Nancy Rappaport, M.D.

Losing my mother to suicide when I was four years old cannot be sugarcoated. I needed her, and there were times that I felt alone and abandoned. I will always want a mother and want to understand the mystery of her suicide. As I was so young when she died, the youngest of six children, I still carry a small child’s wish to make it all right, to fix things. Perhaps that is why I became a psychiatrist specializing in at-risk teenagers: I know what a difference having a safe harbor, and someone who openly listens, can make in our lives. However, I am also cautious: I never want my patients to worry that they need to take care of me or that I am trying to save them because I couldn’t save my mother. The reality is that I am invested in caring for them, in keeping them alive, in treating their debilitating depression, because I value who they are.

In my memoir, In Her Wake: A Child Psychiatrist Explores the Mystery of Her Mother’s Suicide, I explore my mother’s death from the perspective of a daughter seeking answers, desperate to know something of her mother, and as a very

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LIFELONG LEARNING INSTITUTE:
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Autism, Psychotic Disorders (Non-Affective), and Updates on Relevant Topics for Child and Adolescent Psychiatrists

Sandra B. Sexson, M.D.
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# Mission

The American Academy of Child and Adolescent Psychiatry's mission is the promotion of mentally healthy children, adolescents, and families through research, training, advocacy, prevention, comprehensive diagnosis and treatment, peer support, and collaboration.

# Functions and Roles of the American Academy of Child and Adolescent Psychiatry

The American Academy of Child and Adolescent Psychiatry's role is to lead its membership through collective action, peer support, continuing education, and mobilization of resources. In this role, the Academy:

- Establishes and supports the highest ethical and professional standards of clinical practice.
- Advocates for the mental health and public health needs of children, adolescents, and families.
- Promotes research, scholarship, training, and continued expansion of the scientific base of our profession.
- Serves as a liaison with other physicians and health care providers and collaborates with others who share common goals.

# Mission of the AACAP News

The mission of the AACAP News includes: (1) Communication among AACAP members, components, and leadership. (2) Education regarding child and adolescent psychiatry. (3) Recording the history of AACAP. (4) Artistic and creative expression of AACAP members. (5) Provide information regarding upcoming AACAP events. (6) Provide a recruitment tool.
Please join other AACAP members, and family and youth advocates May 6-7, 2010 on Capitol Hill to promote child and adolescent psychiatry and children’s mental health issues. There is no better way for providers and families to work together to effect positive change. Advocacy Day is a great opportunity to learn about the legislative process, develop relationships with legislators, and to discuss the issues that most affect your patients and practice. The AACAP Department of Government Affairs will schedule your Congressional meetings, guide you on what to say and do during your meeting and provide you with the policy materials to shape your message. For more information, please visit the legislative section of AACAP’s Web site at www.aacap.org or contact Karen Davis at kdavis@aacap.org or 202.966.7300, ext. 128.

May 6 | 3 p.m - 5 p.m.
Train as an advocate

May 7 | 8 a.m - 2 p.m.
Learn about AACAP policies and meet with congressional offices.
present mother of three children, now teenagers, and, finally, as a doctor working with teens confronted with deeply disturbing challenges. Having lived through this loss with its sense of betrayal, and ultimately healing, I have studied and worked with understanding how children make sense of a complicated world. I have learned that every life is valuable, that no one is expendable, and that each of us is loved. Although I have rarely mentioned my effort to understand my mother’s suicide to my patients, it has informed my practice as a therapist. The act of examining the loss has given me the energy to sustain my compassion so that I do not flinch as I did in my earlier days.

In his essay, “Why I Write,” Orwell lamented that a writer’s motives are often a deep mystery. He said, “Writing a book is a horrible, exhausting struggle, like a long bout of some painful illness. One would never undertake such a thing if one were not driven on by some demon whom one can neither resist nor understand” (Orwell 1946). My mother’s suicide was the north star of my existence, and my driving demon in writing my memoir. The necessity of self-reflection in a psychiatrist’s work is essential—we make ourselves more available to our patients through understanding ourselves and how our past affects us. After all, we cannot ask more of our patients than we ask of ourselves. I understand my patients’ trepidation at times to ask questions while afraid of knowing the answers. Of course, many of us choose not to reveal ourselves in such a public way as writing a book. Kay Redfield Jamison, Ph.D., in her memoir, An Unquiet Mind: A Memoir of Moods and Madness, took this risk in the hopes of destigmatizing mental illness and providing hope (Jamison 1995). On my writing journey, I sought to take a personal tragedy, my own, and humanize psychiatry by showcasing the ways that therapy and self reflection aided me in navigating my grief and the ways in which I strive to help vulnerable children and build on their strengths.

When I was in seventh grade I attended an all-girls school and was getting into a fair amount of trouble. I found the rules of the school to be tedious and so resisted them as best I could, determined that this school could not define me. Maybe my behavior was an effort to be noticed by someone—anyone—who might pay attention to the fact that I was one pissed-off, frightened kid. I was rude and disrespectful to teachers and it was getting worse. I started to steal things. When I ran away from home and spent the night in the school auditorium—whereabouts unknown for a whole night—that was the last straw. My father and stepmother arranged for me to see a therapist, and it was Dr. Walter who helped me get back on track.

It was only in the sanctuary of Dr. Walter’s office that I began to feel safe enough to find the words for my grief and confusion over losing my mother to suicide. His voice was calming, and he chose his words precisely. It was a relief to talk openly with someone who would listen to my dread and my memories. Soon I was seeing him twice a week and continued to make the trek to his office where, curled up in his black leather chair, I shifted nervously.

Dr. Walter and I talked about a recurring dream that left me forlorn. In this terrifying dream, I am the one who discovers that my mother is dead. Heavy floral drapes dim the light. There is stillness as I open the bathroom door. Multicolored cologne bottles line the windowsill, breaking light into colored pieces. In the reflection of the medicine cabinet, the door left ajar, there is a bottle of pills spilled open on the shelf, capsules red and grey, ten or twenty. I see my mother on the bed. It is hard to tell if she is breathing, but I don’t tell anyone, and I don’t try to wake her.

I was afraid that my therapist would see my dream as evidence that my mother’s death was my fault. If only I had recognized that my mother was unconscious, I might have gotten help to revive her. Gently, Dr. Walter reassured me that nothing I did or thought had caused my mother’s suicide. He helped me to see that my mother’s suicide was tragic, unfair, and probably unexplainable. He listened more than anyone had ever listened to me before about what mattered most to me. His unconditional acceptance restored my confidence.

Revealing my secret and being exonerated of my guilt was liberating. Dr. Walter helped me understand that 4-year-old children often feel omnipotent and rely on “magical thinking” to make sense of the world around them. They see themselves as central to all events, and this can become a set-up for self-blame. By clinging to the idea that I could have saved my mother, I protected myself from a terrifying sense of helplessness. He helped me to understand the process I was going through.

Although I spent 18 years writing this memoir in an effort to understand the “why” of my mother’s suicide, how people kill themselves is just as urgent an issue. My mother overdosed on barbiturates at a time when they were prescribed fairly cavalierly. Suicide is also about access. Just one percent of suicide attempts are caused by guns, but make up 65 percent of completed suicides. I use this fact as an opportunity to warn my readers and listeners that if they have relatives or friends who are angry, impulsive, or depressed to make sure that they do not have access to guns (or to at least separate the bullets from the gun).

I also explain that because I never interviewed my mother, I do not feel capable to diagnose her. There are suggestions in her writings and level of activity that she may have had periods of manic activity and plummeting depression. If this is true, I emphasize that Lithium can be lifesaving to those suffering with bipolar disorder and that people are eight times less likely to kill themselves than if they are on a placebo (Baldessarini et al. 2006).
Often I’m asked how my exploration on my mother’s life and suicide changed me as a clinician. The answer is a complicated one. As a writer I was motivated by a desire to show my process of healing and to make sense of a complicated situation, but I realize that my memoir and my profession together form a powerful vehicle to reach people affected by suicide or who may be suicidal. For my message to reach someone—even one person—is profound and gratifying.

The e-mails and stories I receive from readers who have been affected by suicide are gut wrenching, but reinforce my investment in suicide prevention and forging a community of healing. “I am attaching a photo of our three daughters taken six months before the one in the middle died by suicide,” one woman wrote to me. “we had no warning. She left behind two little girls, ages almost 4- and 5-year-olds. We are struggling every day. It has now been six months since she died. Reading about you and how you have succeeded in life gives me some hope for her children and a reason to carry on.”

The message I want to offer is one of hope: as child and adolescent psychiatrists, we are always trying to build a meaningful narrative with our patients as life–lines of understanding and convey that they are not alone. Because I’ve integrated my personal history with my career as a doctor, some of my colleagues like to joke that I am “out of the closet,” but I like to think of it as a way of showing we are all human, we are always learning, and out of the darkest trauma there is hope, the future is possible; together we are able to find our way to a rewarding life.

References

Dr. Rappaport is assistant professor of psychiatry at Harvard Medical School. She is attending child and adolescent psychiatrist at Harvard teaching affiliate Cambridge Health Alliance, where she is also Director of School Based-programs with a focus on servicing youths, families and staff in public schools. She is the author of In Her Wake: A Child Psychiatrist Explores the Mystery of Her Mother’s Suicide (Basic Books, September 2009 www.inherwake.com).

2010 Catchers in the Rye Awards

The AACAP recognizes and promotes advocacy for children. To better recognize outstanding advocacy efforts, the AACAP established three advocacy awards to:

• Recognize an individual who advocates for children (must be an AACAP member)
• Recognize an AACAP component that best advocates for children
• Recognize a regional organization of child and adolescent psychiatry whose activities best highlight the contributions of AACAP regional organizations on behalf of children.

The award title was taken from Dr. John Schowalter’s Presidential Address in which he alluded to J. D. Salinger’s book and Holden Caulfield’s response to what he wanted to be when he grew up . . .

“I keep picturing all these little kids playing some game in this big field of rye and all. Thousands of little kids, and nobody’s around — nobody big, I mean — except me. And I am standing on the edge of some crazy cliff. What I have to do, I have to catch everybody if they start to go over the cliff . . . .”

Nominations should include a brief paragraph describing the nominee’s work. The Assembly Executive Committee serves as the selection body. Awards will be presented at the Assembly meeting during the AACAP Annual Meeting in October 2010 in New York. Please forward your nominations to: Earl Magee, AACAP, 3615 Wisconsin Avenue, N.W., Washington, DC 20016, or e-mail to emagee@aacap.org.

The deadline for nominations is June 30, 2010.
The Ocean of Madness

He walks along the beach,
The sun beams through the clouds,
Water laps onto the shore,
Soaking his shoes and dampening his socks.

The water startles him,
Suddenly entering his mind,
But he continues to walk,
Disallowing it to impede his way.

