinical Instructor of Psychiatry at the Harvard Medical School.

St. Elizabeths Hospital, America's first Federal mental health facility, had the good luck to attract him and he served her with unwavering devotion. Dr. Gorelick was deeply moved and inspired by founder Dorothea Dix's commitment to "the most humane care and enlightened curative treatment." He lived this commitment in his work at St. E's and in his private practice. He advocated for the hospital and promoted a public knowledge of its distinguished history, founding its Historical Museum and giving the keynote speech at the St. Elizabeths 150th Anniversary in 2005.

Ken Gorelick is widely known as a pioneer in the use of literature, especially poetry, in psychotherapy. He and Sister Arlene Hynes developed the first standardized training curriculum for poetry therapy and he founded the Bibliotherapy Training Program at St. E's., serving as its co-director and clinical supervisor. He trained hospital staff and community mental health professionals in the use of poetry and other literature in the treatment of patients with severe and persistent mental illness. From 1993 to 2007, he co-directed the Wordsworth Center for Poetry Therapy Training.

He was a widely sought after speaker and workshop leader and published numerous articles in such publications as the *American Journal of Social Psychiatry, Arts in Psychotherapy, Journal of Poetry Therapy*, and *Expressive Therapies*, among many others.

He was also a generous mentor, colleague, and friend who was open-hearted and down to earth. This was most apparent in the way he used his own life-threatening illness to teach medical students the power of empathy. He was interviewed by Leslie Milk for an article that appeared in the Washingtonian Magazine in May 2009, called "*The Doctor as Patient*." He emphasized the simple value of being told "I'm sorry" by the doctor who gave him his diagnosis.

Ken held many positions and received many honors. Among these were his positions as Chief of Continuing Medical Education and Vice-Chair of the Residency Training Program at St. Elizabeths Hospital. He taught at the George Washington University Medical School, achieving the rank of Clinical Professor of Psychiatry and Behavioral Sciences and was awarded the special rank of Professor Emeritus. He was a President of the National Association for Poetry Therapy and a Distinguished Life Fellow of the American Psychiatric Association.

Ken is survived by his beloved wife, Cheryl Opacinch Gorelick, a retired international policy analyst; a sister and brother-in-law, Arlene and Joseph Taub of New Jersey; a niece, Michelle Taub Tesser and her husband Scott Tesser; a nephew, Marc Taub and his wife Karen Taub, as well as great-nieces and great-nephews, other relatives, friends and colleagues.

Donations may be made to the Dr. Kenneth & Cheryl Gorelick Fund, The Community Foundation for the National Capital Region 1201 15th Street, NW, Suite 420 Washington, DC 20005.

In November 2007, after the first surgery to remove the brain tumor, Ken wrote this poem:

Looking back I feel my life has been right

No second-guessing that this or that might have been better,

No ache that I might have climbed higher mountains.

I am in a generous leisurely mood with myself

Filled with gratitude and awe for what has been,

The gifts, the luck, the love.

My hunger now is different.

I put into each act more thought and mindfulness.

Eventually the true clichés come to pass: "living in the moment."

Time has slowed to a crawl.

That is a good thing.

Every grain counts as it drops

My being, my spirit are pulled by gravity.

And they soar.

Moment to moment I try to solve, ignore, or transcend the frustrations

My big eye on the big picture.

And that picture is beautiful.

This fall foliage has not been spectacular.

But here, at my back door, there is a city forest

No flaming colors

Yet the palette is subtle and exquisite

A harmony of golds, greens, rusts.

The trees have been challenged by dryness and lack of cold

Out of this dearth has come such beauty

Still clinging with all its tenacity.

21ST ANNUAL ISSUES FORUM OF THE CONGRESSIONAL BLACK CAUCUS

The Congressional Black Caucus Task Force on Veterans and the Congressional Black Caucus Foundation Annual Legislative Conference Veterans Braintrust will be focusing on the homecoming experiences of recent returnees from Iraq and Afghanistan and their successful transition to civilian life.

Reps. Charles Rangel (D-NY), Corrine Brown (D-FL) and Sanford Bishop, Jr. (D-GA) are the conveners.