The tide begins to rise,
Yet he tries to ignore it,
His pant legs get wet,
And soon he’s waist deep.

He looks to the people ashore,
He wants to be one of them,
He hopes they don’t notice,
The water in which he’s submerged.

The sandbar drops beneath him,
He’s pulled out by the current,
Gasping for air,
His arms and legs flail.

He begins to sink,
The more he struggles the further he goes,
Up above,
Sunlight beams through the surface.

He’s enveloped by darkness,
He feels all hope is lost,
But as he reaches upward,
His arm is grasped by a hand.

He rises to the surface,
Being pulled by a dark figure,
At first he resists,
Until he realizes it’s for his own good.

His head breaks the surface,
He coughs and chokes for air,
He’s pulled slowly to safety,
And rests on the shore.

He awakes an hour later,
His clothes somewhat drier,
He’s at one with the sunbathing people,
The rays beam through the clouds.

by Roshan Hegde M.D.

Roshan Hegde M.D. is a graduate from St. George’s University medical school and is currently applying for a residency in psychiatry, and he hopes to one day specialize in child and adolescent psychiatry.

Individuals interested in submitting poetry should e-mail Chuck Joy, M.D., Features Editor at c.r.joy@att.net.
Required Reading: An Argument for the New AACAP Code of Ethics

The code provides a general framework to understand important concepts underlying the quality practice of child and adolescent psychiatry and to conceptualize one’s own perspective on these principles.

Arden D. Dingle, M.D.

My response to, “You must read this,” is helplessness since I am so far behind, especially in my reading. However, some information cannot wait and the revised 2009 ethics code of the AACAP is in that category. It is essential that AACAP members read and understand the organizational Code of Ethics. These documents describe and detail the ethical principles of the AACAP, which represents its members and the field of child and adolescent psychiatry nationally. The Code provides a general framework to understand important concepts underlying the quality practice of child and adolescent psychiatry and to conceptualize one’s own perspective on these principles. It discusses how to approach a number of common issues that can occur while practicing child and adolescent psychiatry. Additional documents have been written on the issues related to conflict of interest (COI) for child and adolescent psychiatrists generally, as well as for researchers. All this information is available on the AACAP Web site, www.aacap.org, with the important points highlighted in the AACAP Transparency Portal.

The 2009 AACAP Code of Ethics is a revision of the 1980 Code; the aim is to provide a document that is simpler, easier to read, and to address in more depth some of the major current issues. It is a written statement of the standards intended to guide the professional conduct of AACAP members, and to facilitate the highest quality of service to children, adolescents, and families. As noted in the introduction, child and adolescent psychiatry requires its own ethical standards that specifically address the unique aspects of working with children and adolescents. They are not developmentally mature, usually do not have decision-making powers about seeking or obtaining care, may have different opinions than their guardians, require considerable coordination of care between various caretakers, and often need significant advocacy both individually and as a group. The Code is organized around ten core principles. There is a focus on the importance of self-awareness of one’s beliefs and actions in all of these areas as an essential aspect of understanding one’s stance on and adherence to ethical issues. The principles are listed and described below.

- **Principle I:** Developmental Perspective is unique to the code. It emphasizes the obligation to understand the developmental context of children and adolescents when providing clinical care, conducting research studies, or making consultation recommendations. All aspects of development should be considered and optimized.

- **Principle II:** Promoting the Welfare of Children and Adolescents (Beneficence) discusses the obligation to promote the optimal well-being, functioning, and development of youth, both as individuals and as a group. This commitment should be prioritized over familial or societal pressures. Practitioner actions should be based on solid scientific knowledge, clinical experience, and an understanding of the significant relationships between the youth and adults or agencies. In situations where the practitioner has obligations to other entities besides the child or adolescent, these responsibilities should be clear to all and the welfare and needs of any involved youth and families should be considered.

- **Principle III:** Minimizing Harmful Effects (Non-malfeasance) reviews the importance of not doing harm. Practitioners should strive to avoid any and all actions that may be detrimental to the optimal development of children and adolescents, as well as to decrease the harmful impact of the behavior of others on youth at the individual, family, local community, and societal levels. The vulnerability of youth and their families should not be exploited for personal gain. Relationships outside of professional interactions should be carefully considered and care must be taken to prevent any adverse impact on patient care. Some types of relationships, such as sexual interactions with current or former patients, are never appropriate.

- **Principle IV:** Assent and Consent (Autonomy) discusses the importance of patients and caregivers making their own informed, unpressured decisions. Youth under the age of 18 years can assent and should be involved in the decision making about their care. Guardians must consent except in emergencies. Practitioners should provide full communication about all relevant issues at all times. Particular care should be taken when the youth and guardian disagree.

*continued on page 72*
• **Principle V:** Confidentiality (Autonomy/Fidelity) is the right to have information kept private and confidential. Practitioners should inform children and adolescents about confidentiality and any associated limits in an appropriate manner. Patients and their families should be told about possible disclosures of information, preferably in advance. Release of information to outside parties must involve the guardian’s consent and the patient’s assent as appropriate.

• **Principle VI:** Third Party Influence (Fidelity) reviews the issues related to the influences of outside entities. Practitioners should place the welfare of the patient above competing interests. There should be constant monitoring by the practitioner to keep the interests of children and adolescents paramount and not allow improper influence on professional judgment and opinion by competing interests. Child and adolescent psychiatrists should fully disclose and describe all possible conflicts to all involved parties. These concerns also are addressed in the separate conflict of interest documents on child and adolescent psychiatry practice and child and adolescent psychiatry research.

• **Principle VII:** Research Activities supports the value of research but emphasizes the importance of minimizing risk. The scientific advancement of the field is essential; however, the first priority of researchers is to protect the child or adolescent from risks. The safety and well being of the participating youth should be paramount. Level of risk should be fully disclosed. Youth should not be forced to participate if they dissent. Research should be conducted in accordance with the ethical standards of all relevant organizations. Investigator and organizational conflicts of interest should be clear and thoroughly discussed.

• **Principle VIII:** Advocacy and Equity (Justice) highlights the importance of competent mental health care being available to all children, adolescents, and families. Practitioners should support efforts to improve access to care at all societal levels. Practitioners should attempt to minimize youth’s exposure to injustice. Research risk should not be borne disproportionately by vulnerable groups and its benefits should be shared equally.

• **Principle IX:** Professional Rewards covers possible issues related to the tangible and intangible reinforcements of child and adolescent psychiatry practice and child and adolescent psychiatry research. Child and adolescent psychiatrists should not exploit their influence or relationships for improper personal aggrandizement or that of others. The pursuit and enjoyment of personal rewards must not interfere with or negatively impact youth, families, or communities. Similarly such rewards compromise the integrity and public trust of the child and adolescent psychiatry profession.

• **Principle X:** Legal Considerations reviews the importance of understanding the local, state, and federal laws that impact child and adolescent psychiatry practice, especially those regulations covering unique issues. For example, in some circumstances, adolescents manage consent and confidentiality. However, legal standards do not replace ethical ones. Practitioners should be knowledgeable in both areas and be able to integrate them effectively in practice.

The Code is best viewed as a consensus document that provides a foundation for practitioners to build upon to understand and manage clinical work and research efforts appropriately. As AACAP works on developing additional resources on ethical issues relevant to child and adolescent psychiatry, I would like to encourage all AACAP members to write with topic or format suggestions, cases, or questions. My e-mail address is: adingle@emory.edu.

Dr. Dingle is the child and adolescent psychiatry training director at the Emory University School of Medicine in Atlanta, Georgia. She is the chair of the AACAP Ethics Committee.

Feeling out of the loop? Sign Up for AACAP’s News Clips!

Stay up to date on breaking news and hot topics in the field of child and adolescent psychiatry. Sign up to receive AACAP’s news clips every Monday, Wednesday and Friday. To take advantage of this member benefit, contact Amanda Greenberg, Communications Coordinator, at agreenberg@aacap.org or 202.966.7300, ext. 154.
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Formerly Abducted Child Soldiers Can Show a Remarkable Ability to Recover

The widespread view... that these child soldiers represent a lost generation is “simply unacceptable,” says Ishmael Beah.

So wrote Ishmael Beah in A Long Way Gone: Memoirs of a Boy Soldier (Farar, Strauss and Giroux 2007). At the age of 13, Beah was conscripted into the Sierra Leone army to fight against the rebel Revolutionary United Front. Rescued in 1996, Beah spent six months in a rehabilitation center with other formerly abducted youth in Sierra Leone. Adopted by an American nurse from Brooklyn, New York, who worked closely with him in the center, Beah completed high school at the United Nations International School in Manhattan and went on to earn an undergraduate degree in political science at Oberlin College. He now serves as UNICEF’s first Goodwill Ambassador for Children Affected by Armed Conflict.

Beah appeared as a guest speaker for a course I co-taught in the fall of 2009, “Global Perspectives of Child and Adolescent Mental Health,” as part of the Child and Adolescent Mental Health Studies undergraduate curriculum at New York University (NYU). Recounting his story to students at NYU, Beah exemplified the resilience of many throughout the world who were kidnapped as children in the throes of armed conflict and forced to commit unthinkable acts.

According to UNICEF, some 300,000 boys and girls under the age of 18 years are fighting in more than 30 conflicts worldwide. The widespread view, often propagated in media reports, is that these child soldiers represent a lost generation, irredeemably brutalized by the violence in which they have participated and incapable of leading productive lives in the aftermath of war. Beah rejects this declaration as “simply unacceptable.”

Research presented at a three-day conference in December 2009, Children and Armed Conflict: Risk, Resilience and Mental Health supports Beah’s view. Sponsored by the National Academy of Science’s Institute of Medicine (IOM), the interdisciplinary conference addressed the development and mental health needs of children in conflict-affected and post-conflict settings throughout the world. Expert speakers conveyed their research findings and stories from the field, highlighting the complex interaction between risk factors, psychopathology, and mental health with resilience as an important moderator.

Though armed conflict can devastate the lives of children, studies from some of Africa’s war zones indicate that most former child soldiers successfully re-integrate into their communities once they return home. Some data even suggests that they are more engaged and productive citizens than their peers who were exposed to violence but not forced into combat.

“We want to present counter evidence to this notion that child soldiers are badly broken,” says Jeannie Annan, Ph.D., a psychologist, director of Research and Evaluation for the International Rescue Committee, and co-director of the Survey of War Affected Youth (SWAY). For several years, Dr. Annan has worked with war-affected youth in northern Uganda where a brutal rebel force called the Lord’s Resistance Army (LRA) has been fighting government troops since the late 1980s.

Previous studies of former child soldiers have mostly been limited to a few dozen individuals, and they have not compared their experiences with non-combatant youth from the same communities. SWAY’s study was much larger in scope, involving interviews with 741 young men and boys and 619 young women and girls in the region. About 40 percent of the male youths reported that they had been abducted by the LRA at some point. Of these, 57 percent had been severely beaten, and 24 percent attacked with a weapon.

SWAY has found that all young people in the affected regions are suffering as a result of the conflict, mostly because of disruption to their education and ability to earn a living. But in relative terms, the former child soldiers demonstrate remarkable resilience.

Fewer than 10 percent of young people in the survey reported symptoms of Post-Traumatic Stress Disorder (PTSD).
In the process of post-conflict reintegration, only three percent of formerly abducted young men reported significant difficulty being accepted by their families, and fewer than 10 percent reported problems regaining trust from neighbors. “They are not social pariahs,” says Annan.

Results from Annan’s work show that formerly abducted child soldiers often become more engaged as citizens. They were 22 percent more likely to have voted in a 2005 referendum on a new, multi-party constitution, and 73 percent more likely to be a member of a peace-promoting organization. “They’re more invested in their community,” says Annan.

Neil Boothby, Ed.D., director of the Program on Forced Migration and Health at Columbia University in New York, has followed the long-term well-being of 40 boys who were abducted and forced to fight by the Renamo rebels in Mozambique during the 1980s.

In 1988, Dr. Boothby’s team began assisting the group of boys (then ages 8 to 16 years) in relocating their relatives and returning them to their villages in southern Mozambique. When Dr. Boothby interviewed the men 15 years later, almost all owned their own homes, and 80 percent were married. They were more likely than an average rural Mozambican to earn extra money doing odd jobs in addition to farming, and 75 percent were parents who had children attending primary school compared to the national average of 52 percent.

Psychological treatment for former child soldiers in Uganda shows promise as a way to ease lingering depression, says Judy Bass, Ph.D., M.P.H., of Johns Hopkins University in Baltimore, Maryland. In a 2007 study, her team adapted a form of interpersonal therapy for use in Uganda. Trained, local counselors delivered this therapy to 105 teenagers in two camps for displaced persons. The youth had been abducted by rebels and had witnessed murders or had experienced other war-related traumas. Anxiety, social withdrawal, and other signs of depression substantially diminished after four months of weekly group interpersonal therapy.

Dr. Davis, a second year child and adolescent psychiatry resident at the NYU Child Study Center/Bellevue Hospital Center, is currently serving as the John E. Schowalter, M.D., Resident Member of Council. Prior to medical school, Dr. Davis served for three years as a rural health educator with the United States Peace Corps in Burkina Faso (West Africa). Through his participation in a UNICEF sponsored training, Dr. Davis spent three weeks working with mental health specialists treating formerly abducted child soldiers in northern Uganda.

**New Research Poster Call for Papers**

The 57th AACAP Annual Meeting will take place on October 26-31, 2010 at the Hilton New York in New York, New York. Abstract proposals are prerequisites for acceptance of all presentations given at the meeting. Topics may include any aspect of child and adolescent psychiatry including clinical treatment, research, training, development, service delivery, or administration.

Verbal presentation submissions were due by February 16, 2010 and may not be submitted after the deadline. Abstract proposals for (late) New Research Posters must be received at the AACAP by **Tuesday, June 15, 2010**. All Call for Papers applications must be submitted online at www.aacap.org. Step-by-step instructions for how to use the online submission system are available at www.aacap.org. If you have questions regarding this process, please call 202.966.7300, ext. 101 or e-mail meetings@aacap.org.
A real, current dilemma troubles me in my own clinical work and in teaching medical students in our training program. Have trainees and I become so focused on psychopharmacologic treatment that we are at a loss to help children who do not respond to medication or the many adolescents who refuse to take medication? Does our ever-increasing focus on medication affect our ability to provide necessary and sufficient psychotherapeutic intervention? Would robust psychotherapeutic intervention, especially when used in conjunction with medication, enhance our patients’ development and long-term outcome?

I wonder why child and adolescent psychiatrists in the United States are mostly treating children and adolescents with medication, and losing sight of the possibility of enhancing developmental interventions, working with the school, engaging in parenting work, and employing psychotherapy. This was not the case in the past when psychotherapy was a very solid, indeed a core, component of being a child and adolescent psychiatrist. When the medication formulary for children and adolescents was scant, their use was seen as adjunctive to the psychosocial and psychotherapeutic interventions, which were thoughtfully constructed and implemented to contain, support, and transform the patient. Have we shot past some middle ground where medication became a robust element in the overall plan, overshadowing or even choking out the psychotherapeutics? Being comprehensive and masterful at both psychopharmacology and psychotherapy made child and adolescent psychiatrists artists in therapeutics similar to conductors of orchestras.

I am a consultant in a therapeutic school in Rhode Island for behaviorally disturbed children and adolescents. I follow them through their elementary school years. Most of them come with a list of numerous medications that I have to quickly disentangle. They have not had therapy in the past, or if they did, it was inconsistent and poorly executed. I observed that after a few months of structure, consistent therapy, and containment by our clinicians, as well as working in groups, and their parents receiving skills training, many of the children improved significantly. They became more loving, respectful, and less angry. They were still receiving the same medications but a different variable, the psychosocial/psychotherapeutic program of the school, had been introduced to their care. I started to taper some of their medications and saw no major deterioration in their behavior. Some children were discharged from our school with minimal medication or none whatsoever.

On the other hand, some children in whom we tried different kinds of therapies for depression, anxiety, or trauma, even with the building a good working alliance, their impairing symptoms were unchanged. Once I saw enough to better formulate the case and revise the treatment, I started medication to target specific symptoms aiming for a synergistic effect between the medication and psychotherapeutic interventions. These children and adolescents responded and as symptoms receded, perhaps making depression less severe or removing anxiety, their ability to utilize therapy increased and the process improved.

My impression from this experience is that to do psychopharmacologic treatments well, effectively, and efficiently, the treatment needs to be contained in a solid psychotherapeutic relationship with the child and their parents, rather than the reverse. This is necessary in order to zero in on the diagnosis, re-establish compliance with medication where it has been lost, avoid escalating polypharmacy, and treat medication non-responders.

Psychopharmacological research has grown through the years and has been a very valuable addition to the child and adolescent psychiatrist’s tool box. Children with biological predisposition to suffer from depression, anxiety, and ADHD, for example, have had positive recoveries in recent years, recoveries that it was not possible to see prior to recent advances in psychopharmacology, even with the best efforts using psychotherapeutic treatments alone. However, it is also important to recognize that all placebo-controlled studies demonstrate that a certain percentage of children respond to the placebo effect of the drug and not to the drug itself.

Emslie et al. (1997) report that symptoms of 56 percent of children and adolescents treated with fluoxetine, and 22 percent of those treated with placebo, for Major Depressive Disorder were rated “much or very much improved.” The collaborative Treatment for Adolescents with Depression (TADS) study found that 61 percent of adolescents diagnosed with MDD responded to fluoxetine, and 35 percent to placebo, after 12 weeks of treatment (March et al. 2006).
In terms of compliance, there are also a significant percentage of children and adolescents that are non-compliant with their psychopharmacological treatment. According to DelBello et al. (2007), a year after initial hospitalization for a manic or mixed episode, 39 percent of adolescents had achieved symptomatic and functional recovery. Interestingly, only 35 percent reported being fully compliant with their medication regimen.

Wilens and Spencer (2000) reported that 25 to 35 percent of patients are not benefited by stimulants because of insufficient symptom relief, side effects, or non-adherence. With respect to recurrences, Birmaher et al. (2006) in a 2-year prospective study of bipolar children and adolescents (mean age 13 years) found that 70 percent recovered from the index episode, but half of them experienced recurrence. These studies show nearly a third of patients will have difficulties in terms of responding to the efficacy of a drug, compliance, or recurrences.

A common occurrence in clinical settings is the off-label, trial and error target-symptom oriented use of psychiatric medications in treating children and adolescents, relying on the competence and judgment of the prescribing clinicians rather than an evidence base of clinical trials. In this way an empirical approach replaces the traditional medical approach of diagnosing before treating as a standard for prescribing (Bloch 1995).

This can also be seen as a result of an unclear diagnosis, leaving the prescriber to target impairing symptoms. At times, when clinicians do not spend enough time to know the person, to make a formulation, and to offer psychotherapeutic interventions for the symptoms, clinicians are prescribing based on increasing demands for services for a troubled child as well as the appropriate therapeutic wish to relieve suffering quickly. However, these widespread empirical practices of prescribing expose children to medical risks. The challenge is to do an adequate trial of psychotherapeutic and psychosocial interventions to clarify which conditions truly require medication.

Finally, psychoeducation given to parents is a valuable piece of the treatment. Parents should be educated regarding the importance of psychotherapy in combination with psychopharmacological management. Parents should know about evidence-based studies, for example, in depression and anxiety disorders in children and adolescents, in terms of medication alone not being as effective as the combination with psychotherapy. Sometimes parents do not take as seriously the use of therapies to treat children and adolescents as medication management. I wonder if what is missing is the opportunity to educate parents with the cutting edge research of today.

Parents should know that therapy is a process and a commitment they have to follow for a better outcome. When psychotherapy is indicated, I discuss with parents that it should be taken analogous to another extracurricular activity besides dance, music, or sports. They pause and then with some surprise they realize that it is an interesting way of thinking about it as it can bring balance to a comprehensive view of physical and mental health in the child’s everyday life.

References


Dr. Hojman is a member of the AACAP Psychotherapy Committee and clinical assistant professor, Department of Psychiatry and Human Behavior Alpert Medical School at Brown University. Dr. Hojman may be reached at hhojman@lifespan.org.
I am writing this article to give thanks to a man whose kindness and generosity has often gone unnoticed. He is not one who seeks recognition for his own accomplishments, but rather is gratified by seeing those he cares about make their way in this world. He is known to child and adolescent psychiatrists both here and abroad; and if you are ever trying to find him at a reception, he will likely be found taking an international guest around so that they can be welcomed into the fold.

It was by chance that I met John Sikorski, M.D. It was the fourth year of medical school and I was lucky to have secured a research fellowship that was taking me to San Francisco for two months. I arrived in California ready for a new adventure. Time in the lab was exciting and the weeks flew by. As the end of my fellowship approached, I realized I was not quite ready to leave the Bay Area and inquired about doing a rotation in the forensic fellowship at University of California San Francisco (UCSF). I had heard it was one of the few places that has a child focus, and I thought it would be a terrific way to combine my then budding research interest in disruptive behaviors with the treatment of children within the judicial system.

Dr. Sikorski was on faculty at UCSF and was involved with the child and adolescent psychiatry part of the forensic program. When I approached him with the idea of doing a rotation, he warmly welcomed me and took me under his wing. He introduced me all around, made himself available to answer my questions and to offer guidance. John was always giving thought to who might be interesting for me to meet and how I could further explore my research interests. He never seemed to tire of my talk about heart rate measurements and how they related to behavior.