Panel #1 on Health will take place on September 25, 2009 and will be represented by:

- **Dr. David Satcher, MD, PhD, 16th Surgeon General of the United States.**
- **Dr. William Lawson, MD, PhD, Professor of Psychiatry, Howard University, accompanied by:**
- **Dr. Annelle Primm, MD, MPH, Director of Minority & National Affairs for the American Psychiatric Association (APA)**

RED FLAG RULE DELAYED

The **Red Flag Rule** implementation has been delayed for all businesses until November 1, 2009. More details to come in the next issue of the newsletter.

WPS AMBASSADORS WANTED

WPS is launching a new **Ambassador program**. This is a great way to find out more about the Washington Psychiatric Society, make strong professional connections and increase the value of your WPS and APA membership. At the same time, you will help WPS reach out to psychiatrists who are not yet WPS members. If interested, visit the WPS Website at http://**www.dcpsych.org** or call **202-595-9498**.

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in therapeutically untargeted parts of the brain leading to phenomena like reduced drive and enthusiasm, and emotional detachment or apathy, particularly in a subset of patients. In fact, such inadvertent psychological effects may be common, at least to lesser degrees. As these iatrogenic aberrations are counter-therapeutic, the bottom-line efficacy of SSRIs and SNRIs suffers .

Thus, TMS, as a spatially-selective biomedical treatment alternative, represents a significant advancement. None of our previous therapies could fulfill this role. ECT, for example, is diffuse (spatially non-selective) in the brain. In contrast, TMS does not seize the whole brain, sparing subsystems or circuitry that are not relevant to depression, and thus avoiding neurobehavioral toxicities, such as memory loss.

Over the last few decades, various types of studies documented a common pattern in depression involving two types of asymmetries : (1) Between hypoactive dorsolateral prefrontal (DLPF) cortex and hyperactive paralimbic and limbic regions; and (2) between right versus left DLPF cortex (right being relatively more functionally active in depression compared to the left.) TMS can increase or decrease neuronal firing patterns, depending on the stimulation parameters, principally the pulse frequency. High frequencies (3-20 Hz) lead to increased activity in the cortical neurons beneath the treatment coil (through a depolarizing influence), whereas low frequencies (1 Hz or less) lead to the opposite. It is therefore possible to alter functioning patterns of a selected neural network in different ways. Brain imaging reveals that these effects right under the treatment coil are selectively carried over to certain other regions of the brain trans-synaptically following relevant anatomical and functional circuitry, not in an indiscriminate and diffuse way. In this way, as I apply TMS to a patient's DLPF cortex, I am not only aiming for a direct functional enhancement there, but also for a trans-synaptically mediated amelioration of overactivity in deeper regions, thus correcting the principle functional asymmetry in the neurobiology of depression. TMS achieves this feat in a top-down fashion and completely noninvasively, as opposed to deep brain stimulation via surgically implanted electrodes which electrically suppress this overactivity in deeper regions. As a plus, TMS is also capable of improving the right over left DLPF cortex bias in depressed affective states by using high frequency TMS to the left DLPF cortex (as in the currently FDA approved version) or low frequency TMS to the right DLPF cortex.

Using isolated magnetic pulses, we can use TMS to induce either positive or negative neuropsychological phenomena, and this capability has been harvested by researchers, neurologists and neurosurgeons for brain mapping purposes. For example, we can either make a person perceive "phosphenes" (slowly flashing lights) or scotomas in a specific sector of either the right or left visual field by applying either high frequency or low frequency TMS directed to the corresponding regions of the primary visual cortex. During some of these studies, transient mood changes were also observed. Today, we aim for enduring positive changes in the mood states and inherent cognitive biases involved in depression by applying TMS repetitively within a session and for 20-30 sessions in a course of 4-6 weeks. This manner of application of repetitive TMS (rTMS) has been shown to possess the hallmarks of other effective biological treatments for depression, including induction of genes involved in neuron and synapse formation and maintenance, normalization of abnormal stress hormone responses, increases in brain monoamine turnover, adaptive changes in certain serotonin and norepinephrine receptors, normalization of regional cerebral blood flow and glucose utilization in the mood circuitry of the brain, and efficacy in animal behavioral models of depression. Several clinical studies in recent years, including the ones submitted to the FDA conducted in 23 premium research sites in a randomized, triple-blinded, sham-controlled fashion, demonstrated the efficacy and safety of TMS for depression. These studies indicate that we can expect to see clinical response in at least half of patients and complete remission in about one out of three patients even though they have already failed one antidepressant medication at therapeutic dosage and for a long enough duration in the current episode. These studies have confirmed the lack of any CNS or systemic side effects that are associated with pharmaceuticals or ECT. There have been no inadvertent seizures, drug-device interactions, treatment-emergent suicidal ideation, or cognitive impairments. Of interest, studies hint at cognitive improvements with TMS going beyond what is expected from lifting of depression alone. The main side effects are limited to discomfort or pain in the scalp or skin under the treatment coil and tension-type headaches in a subset