As part of my rotation, I was asked to present the research in which I had been involved. Toward the end of my rotation, I presented my work one morning to the forensic fellows and a few faculty members. Later that day, I received a call from Dr. Sikorski asking me if I would be interested in doing grand rounds. I was simultaneously thrilled and scared to death. Grand rounds as a fourth year medical student? He was so supportive that I said yes.

I have often looked back on that moment, and the importance on having someone that not only takes an interest in you but encourages and supports you in a way that you are willing to stretch and grow. Dr. Sikorski’s style of mentorship is never heavy handed and is without any sense that his support serves his personal agenda. Advice is given with a warm chuckle and will often include a story from his past that helps to illustrate his point. He is the wise sage who has seen the world and understands it, and is still bemused by all that transpires around him.

For Dr. Sikorski mentorship does not end with advice and counsel and all things professional. With his big heart and generous nature, he is quick to open his home and to prepare sumptuous dinners of fish that he caught and prepared himself. Dinners are lively affairs that provide sustenance not only for the body, but the heart and soul. And if you mention an interest in sailing and happen to find yourself in the Bay Area, Dr. Sikorski will be signing you up as a deckhand for his next sailing trip. Sailing with him is when you learn the real lessons of life; that an open heart and a generous spirit can create a world where the mind and spirit can grow.

Thank you Dr. Sikorski for all that you have given me and so many others who have had the good fortune to have known you. You have touched the lives of many.

Dr. Pope is a clinical research fellow at the Children’s National Medical Center/ NIMH.
Michael Houston, M.D.
Chair of the Assembly of Regional Organizations

The AACAP’s Assembly of Regional Organizations met for the 37th consecutive year during the AACAP Annual Meeting in Hawai’i last October. Since its inception in 1972, the Assembly has served as the bridge between the AACAP’s 61 Regional Organizations and the AACAP. During the Annual Meeting, Assembly delegates heard from then President Robert Hendren, D.O., Executive Director Virginia Anthony, and AACAP Treasurer William Bernet, M.D., about the latest AACAP initiatives and its finances. Each Regional Organization, through its elected delegates, has the opportunity to speak to the issues that members and their patients are encountering at the local level. During this year’s meeting, perhaps the main focus for discussion was on the current economic downturn and its effect on members and their practices throughout the country. This discussion was organized around a survey initiated by the outgoing chair of the Assembly, Martin Drell, M.D.

Alan Axelson, M.D., a delegate from the Pittsburgh Regional Organization of Child and Adolescent Psychiatry, introduced two topics that sparked a great deal of discussion. The first being the use of electronic medical records within outpatient practices. Having recently taken his practice on-line, he saw a role for the AACAP to help members in the selection and implementation of “psychiatry-friendly” electronic medical records. Dr. Axelson also raised the issue of the disposal of unwanted or expired medication, hoping that the AACAP might be able to join in national efforts to develop a safe and effective means for patients and physicians to dispose of unused medication.

Invited guest and speakers to last fall’s Assembly meeting included Ken Thompson, M.D., the medical director for the Substance Abuse and Mental Health Services Administration (SAMHSA) and Gary Blau, Ph.D., chief of the Child, Adolescent and Family Branch of the Center for Mental Health Services within SAMSHA. Drs. Thompson and Blau congratulated the AACAP on its efforts to improve access to mental health services for children and adolescents and spoke of new initiatives within SAMSHA to improve mental health systems of care. In addition, Saul Levin, M.D., M.P.A, vice president of Science, Medicine, and Public Health for the American Medical Association (AMA), spoke to assembly delegates about the AMA’s position on healthcare reform.

The Assembly consists of elected delegates from the Academy’s Regional Organizations. Determined by the number of local members, Regional Organizations elect from one to seven delegates, who each serve three year terms. An ongoing focus of the Assembly is to strengthen those Regional Organizations in less populated areas of the country or in areas where geographic distance makes it hard for members to meet regularly. The Assembly meets twice each year: once during the AACAP Annual Meeting and again in the spring when the assembly meets in Washington, D.C., at the time of the AACAP’s Annual Advocacy Day.

For more information regarding the Assembly, or if you would like to become more involved in your local regional organization, please contact one of the Assembly officers or the assembly administrator in the National Office, Earl Magee at emagee@aacap.org.

For 2009-2010 the current Assembly Officers are:

Michael Houston, M.D., Chair
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Louis Kraus, M.D., Vice Chair
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Gabrielle Shapiro, M.D., Secretary-Treasurer
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Dr. Houston is chair of the Assembly of Regional Organization of Child and Adolescent Psychiatry. He is associate clinical professor of Psychiatry and Behavioral Sciences and, assistant clinical professor of Pediatrics at George Washington University and in private practice in Chevy Chase, Maryland.
The New York Council on Child and Adolescent Psychiatry (NY Council) has always been dedicated to fostering the careers of trainees with an interest in child and adolescent psychiatry. Each year we try to find new and inventive ways to educate medical students and residents about child and adolescent psychiatry, the NY Council, and the AACAP. The following are ten projects that we have found beneficial for our community:

1) High School Student Presentations. For the past year, our fellows have been involved with the Heath Professions Recruitment and Exposure Program. This is a community service/mentorship program organized for New York City high school students by medical students at Cornell/Weill Medical School. The program gives guidance to students with interests in medical careers and fosters their career goals.

2) Medical School Dinners. Each year we provide opportunities for medical students to have a meal and a lively discussion with a group of child and adolescent psychiatrists and fellows. As you may remember from your own years in medical school, food is always a great way of enticing medical students to do anything. However, the goal really is to provide a chance for soon-to-be doctors to understand more about the great opportunities in our field.

Also, we collect participants’ names and contact information in order to include them in future events through the years. While many of us have spoken at medical schools in the past years, we have been making a concerted effort to reach out to all local medical schools on a yearly basis since 2005 when the AACAP Assembly encouraged all councils to contact the coordinators of Psychiatry Special Interest Groups.

3) Participation in Talks at Medical Schools. Throughout the year, there are several initiatives sponsored by medical schools inviting different organizations to attend an event and to discuss their specialties. These events are often co-sponsored by the medical school’s psychiatric interest group and are somewhat less intimate than events we sponsor. These events expose many medical students to the benefits of our field. We have found that it is extremely helpful to discuss the role of child and adolescent psychiatrists with all students. We also provide information about becoming a member of AACAP and include them on mailings for future events.

4) Movie Nights. Our Board has collaborated with the local branch of the American Psychiatric Association (APA) to co-host movie nights. We show a film and then discuss the psychodynamic and relevant psychiatric aspects of the film with the students. Medical students like to share their perspective on the films and it also allows them the opportunity to get an understanding of how a psychiatrist might interpret a situation. We have also co-sponsored events with student groups at the medical schools in order to help with publicizing the events. The last film we showed was Ma Vie en Rose (My Life in Pink), a Belgian/French film about a boy who believed that he was born the wrong gender. Our discussant, Richard Pleak, M.D., definitely perked the students’ interests.

5) Welcome Night. In the end of July of every year, we host an evening where all the child and adolescent psychiatry fellows are invited to meet together along with child and adolescent psychiatrists. This is an
opportunity for the fellow not only to get to know people from their own program but all of the programs in the district. It is also a great opportunity for the NY Council Board members to introduce ourselves and explain our purpose and our upcoming events. The evening of casual conversation allows the fellows to become more interested in the NY Council and provides an opportunity for fellows to talk with members about how they can become involved.

6) Career Night. In the late winter or early spring of each year, we host a dinner (food again, of course) where four child and adolescent psychiatrists each give a talk about their experiences in the field. This was created to help child and adolescent psychiatry fellows who are graduating hear from others before committing to a job in July. Generally, we try to choose psychiatrists who each have a distinct career path. Following the talks, we have a casual Question and Answer period. Recently, this event has attracted first and second year fellows, as well as adult psychiatry residents and medical students.

7) Raffles. Yes, food, movies, and now money! At events throughout the year, we sponsor a raffle that provides two trainees with a free membership to AACAP for that year. At the beginning of the event, we take all the names of the residents. Then, at the end of the event, we blindly choose two names. We then sponsor the winner’s membership to AACAP for one year. This provides some lucky child and adolescent psychiatry residents, who might not join AACAP, a chance to see what the benefits are for one year, and hopefully, continue with his or her membership.

8) Travel Grants. For the past two years, we have offered a travel award to exceptional child and adolescent psychiatry fellows to attend the AACAP Annual Meeting. The award winners receive a stipend which helps defray costs. Each trainee is paired with a child and adolescent psychiatrist so that they can meet throughout the convention. Also, we have each trainee write an article about their experience for our regional organization’s newsletter. This year we also asked applicants to suggest ways to get trainees more involved in the NY Council and, thus, we have the opportunity to benefit from their creative ideas. Not only does this grant provide certain trainees a memorable experience, it also encourages other trainees to consider attending the convention in the future and even applying for the grant the next year.

9) Inclusion in the Council itself. Probably the most important aspect of recruitment is by including these junior members in the NY Council Board. Generally, we have one medical student, two psychiatry residents, and two to four child and adolescent psychiatry residents on the council. There are so many advantages to having the NY Council set up this way. For one, we generally have a great representation from the many residencies and medical schools in the New York area. This diversity allows for more of a spectrum of participants in the above listed events.

10) The Training Committee of the NY Council. The trainee members of the NY Council have an opportunity to participate in planning events. Generally, the trainee members are responsible for coordinating events, helping with publicity, and emceeing events. This not only gives the trainee an important and visible role in the NY Council, it hopefully, prepares them for other positions, such as a future President of the Council.

We hope these ideas can be helpful to each of the districts of AACAP. Everyone knows the importance of recruiting young members into becoming active, more senior members and hopefully these ideas could be implemented in your area. Please feel free to contact us if you are interested in hearing more details about any of our programs. Additionally, if your regional organization has had different types of successful initiatives to involve trainees, we’d be excited to hear about them.

Dr. Galanter is an assistant professor at Columbia University and the Chair of the New York Council’s Training Committee. She may be reached at cg168@columbia.edu.

Dr. Palyo is a second year child and adolescent psychiatry fellow at Saint Vincent’s Hospital and a Fellow Representative to the Board of the New York Council for Child and Adolescent Psychiatry, New York’s Regional Organization. He may be reached at smpalyo@yahoo.com.
COMMITTEE ON SCHOOLS

LESSONS LEARNED:
Look before you leap

Setting up a collaborative school-based mental health program, however, is not as elementary as it seems, not by a long shot. As it turns out, it can be quite daunting and riddled with a gauntlet of unexpected and seemingly overwhelming challenges akin to reaching shore while caught in a heavy undertow.

LESSON #1
TRANSITION PLANNING: Remember to cross your t’s and dot your i’s.

The challenge of taking a collaborative school-based mental health program from its conceptual framework to its actuality requires careful planning and organization and dictates that representatives from both the school and from NYU/Bellevue meet weekly at least two or three months prior to the start of the school year to insure that clear cut procedures are in place which outline the referral process, team member responsibilities, lines of communication, confidentiality of information and records, and training of child and adolescent psychiatry residents from NYU/Bellevue completing their school rotation. Working pro-actively and intensely on these issues greatly contributes to collaborative team cohesiveness and ultimately a greater assurance of the program’s success.

LESSON #2
ETIQUETTE: Mind your p’s and q’s.

From its inception, a commitment to working collaboratively through mutual trust and respect is a crucial ingredient to the smooth operation of a school-based mental health program. Visibility, accessibility, mindfulness, and frequent communication as co-equal team members, strengthen its capacity to fulfill its primary mission of helping students reach their full potential. Visibility assures that team members are reliable and accountable. Accessibility fosters an environment of openness and provides teachers with a supportive avenue to identify at risk pupils and learn how to help them. Frequent communication, awareness, and sensitivity to the school’s cultural and ethnic climate promote acceptance, trust, and cooperation.

LESSON #3
REFERRALS: You can’t judge a book by its cover.

Attendance at weekly meetings chaired by the principal along with the assistant principal, school counselor, school psychologist, school social worker, supervising psychiatrist, and resident from NYU/Bellevue is an important venue to identify students with behavioral, developmental or emotional problems that interfere with their ability to learn and refer them for a psychiatric evaluation at the school. This meeting serves as a viable forum to review and discuss teacher requests for evaluation of students at risk for failure, encourage fresh problem-solving, and determine which students would benefit from having a psychiatric assessment. Once

John McCarthy, M.D.
Steven R. Abramowitz, Ph.D.

Following the attacks on the World Trade Center on September 11, 2001, the New York University Child Study Center established a grant-supported, school-based mental health program at several selected public schools near “ground zero” to provide services to its traumatized students. This grant-funded program expired at the close of the 2007-2008 school year. Around this time, school officials from a Manhattan public school petitioned the New York University Child Study Center and Bellevue Hospital’s Child and Adolescent Mental Hygiene Clinic (NYU/Bellevue) to join hands in creating a collaborative school-based mental health program for the 2008-2009 school year. The goal of the program would be to evaluate students whose escalating behavioral, developmental, and emotional problems were adversely affecting their academic achievement, and if indicated, refer them for treatment at Bellevue.
parents consent to having their child undergo a psychiatric evaluation at the school, the psychiatrist and resident conduct a comprehensive evaluation over the course of one to three visits. This includes a classroom observation, talking with teachers and other school personnel familiar with the student, interview of the parents and student, meeting with the parents to share the results, giving treatment recommendations, and writing a report.

LESSON #4
CONFIDENTIALITY: Do not go where angels fear to tread.

Few things are more sacred than the physician-patient relationship even within a collaborative school-based mental health program. In fact, the Health Insurance Portability and Accountability Act (HIPAA) enacted by the U.S. Congress in 1996 underscores the importance of this relationship. This act specifically constrains physicians, including psychiatrists, from disclosing confidential information to anyone without the patient's written permission, regardless of where it was obtained. Adhering to the HIPAA guidelines needs emphasis and clarification as early as the transition planning phase of the collaborative school-based mental health program and must continue throughout the school year.

When the mental health team completes its psychiatric evaluation and writes its report, it is natural for certain school personnel, especially the student's teacher, to inquire about the diagnosis and treatment plan recommendations enabling them to better understand how to best help their student. Given the HIPAA restrictions, the psychiatrist, resident and parents can decide collectively what confidential information, if any, can be shared with selected school personnel on a need-to-know basis. Nevertheless, it must be clear to all concerned at the school that the student's psychiatric evaluation report is privileged and confidential information and must be stored in a safe area with limited access.

LESSON #5
RESIDENTS AND SCHOOL ROTATION: Tempis Fugit (time is of the essence).

During the second year of their child and adolescent psychiatry residency training program, residents spend half of one morning, once a week, over an eight-week period completing their school rotation as a member of the collaborative school-based mental health program. It includes onsite direct supervision by an NYU/Bellevue faculty board certified child and adolescent psychiatrist. Providing each resident with an orientation to the program at the beginning of their rotation greatly facilitates their acculturation and gets them off to a good start thereby enhancing their clinical learning experience. Vacations are a "no no." During this brief rotation, residents need to be punctual, efficient, accessible, observant, visible, responsive, collaborative, and know how to conduct a comprehensive psychiatric evaluation of a student at school. When a student is recommended for treatment at Bellevue Hospital, the resident will be responsible for maintaining the continuity of care for that student and his family even after they complete their school rotation and until they finish their residency.

LESSON #6
CONTINUITY: It's not over until it's over.

Yogi Berra’s apt quote applies to continuity of care within the collaborative school-based mental health program. This means that a student initially evaluated at the school and in need of treatment, will continue to see the resident who evaluated him or her during the school rotation at Bellevue’s Child and Adolescent Mental Hygiene Clinic. It also means that the resident and school will have direct access to each other to coordinate treatment. For example, if a student is taking a medication for ADHD, the resident will need to be in contact with his teacher to determine its effectiveness. In turn, the teacher may want to talk with the resident about more effective techniques of managing disruptive behaviors that continue to interfere with learning in the classroom. For both the resident and teacher, this becomes an important collaboration that is mutually beneficial. The supervising psychiatrist at the school keeps track of all students being treated at Bellevue Hospital and insures that there is a continuity of care. When the resident completes the two year residency, the supervising psychiatrist makes sure that the clinic assigns an appropriate resident to take over the student's care and that the lines of communication remain open between both the school and Bellevue Hospital.

CONCLUSION
Following the tragic events of September 11, 2001, a fund-granted, school-based mental health program opened in several public schools near the former World Trade Center site to bring deeply needed services to children traumatized by the attack. Now, nearly a decade later, it appears that schools throughout America are recognizing that having a school-based mental health program is no longer a luxury but a necessity. Child psychiatrists and psychologists are increasingly learning that the best way to help many of the children referred to them is to be where the action is—in the schools. Those who wish to establish and work in such a program in the future will do well to heed the lessons we have learned over the past eighteen months.

Dr. Abramowitz has worked with the New York City Department of Education since 1984 and is a certified school psychologist. He obtained a Ph.D. in Clinical Psychology from Calamus International University in 2009. Dr. Abramowitz is a member of the American Psychological Association, has published three articles on traumatic brain injury, and is fluent in several languages including Spanish and Russian.

Dr. McCarthy has been a clinical associate professor of child and adolescent psychiatry at the New York University School of Medicine since 2002. He obtained his M.D. from the State University of New York, Upstate Medical University in 1969, and is board certified in pediatrics, psychiatry, and child and adolescent psychiatry.
When a parent first receives the diagnosis of autism for their child, they often feel overwhelmed and uncertain for their child’s future. They grieve the loss of the normal developmental pathway that they had envisioned for their son or daughter and face the difficult task of adapting to their child’s specialized needs. Often there are many unanticipated challenges in their quest to find optimal treatment and educational placement. One of the most difficult obstacles that parents encounter involves dealing with the legal aspects of a child with disability. As the child ages, parents often express increasing anxiety about transitioning their child into adulthood with minimal disruption.

As a clinician, it is essential to be knowledgeable about the laws that protect children with disabilities, including children with autism, ADHD, and intellectual disabilities, as well as those with physical handicaps. Psychiatrists commonly have to assist parents who are struggling to find appropriate care at school and at home for their child with autism. Frequently, you may be their primary resource for finding information about and accessing programs and benefits in the community. Our goal here is to review laws pertaining to educational and legal rights, focusing on definitions, reasons why the laws may be relevant for the child, and provide some examples of applications.

Historically, there are three major laws that pertain to children with autism:

- **Section 504 of the Rehabilitation Act of 1973**, which details the legal rights of disabled individuals to access programs and benefits from federally funded organizations or employers.

The **Rehabilitation Act of 1973** is the oldest law protecting the rights of qualified individuals from discrimination based on their disability. The most important portion of the Rehabilitation Act is Section 504, which details the nondiscrimination requirements of the law to employers and organizations that receive Federal financial assistance, including funding from the Department of Health and Human Services (DHHS 2006). Included organizations are hospitals, nursing homes, mental health centers, and human service programs. Section 504 forbids these organizations and employers from denying disabled individuals equal opportunity to participate in, and have access to, program benefits and services. In childhood, Section 504 specifies the rights of the autistic adult when trying to seek gainful employment. The applicant must be able to demonstrate the ability to perform the essential functions of the job with “reasonable accommodations,” which is defined as steps that accommodate the disability without causing undue hardship for the employer. The federal government employer can be found guilty of discrimination for refusing to hire the disabled applicant, if the applicant is able to perform the job after the accommodations are in place.
In addition, Section 504 includes an anti-retaliation clause that protects the child and the family. In 2007, in the case of Draper v. Atlanta Independent School System, a District Court ruled that Jarron Draper and his family were entitled to payment from Atlanta Public School District for prospective educational services to be provided at a private school after the school district failed to provide an appropriate education (Wright November 2009). Jarron had been initially misdiagnosed as mentally retarded in the fourth grade. Following that, the school refused to move him out of the “mildly intellectually delayed” class at the request of his parents, failed to re-evaluate him after five years, and placed him into regular classes in 10th grade, after being diagnosed with dyslexia without further accommodations. By the time the parents sought legal recourse, Draper was 18 years old and in the eleventh grade, but could only read at the third grade level. In addition, his family reported that the school district intimidated them throughout those school years when they made attempts to challenge the district’s decisions. In March 2008, this ruling was unanimously upheld by the Court of Appeals. The court relied on the Supreme Court decisions in School Commission of Burlington vs. Department of Education (1996), which held that school districts are required to reimburse parents for the cost of private placements in nonpublic schools when the public school failed to provide an appropriate education.

The Family Educational Rights and Privacy Act, enacted in 1974, implemented regulations over federally funded educational programs requiring them to provide to students access to school records, opportunities for amending those records, and student consent for release or disclosure of records (FERPA 2009). During the school years, this law can be invoked by the family of the child with autism to view the school records, dispute any discrepancies on the record, and to restrict access for other parties on behalf of the student. The school employees are forbidden by law to divulge any information to anyone other than the student about their grade or behavior at school unless expressly given permission by the family or student (FERPA 2009). This could also apply to keeping the school from posting the list of student grades on a bulletin board, which can be very helpful in supporting the child’s self-esteem and help minimize teasing or bullying by other students based on academic performance.