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Classified Ads

Office Space Available

RESTON, VA office space in Faraday Professional Center ideally located only two blocks from Dulles Toll Rd. Have own office and share waiting room, kitchen, and fax/copier with two established Reston psychiatrists. Plentiful parking. Unique opportunity for established clinician or beginning practitioner who might benefit from referrals. Contact Michael Arons, MD at 703-709-8945 or James Blitch, Jr., MD at 703-435-4434.

OFFICE SPACE FOR RENT: Available immediately: Large, quiet, bright & airy consulting room in two office suite. Fully furnished for individual or group psychotherapy & small conferences. Attractive waiting room, bathroom & kitchen space w/office equipment. Cleaned weekly. 24/7 concierge desk in lobby of well maintained apartment house on Conn. Ave. in Chevy Chase DC. Bus at door; 15 min walk to metro, restaurants, shops nearby. Street parking; w/additional parking available for rent in rear lot. $1,500/mo. Contact Steven Wolin 202-966-7540; email: swolin@erols.com.

OFFICE AVAILABLE: Part time rental in Chevy Chase Metro Building (above Friendship Heights Metro Stop-corner of Western and Wisconsin) in-suite with other psychiatrists and therapists. Excellent Bldg. with great view from office. Call Dr. Slater at 240-447-9051.

ATTRACTIVE OFFICE in Medical bldg. w/excellent location adjacent to INOVA Fairfax Hospital. Suite of 3 independent practicing psychiatrists seeking a 4th psychiatrist to be part of our collegial and friendly office. Rent including utilities is approx $940. Call Ross Silverstein at 703-876-9067 for further details.

BETHESDA: Half-time, furnished office. Excellent downtown location. Walking distance to Metro. Attractively furnished waiting room. Kitchenette and private restroom in suite. Share space with 3 other mental health professionals. Collegial atmosphere. Call 301-656-5360 or email: jacobmelamed@erols.com.

ALEXANDRIA, VA OFFICE available immediately, full or part-time, in the Alexandria Professional Center which is conveniently located right off the Seminary Road exit off Rt. 395. Share a suite with 4 psychologists who are the only mental health professionals in this referral rich medical building. Offices are appoximately 12'x17', furnished, and have a large waiting room and kitchenette. Contact Bob Morin, PsyD, 703-823-0970 or morinr703@aol.com.

VIENNA OFFICE SPACE FOR RENT: 1200 SF, 3 soundproof offices with reception area and 2 bathrooms. Great location on Rt. 123 with ample parking. Call 703 860-2458.

TYSONS CORNER OFFICE avail. immed., F or P/T. Share a spacious six office suite with 5 psychologists: Near Toll Road, Rt. 66 and 495. Priv. entrance, waiting room, fax, copier, internet, kitchen, deli and free parking. $1000 monthly w/1 year lease, hourly rates avail. Call 703-349-1161 for info.

ROCKVILLE, MD Near 270/Montrose. Part-Time office,1-3 days per week in beautiful 3 office therapy suite in grade A office park. Furnished 12'x17' room, seats 5 with large desk area. Wall of windows with view into wooded parkland. New construction, kitchen, separate entrance, soundproofing, locked storage, waiting room, on-site gym, free parking. Other amenities available. Call Kathleen Landers at 301-468-7711, ext 2 or email kl.tower-oaks@mindspring.com.