In February 2002, the Supreme Court reversed a decision made by the Court of Appeals previously in Falvo v. Owasso Independent School District (Wright June 2009). In this case, the mother of the four Falvo children argued that the school district was violating FERPA by allowing peer grading, then requiring each student announce their grade out loud in class. Although the Supreme Court held that peer grading was not in violation of FERPA, they did acknowledge that the situation would be different if the mother had argued the grades were recorded into the teacher’s grade book, and then announced. In that case, there is potential violation of FERPA. The law is also very helpful for families of children with autism spectrum disorders in that they can dispute any school records they feel are inaccurate or misleading. This allows for the family to request review of the records, amend the record as needed, and to be able to maintain as accurate a record as possible. An accurate school record may allow the family to assist the child with autism in obtaining further education or work. In addition, FERPA was amended in 1997, and now can be used by parents to view the actual testing protocols and answer sheets used by the school district (FERPA 2009). Upon entering adulthood, this law also allows the student to view any recommendations that were submitted by others while applying for entrance to an educational institution, such as graduate school.

The Individuals with Disabilities Education Act came out of a federal case law that held deprivation of free public education for children with disabilities in violation of due process. Many states, at the time, actually had laws against allowing children with certain disabilities, including mental retardation and emotional disturbance, to attend public schools. Many of these children were being housed in state institutions, and only one in five children with disabilities was being educated in the public school system. The EAHCA (Education for All Handicapped Children Act) or EHA, was introduced in 1975 to allow for nationalized regulation of free public education for children with handicaps. There were several Supreme Court cases that clarified and further defined the rights of children with handicaps in the ensuing fifteen years, including:

- Board of Education of Hendrick Henson School District v. Rowley (1982): Defined “free appropriate public education” clearly. Amy Rowley, a young deaf girl, was denied the use of a qualified sign-language interpreter in class with her by the school district based on the assertion that she did not require the service to perform in school. Although the Supreme Court reversed the ruling of the lower courts in favor of the Rowley family, this case much more clearly defined the concept of “free appropriate public education.” (Wright June 2009).

- Burlington Sch. Committee v. Mass. Bd. Of ed. (1985): Clarified procedural safeguards, parental role in decision-making process, and tuition reimbursement for placement under EHA. Michael Panico, a child that was diagnosed with emotional disturbance and severe learning disability, was placed by his father into a private school for children with disabilities after the town was unable to assist Michael in his schooling in a public setting. The town refused to help reimburse Michael’s father for the private tuition during one of the years he was in school (refusal was based on district’s belief that the IEP provided that year was sufficient; father disagreed). The Supreme Court ruled

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that under the EHA, the town was obligated to provide reimbursement (Wright June 2009).

• Honig v. Doe (1988): Clarified procedural issues involving protection of handicapped children from school officials and parental role models, including protection from expulsion of emotionally disturbed children from school. John Doe, age 17, and Jack Smith, age 12, were both suspended, then expelled from their respective schools for their behavior. Doe was expelled after choking another student after getting angry. Previously, psychological reports noted deterioration of social skills and severe anger outbursts over minor issues. Smith was diagnosed as emotionally disturbed by age 8, and was expelled after making repeated sexually inappropriate comments towards female peers. In both cases, the Supreme Court ruled strongly in favor of the handicapped children, stating they could not be expelled for behavior related to their disabilities (Wright June 2009).

The EHA was renamed as the Individuals with Disabilities Education Act, or IDEA, in 1990. Soon after IDEA came into existence, a landmark Supreme Court case occurred involving ninth grader Shannon Carter, a learning disabled child attending public school in Florence County School District (Wright June 2009). In Florence County School District Four v. Shannon Carter, her father challenged the IEP she had during her ninth grade year, stating it was inadequate, but the school district denied him a review. In the meantime, Shannon was placed in Trident Academy, which specialized in schooling children with disabilities. After her graduation, her parents filed suit against the school district, requesting reimbursement because Free Appropriate Public Education (FAPE) was not provided. In 1993, the Supreme Court ruled unanimously that reimbursement was appropriate. This case has since been used to provide reimbursement for children with autism when attending private schools that provided Applied Behavioral Analysis (ABA/Lovaas) therapy (Wright June 2009). In addition, several amendments were added in the next two decades, with the most recent amendments occurring in 2004.

IDEA is the primary law that is invoked when parents are trying to access services for their children with autism. The law covers qualified individuals from age 3 to 21 years for educational needs (FAPE 2009). IDEA has multiple components, including the establishment of an IEP, or individualized education program, FAPE, or free appropriate public education, and a LRE, or least restrictive environment. IDEA also covers early intervention from birth until 3 years old, and identification of children with disabilities by the school districts, whether they are attending public schools or privately educated (Sherman 2009). There are also procedural safeguards that are in place to protect the rights of the parents, which includes viewing of school records, as previously specified by FERPA (FAPE 2009).

As we enter this new decade, new legislation protecting and providing for families with children with autism is being presented to Congress. Most recently, Autism Speaks, the largest national autism science and advocacy program assisted in the development and inclusion of a provision for autism insurance reform in the Senate health reform bill. This provision would prohibit discrimination by insurance companies against people with autism by providing behavioral health treatments as part of essential benefits packages. The original act was called the Autism Treatment Acceleration Act of 2009, which included 12 sections that each detailed different programs for treatment of autism. Section 12 included the program on autism insurance reform, which was later added to the Senate health reform bill that was passed in mid-December (Autism Votes 12-31, 2009). In addition, they encourage individual state legislatures to do the same.

In June 2009, a class action suit was brought against a private insurance company in Michigan for services that were unpaid for treatments for their clients with autism (PR Newswire 2009). In Johns vs. Blue Cross Blue Shield Michigan, the family sued the insurance company for refusal to acknowledge that applied behavioral analysis, or ABA, was a scientifically accepted method of therapy for children with autism. It was discovered through the course of the case that the company’s own 2005 medical policy included information on ABA, stating that it was the “most thoroughly researched treatment modality for early intervention approaches to autism spectrum disorders…” As a result, the insurance company agreed to reimburse over 100 families of children with autism. This case, along with many others, are attempts by families to encourage the state legislatures to also pass laws requiring insurance companies to cover the expense of autism treatments and assessments.

In addition to pushing for coverage by insurance companies for children with autism, there has also been legislation in the pipeline for protection of the children and their rights. Autism Speaks just announced their endorsement of the Preventing Harmful Restraint and Seclusion in Schools Act (H.R. 4247), which would set federal standards for schools in dealing with restraint and seclusion, as misuse of both methods for agitation has been documented in hundreds of cases (Autism Votes 12-9, 2009). Many times, the children were inadvertently abused secondary to improper method of restraint, liberal use of seclusion, and utilizing these methods as part of the students’ educational plans.

The Achieving a Better Life Experience (ABLE) Accounts Act of 2009, another endorsed piece of legislation recently introduced, would authorize “ABLE
accounts,” to encourage families of children with disabilities to save for disability-associated expenses. These accounts would be similar to the 529 college savings plans already in place for parents. If passed, the money placed in these accounts would be federal tax deductible. Most recently, in the last month, Autism Speaks applauded the Senate for including portions of the Cure Accelerations Network Act (Autism Votes 12-25, 2009), or CAN Act, that creates a large fund for “bench to bedside” research, which accelerates translation of medical research into practical applications for patient care.

These and future legislation will continue to provide better quality of life and access to services for children with autism and their families. As a mental health provider, keeping up with the most recent legal information, both federally and statewide, can be invaluable. In addition, it would be extremely helpful to alert the parents to consider planning ahead for the child’s future as they transition to adulthood. The laws mentioned, Section 504 of the Rehabilitation Act, FERPA, IDEA, and the new provisions in the healthcare reform bill all help to provide services for the child. IDEA, especially, can be utilized to help make transition planning for the adult child before they complete their education. The IEP involves a team of professionals that can assist the families in looking for suitable placements for the maturing child with autism, job hunting, skills training, and continued accommodations for learning. Unfortunately, once the child turns 21, IDEA is no longer in effect and cannot be accessed to help the parents with the transition into adulthood, so early planning for gaining access to programs for adults with autism is essential. Helping the families navigate through the legal wording and the process of accessing appropriate educational programs will facilitate optimal development and habilitation for the child with autism. We hope that you will be able to actually copy and provide copies of this article to the families of the children that you are treating so that they will be able to begin the process of finding appropriate services for their child.

References

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# The University of Utah

## Department of Pediatrics

The Department of Child and Adolescent Psychiatry at Primary Children’s Medical Center (PCMC) and the Division of Behavioral Health in the Department of Pediatrics at the University of Utah (U of U) is seeking a Child and Adolescent Psychiatrist to join our clinical team. The successful candidate will receive a joint faculty appointment in the Departments of Pediatrics and Psychiatry. The psychiatrist will participate in clinical care as an attending physician on the Psychiatric Inpatient Unit and in the General Outpatient Clinic, will educate and supervise trainees, and have an opportunity to pursue academic initiatives. Candidates must be BC/BE in Adult and Child and Adolescent Psychiatry, with excellent clinical skills. The U of U offers an excellent benefits package that includes 20.2% retirement contributions that vest immediately, and excellent health care choices.

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Interested individuals should send a cover letter and curriculum vitae to: D. Richard Martini, M.D., Director - Child and Adolescent Psychiatry
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**Academic Child and Adolescent Psychiatrist**

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The ‘Black Box Warning’ and the 2003 Media Frenzy: How Many Needless Deaths?

Introduction
I have been working on this essay for three years. Both an esteemed colleague and my wife said it sounded angry – the anger not necessarily without foundation. The fact is that I am angry. The unintended consequences of decisions made outside the clinical and scientific arena affect our patients, affect real people, affect real people who then choose not to become patients, and finally affect statistics. Statistics are not people. Statistics are interesting in an intellectual sense. Statistics do not lie in a morgue. People who die of suicide, young people, young people who have parents, grandparents, siblings, and friends, lie in morgues. My anger is with the whole process that led up to the black box warning, the warning itself, and the downstream effects.

The interaction of many factors, including the famous meta-analysis (Rosack 2004a), live television coverage of government hearings, age-old news sensationalism, political considerations, regulatory deliberations, even the influence of a ‘religion,’ as well as professional and public inertia, and a total lack of common sense, led to the FDA decision (Rosack 2004b). The decision had to, and was perhaps intended to, result in a decrease in the number of youths receiving a proven component of the treatment of severe depression, a disorder that sometimes leads to suicide – the very event supposedly the focus of all the attention.

No other effect of the black box was possible – none. That this regulatory decision resulted from a false conversation in both the public and regulatory arenas is proven by the lack of attention in all of the above-mentioned forums to the actual deaths that have subsequently occurred (Bridge et al. 2007). There were no deaths in any of the 23 studies in the meta-analysis. But there have been deaths since, more youth suicides each year compared to 2003, and more than the number predicted based on a steady nine-year decline that began in 1995, for each of the three ensuing years for which there is data. A larger and bolder black box is needed that warns of non-clinical, non-scientific, interference in the practice of medicine.

It is clear that complex factors are at play in each individual suicide and the more complex issue of preventing suicide. How did an agent that helps prevent suicide, and is a component of the usual treatment of severe depression, become the villain? How did people who were prescribed this agent and who subsequently committed suicide become victims, not of depression, but victims of antidepressant medication?

In the current iteration of news sensationalism, it became more important to protect people with depression from an important component of its treatment than it was to present the news. I was taught that the word news (n-e-w-s) meant the whole story: North, East, West, and South. A major public health problem was thus turned upside down in favor of the more sensational interest in an occasional, not well understood, perhaps even false, aspect of the treatment of this complex problem.

Brief History
For a time during 2003, there was news coverage of a potential connection between antidepressant medication in children and adolescents and a theoretical increase in the risk of suicide (Harris 2003). Government hearings were broadcast in a manner similar to a daytime soap opera implying a direct connection between taking antidepressant medication and the terrible event of a child’s life ending by suicide. I remember channel surfing back then, and there being little to distinguish the soap opera from the government hearing – except perhaps that the hearings were more emotional.

<table>
<thead>
<tr>
<th>Year</th>
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<tr>
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<td>11.14</td>
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<tr>
<td>1991</td>
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<tr>
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<td>1,621</td>
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<tr>
<td>2001</td>
<td>1,611</td>
<td>7.94</td>
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<tr>
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<tr>
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<td>1,613</td>
<td>7.68</td>
</tr>
<tr>
<td>2006</td>
<td>1,555</td>
<td>7.31</td>
</tr>
</tbody>
</table>
This led to an impression, at least as I still observe among many parents of depressed children and adolescents, that somehow antidepressant medication might be more dangerous for youth than severe depression. It also led to the black box warning for antidepressant medication by the FDA despite zero suicide deaths in any of the studies being analyzed with respect to this issue. The meta-analysis of 23 clinical trials that led to this warning appeared to demonstrate a very slight increase in thoughts of suicide, or at least verbalized thoughts – perhaps a very important distinction – among this age group. A 16-year-old told me a few months ago that he had thoughts of suicide for three years that he first divulged two weeks after I started an SSRI. There also appeared to be an increase in “suicide behavior,” a term defined somewhat creatively in the meta-analysis (Hammad 2004).

We now know that death by suicide among people age 19 and under suddenly rose 18 percent from 2003 to 2004, paralleling a just as sudden 20 percent drop in antidepressant prescribing over the same period for this age group (Rosack 2007). This followed a steady decline in youth suicide over the preceding nine years when the use of antidepressant medication in the treatment of depression in youth became widely accepted and programs to achieve early detection implemented. The actual number of deaths nationally for children and adolescents increased from 1,737 in 2003 to 1,985 in 2004 – an additional 248 deaths.

Most of the literature on youth suicide with reference to the black box issue has focused on data from the CDC (WISQARS™ online data) for the 0-19 age group. One exception is the recent analysis of the 10-19 subgroup by Bridge and colleagues (2009). In fact, both approaches dilute the effect of the black box. The vast majority of youth who die of suicide are 15-19 years old. For the 2006 data, for instance, 88 percent of the completed suicides in the 0-19 group were in the 15-19 age group. For this subgroup, the Table on page 88 shows both the number of completed suicides and the rate per 100,000 for the years 1990-2006.

The Figure above shows two things: 1) the suicide rate for 15-19 year olds per 100,000 for the years 1990-2006; and 2) the most conservative extrapolation of the nine-year decline (1995-2003) to 2006. The actual rates for 2004, 2005, and 2006 were 8.22, 7.68, and 7.31 suicides per 100,000 respectively. The nine-year decline in suicide rate in the 15-19 group was exactly 33.3 percent. Why wasn’t this in the news? This is front page, “above-the-fold,” headline material.

The extrapolated rate, if the decline had continued on the same slope for three more years, would have been 6.87, 6.45, and 6.07 per 100,000 respectively, equating to 1,421, 1,354, and 1,291 suicides compared to the 1,700, 1,613, and 1,555 that did occur. The actual number of deaths for the three years was 4,868. The total predicted by a continuing decline is 4,066 – a difference of 802 over the three years.

**Discussion**

In the end, there are many factors that lead to or fail to prevent each suicide. The one clear difference between 2003 and subsequent years is the black box warning – following sensationalized news coverage. An unknown number of youths, over and above the number predicted from previous experience, have died and are dying each year in the United States due to the inadequate diagnosis and treatment of severe depression. How many lives are forever changed with each of those deaths? If the 802 additional deaths predicted continued on page 90
from the above extrapolation for the 15-19 age group seems high, is 600 closer? Or is it 400? Suppose it’s “only” 200. Is that okay? For parents and families, the death of a child is never a statistic.

The 20 percent decrease in prescribing antidepressants to patients age 19 years and under in 2004 resulted from families choosing not to seek treatment, now leery of the medication component of such treatment; and a decrease in the willingness of primary care physicians and some psychiatrists to prescribe these medications. I had a conversation this week (2nd week of 2009) with an excellent, hard-working, pediatrician who has never believed that antidepressants were more of a risk than depression, but who would not prescribe to a 13-year-old due to the risk of the black box. At a minimum, good care for severe depression in the 19 and under age group includes psychotherapy for the child or adolescent, counseling with his or her family, and antidepressant or other appropriate medication – depending on the formulation and the actual diagnoses (Sibley and Kramer 2004).

The number of suicides over predicted per year seems to be slowly decreasing. We have no way of knowing if the decline in suicide deaths that ended in 2002-03 would have continued at the same pace, slowed, or leveled off if the black box frenzy had not occurred. Nothing predicts that deaths would have increased. And there is zero evidence that the black box prevented suicides – which was its intent. Is it not the responsibility of those responsible for the black box to show that the estimate of 802 additional deaths is inaccurate?

Clinical experience suggests that physicians, parents, and patients are gradually reverting to common sense and good clinical care in spite of the black box and the accompanying sensationalism and emotion. We may know in ten years. One way to be sure, in lieu of waiting to see – while studiously counting deaths each year as we did during Vietnam – would be for the FDA and the media to loudly declare the unintended consequences of its decision and the associated proceedings and, with fanfare and publicity, recall the black box warning. Product safety should apply to the FDA as well.

**Conclusion**

In my opinion, the antidepressant crisis in 2003 was media-generated, with multiple additional contributing factors resulting in political pressure on the FDA to take action – action that had the entirely predictable effect of restricting from children and adolescents this important component of life-saving psychiatric treatment. Reporting research data, the meaning of which requires careful deliberate evaluation, without the whole story, in the context of a media-generated crisis, to attract more viewers or readers, without concern for the potential negative consequences of such journalism, is irresponsible. The only behavior less responsible is allowing such information to result in regulatory change. Incomplete truth and false conversations are the real villains. Is the news business dangerous to the health of our children? A paucity of thoughtful discussion certainly is. ■

**References**


**Dr. Kramer is in the Division of Child and Adolescent Psychiatry at the University of Wisconsin School of Medicine and Public Health. He is co-chair of the AACAP Family Committee and Columns Section Editor of the AACAP News. He may be reached at dakrame1@wisc.edu.**
William Bernet, M.D.

While evaluating or treating a child of divorced parents, have you ever noticed the phenomenon of parental alienation? Almost certainly you have, even if you did not know the name of what you observed.

Every child and adolescent psychiatrist should know about and thoroughly understand the mental condition of parental alienation. There will be occasions for almost every child and adolescent psychiatrist when the psychodynamics of a difficult, complex case will become clear once the data are organized within the context of parental alienation. This concept is so important that a large group of mental health and legal professionals have submitted formal proposals that parental alienation be included in the next editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) and the International Classification of Diseases (ICD-11) (Bernet et al., 2010; Bernet, in press).

During the last year and a half, I have repeatedly heard the following reflexive reactions to our proposal that parental alienation be included in DSM-V:

- “Parental alienation is controversial, so we should not include it in the DSM.”
- “Parental alienation is a serious problem, but it shouldn’t be a diagnosis.”
- “There is not enough research for parental alienation to be considered a mental disorder.”
- “If parental alienation is put in the DSM, it will be misused in court by abusive fathers to take custody away from protective mothers.”
- “Why are you going to all this trouble?”

Let’s take a look at each of these objections, since there is a great deal of misinformation and misunderstanding regarding this topic.

Is parental alienation a controversial concept?

Our definition of parental alienation is: a mental condition in which a child – usually one whose parents are engaged in a high-conflict divorce – allies himself or herself strongly with one parent (the preferred parent) and rejects a relationship with the other parent (the alienated parent) without legitimate justification. There is nothing controversial about this definition. Almost everyone who evaluates, treats, or conducts research on children of divorced parents agrees that parental alienation – as the phrase is defined in our proposal – really exists and is a serious problem.

Sometimes our use of “parental alienation” is confused with “parental alienation syndrome” (PAS), which has been a controversial concept ever since Richard Gardner, M.D., described it in 1985. Gardner’s definition of PAS has been criticized because it included the notion of blame, that is, an alienating parent caused the child to have parental alienation. Many writers now believe that parental alienation – as we define it – can be brought about through several different mental mechanisms. As you can see, our definition does not even include the words, “alienating parent,” but refers to “the preferred parent.”

Should parental alienation be a diagnosis?

Parental alienation should be a diagnosable mental condition for the following reasons. 1) The behavioral manifestation of parental alienation is the child’s adamantly refusal to visit or have contact with the alienated parent. This refusal is similar to but typically much stronger than the negativistic behavior seen in children with oppositional defiant disorder. 2) The mental component of parental alienation is the child’s firmly held false belief that the rejected parent is dangerous and evil. In severe cases, there is a folie à deux or shared psychotic disorder involving the child and the preferred parent. 3) Parental alienation may be conceptualized as a disorder of attachment, in that there sometimes is a dysfunctional, enmeshed relationship between the child and the preferred parent. In some cases, the child’s symptoms resemble those seen in separation anxiety disorder. 4) Parental alienation causes considerable morbidity. In severe cases, the child entirely loses his or her relationship with a loving parent – for years or perhaps a lifetime. How many other mental disorders cause that degree of impairment?

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Is there enough research for parental alienation to be considered a mental disorder?
During the last year, my colleagues and I have widely distributed our proposal that parental alienation be included in DSM-V, which has been discussed in numerous meetings with mental health and legal professionals. Upon hearing the proposal, some people said there was not enough research regarding validity, reliability, and prevalence to support this novel concept as a diagnosis. In response, our group of contributing authors has developed a comprehensive bibliography regarding parental alienation from all over the world—more than 500 articles, book chapters, and books from 31 countries. I am referring to articles written by mental health and legal professionals and published in professional journals, not the thousands of newspaper, magazine, and Internet articles regarding parental alienation and PAS intended for the general public.