Positions Available

Child Psychiatrist for PT or FT position in thriving fee for service multidisciplinary practice. Excellent compensation and rewarding clinical work. Please call Dr. Oberschneider at 703-338-1138. Please visit www.ashburnpsych.com to learn about the practice.

Spectrum Healthcare Resources has a **Psychiatric NP** opportunity at Portsmouth Naval Medical Center in Virginia. This civilian position offers: Full Time, Monday - Friday Hours, No Call, Weekends, or Holidays, 5 Weeks PTO Accrual, 48 Hours of CME, 10 Paid Holidays, 100% Malpractice Covered, Outpatient Clinic. The position requires: Psych NP Certification, ANCC Certification, 1 Year Experience, Any State License, BLS. Please contact: Kit Oden, Phone: 800-325-3982 x4258 e-mail: koden@spectrumhealth.com, www.shrusa.com, EOE/AA/D.

Adult/Adolescent Psychiatrist. BC/BE, initially P/T, to join collegial respected multidisciplinary group practice in Montgomery County. To perform psychiatric evaluations, psychotherapy, and medication management. Fax CV to 301-948-6199.

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of patients. These are typically mild to moderate and manageable, largely dissipating after the first 5 sessions. Less than 5% of patients discontinued treatment due to side effects in an FDA-submitted study. In a maintenance study, about 50 % of responders maintained their level of response for 6 months without need for any repeat sessions. The other half of patients received repeat sessions as they began to show break-through symptoms (but before they actually relapsed). Those who needed repeat treatments almost invariably responded again. All patients were placed on one antidepressant for maintenance purposes, mostly at lowest therapeutic dosages. With this strategy, less that 10% of patients relapsed at the end of 6 months. This statistic compares favorably with ECT, which does not have a good track record when it comes to maintenance of efficacy in 6-month studies. The effect size with TMS in patients who failed one adequate antidepressant trial in the current episode was 0.52, which compares favorably with the effect size observed with medications, 0.31.

In conclusion, this is an exciting time for our profession, and for a large group of our depressed patients. TMS is a unique biomedical treatment option, either alone or in conjunction with medications, for patients who continue to suffer due to tolerability and/or efficacy limitations of pharmacotherapy. With this novel option comes a good potential to move many patients out of their unending misery or off the track toward riskier options, such as ECT. I know from numerous phone calls as well as electronic communications I am receiving through my website that a lot of colleagues share this excitement. When a patient or a colleague contacts me directly regarding TMS therapy at my practice, often there are numerous important questions to address and issues to discuss. I have included a good amount of TMS-related information on my website (www.brain2mind.com) in order to facilitate this process. However I would like to encourage all colleagues interested in referring a patient to contact me directly to address all of the specific questions involved. I am committed to make this treatment option work for everybody in the best way that I can. For that, however, I need your feedback and suggestions in order to help me help you and your patients tap into the potential of TMS in the most optimal way that we can.

APA FELLOWSHIP APPLICATIONS

By Maryam Razavi, MD, Chair, Membership Committee

During the 1990s, the Washington Psychiatric Society, through its Assembly Representatives—Larry Kline, Larry Sack and Roger Peele—advocated that the APA's Fellowship criteria be consistent with the Fellowship designations of other Medical Specialties; namely, that the basic requirement for Fellowship be passage of the specialty board exam. This change in the APA's Bylaws was finally achieved in 2001. We want to see WPS lead the way in distinguishing members who have passed Boards—as other medical specialties do.

The criteria to become an APA Fellow are:

- General Member for at least five years
- Certification by the American Board of Psychiatry and Neurology, the Royal College of Physicians and Surgeons of Canada, or the American Osteopathic Association
- Two letters of recommendation from current Fellows, Life Fellows, Distinguished Fellows or Distinguished Life Fellows (WPS will provide these for you)
- 30-day review period for the district branch to offer comments about the Fellowship candidate
- Approval by the APA Membership Committee
- Approval by the APA Board of Trustees

We invite those eligible for APA Fellowship to apply through WPS as soon as possible. Completed paperwork is due to the WPS office before September 1, 2009.

For more information, please contact Jane Martin, Director of Member Services, at janemartinso@yahoo.com or 410-626-1182.