The critics of parental alienation as a diagnosis probably do not know about Irena Namyslowska, M.D., Ph.D., perhaps the leading child and adolescent psychiatrist in Poland, who published an article in Psychiatry Polska regarding PAS. The critics have never heard of Professor Guglielmo Gulotta, a professor of forensic psychology in Italy, who published a book on a method for identifying alienating behavior by means of psycholinguistic analysis. They have never read anything by Ludwig F. Lowenstein, Ph.D., a prolific writer in England who recently published Parental Alienation Syndrome: How to Understand and Address Parental Alienation Resulting from Acrimonious Divorce or Separation.

In the end, the developers of DSM-V may decide there is not enough systematic research for parental alienation to be in the front part of the book as a full-fledged mental disorder. However, there is certainly enough research for parental alienation to be included in the appendix of DSM-V called “Criteria Sets and Axes for Further Study.” Also, there is certainly enough research for parental alienation to be considered one of the relational problems, which are currently V-codes in the chapter called “Other Conditions That May Be a Focus of Clinical Attention.”

Will the diagnosis of parental alienation be misused in court by abusive fathers?
Mental health and legal professionals who are concerned about domestic violence have frequently expressed their concern that abusive fathers and unscrupulous attorneys misuse the concepts of parental alienation and PAS in legal settings. They explain that a mother, who has been the victim of domestic violence, would want to protect her children from the abusive father. The mother and the children would agree, of course, that the father is dangerous and the children might refuse to have any contact with him. However, when the children refuse to visit the father, he might accuse the mother of brainwashing the children and causing parental alienation.

I agree that in high-conflict divorces involving custody and visitation disputes, there are frequent allegations of domestic violence (some of which are false) and allegations of parental alienation (some of which are false). Judges hear these allegations every day and they must sort out the true from the false allegations, using whatever methods they have at their disposal. Although I realize that allegations of parental alienation are frequently made in court, I believe it is very unusual for a judge to mistakenly and wrongly grant child custody to an abusive parent based on false allegations of parental alienation.

Furthermore, it is clear that the diagnosis of parental alienation does not apply if the rejected parent abused or neglected the children. That is, if a child refuses to visit a parent who was abusive, that is normal behavior, not a mental disorder. If a child refuses to visit a loving parent because of a false belief that the parent is evil, that is probably a mental disorder.

Why are we going to all this trouble to add one more mental disorder to DSM?
In severe cases of parental alienation, the child can irrationally fear the parent, hate the parent, and wish the alienated parent were dead. It is heartbreaking to watch a child or adolescent—who previously had an affectionate and mutually satisfying relationship with both parents—totally and adamantly reject any contact with one of the parents. These children need to be identified and treated. Although there has been considerable research on families affected by parental alienation, there needs to be much more. In order to conduct systematic research, we must first adopt diagnostic terminology, uniform criteria, and consistent descriptors.

For me, it is exciting that a new mental condition has been discovered, defined, and researched, and now is being considered for inclusion in DSM-V and ICD-11. Our proposal for DSM-V and ICD-11 was written by 60 contributing authors from all over the world, representing 11 countries. If you want more information about our proposal, contact william.bernet@vanderbilt.edu.

References

Dr. Bernet is a professor in the Department of Psychiatry, Vanderbilt University School of Medicine, Nashville, Tennessee. He is the treasurer of the AACAP.

Dr. Bernet has encouraged members to respond to his editorial on a controversial topic. AACAP News welcomes member input and would like to publish commentary on his editorial. If you would like to respond please send a letter to the editor of 300 words or less directly to the Editor at kimwj@upmc.edu or through the National Office at pjutz@aacap.org.
The Ongoing Story of Project Future

Richard L. Cohen, M.D., Norbert B. Enzer, M.D., and Virginia Q. Anthony

During the late 1970s, as the AACAP reached its 25th year, George Tarjan, M.D., who was then president of AACAP and Robert Stubblefield, M.D., president-elect, conceived of a venture that would take stock of the field of child and adolescent psychiatry and develop a plan for the coming decades. Appropriately, it was called “Project Future.” Irving Philips, M.D., was named chair, and two of us (Drs. Cohen and Enzer) were appointed as co-chairs. In addition to scores of members who did yeomen’s work on the various task forces, Dr. Stubblefield, E. James Anthony, M.D., Helen Beiser, M.D., Frank Rafferty, M.D., Carolyn Robinowitz, M.D., and Larry Silver, M.D., served on the Steering Committee. The project was considered important enough for the AACAP executive director, Virginia Anthony, to staff it herself, with the support of the entire administrative staff of the AACAP.

There is not space here to describe the efforts of a large portion of the membership to meet the charge outlined by Dr. Tarjan. Suffice to say that over three years were spent in collecting information, analyzing it, and outlining future directions. These are described in some detail in the final report of the project (AACAP 1983). A decade later, Dr. Cohen devoted his entire presidential address to a progress report on our mutual efforts to reach the goals highlighted in that report (Cohen 1992).

Now, almost 30 years later, current AACAP president, Larry Greenhill, M.D., has charged current AACAP members to undertake Project AACAP, an ambitious undertaking that will move the AACAP into the 21st century.

This is a good time also to remind ourselves of the goals proposed by Project Future and to make some observations about what lies ahead.

The goals of Project Future are paraphrases below:

I. With respect to the psychiatric needs of children and adolescents, it was recommended that child and adolescent psychiatrists:
   a. Devote more of their skills and knowledge to children and adolescents who are chronically or severely ill, maladapted, and disabled.
   b. Maintain medical responsibility for their patients.
   c. Provide support to other physicians and other care providers.
   d. Develop strategies for delivering primary and secondary care.
   e. Take an active role at all levels of government regarding policy decisions and funding levels effecting services and programs.

II. With respect to the training and educational needs of the field, it was recommended that:
   a. Training priorities be altered to place more emphasis on the needs of the severely maladapted and/or disabled and their families.
   b. Post-residency training programs be developed in specialized areas.
   c. An adequate complement of faculty be required in all approved training programs.
   d. All child psychiatry training programs be closely affiliated with a general psychiatry program; and a full partnership be maintained between them.

III. With respect to research, it was recommended that:
   a. Child and adolescent psychiatry expand its enterprise with particular emphasis on nosology, epidemiology, outcome studies, and developmental psychopathology.
   b. Collaborative research relationships and projects be established.
   c. Research concepts and methods be taught in all training programs.
   d. Post-residency research programs be established.
   e. Child psychiatry research centers be established, encouraging a larger share of public and private resources be invested in child psychiatric research.
   f. Clinical units collaborate on the utilization of a uniform clinical information system.

IV. With respect to increasing the number of trained child and adolescent psychiatrists, it was recommended that:
   a. The entire profession vigorously pursue the recruitment of new trainees.
   b. The profession cooperate with other professions to enhance the delivery and quality of services.

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Considering our resources at the time (including the size of our manpower pool) and the obstacles facing the field, these seem like heroic goals. But subsequent developments have validated the wisdom of our members. Now, a generation later, we are well on the way to achieving many of these aims. Equally, they all appear to us to be appropriate to the field.

As Dr. Cohen observed almost twenty years ago:

“...But the Academy will be here forever and, with additional midcourse corrections, we can continue to work together into the 21st century.

“I am not speaking figuratively when I urge that we think that far into the future...we are all paddling furiously in this sea of change. We are understandably preoccupied about not being swamped by the next regulatory or fiscal or trendy marketing wave.

“But this is all the more reason why we must constantly focus on the long range goals that may yield the strongest chance of stabilizing our situation. We cannot permit ourselves to be overwhelmed by change.

“...Our professional lives would be simpler if we did not have to cope with all of these challenges at once. But I believe that approach is not an option. These goals we have agreed upon cannot be pursued in linear order. They are, in fact, circular. They feed into and on each other.

“We cannot expect that our struggles with managed care organizations and third party reimbursers will abate until we can demonstrate through controlled studies that our diagnostic and treatment modalities are efficient and effective. Our manpower problems will not be handled until much larger numbers of bright young people come into the field. This is not likely to happen until the image of child and adolescent psychiatry as an important field of clinical science is attained. That won’t happen until there is a logarithmic growth of our research enterprise which is at least partially dependent on the recruitment of large numbers of top quality trainees who are waiting in the wings to be satisfied that our residences are based on the latest scientific data available....”
(Cohen 1992)

References


Dr. Cohen is past president of the AACAP and is the Professor Emeritus of Child Psychiatry, University of Pittsburgh School of Medicine.

Dr. Enzer is Professor Emeritus of Psychiatry at Michigan State University and has been a Life Member since 1970.

Ms. Anthony is the executive director of the AACAP.

Missed an AACAP Meeting? Interested in AACAP’s Educational Resources?

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Questions? Call 202.966.7300, ext. 155
NEWS UPDATES by Stuart Goldman, M.D.

In each issue of AACAP News, I include brief commentary and a link to newsworthy items that the membership might have missed or that merit repeating. If you have suggestions for this column, please send them to me at stuart.goldman@childrens.harvard.edu.

ADHD and Environmental Exposures
The etiology of ADHD is complex with many contributing factors. It clearly has both inherited and environmental components. In December’s Pediatrics, Froehlich et al. shed more light on this subject. In their study of almost 2600 youths, they looked at the relationship of rates of ADHD, prenatal exposure to cigarette smoking, and lead levels. They found that the overall rate of ADHD was 8.7%. For children with prenatal tobacco exposure the adjusted odds ratio was 2.4. For children in the highest lead exposure it was 2.3. Additionally there was a marked synergy between joint smoke and lead exposure with an adjusted odds ratio of 8.1. While earlier studies have demonstrated the association between smoking, lead, and ADHD, this study had several noteworthy additions. They used contemporary ADHD criteria, it was a very large national sample, and the lead levels were both lower and current rather than higher and peak-early childhood, as often has been the case. (It has been suggested that lead induced problems are more clearly a function of current rather than peak levels.) A recent survey revealed that 15% of all mothers smoked during pregnancy. Additionally, many of our patients are inhabitants of older dwellings (particularly in older urban pre-1977 built properties when lead paint was finally banned). The combination of the two puts their off-spring at very high risk. This is a major opportunity to counsel parents in a primary prevention.


Cannabis and Pregnancy
Continuing in the preventative mode, Marroun et al. in December’s JAACAP, looked at the effects of prenatal maternal cannabis use on fetal growth. In their study of almost 7,500 mothers they found that prenatal cannabis negatively impacted both fetal growth and head circumference, both of which are “known risk factors for neurodevelopmental and behavioral problems.” These findings were true independent of tobacco usage, another known risk factor. Additionally, they found that the impact increased with increased maternal usage. The authors speculate that the increased THC content of today’s cultivated marijuana may be making for greater exposure. Usage before pregnancy and paternal use appeared to have no impact. However, both early use and on going use did. This presents clinicians with another prevention opportunity. Woman who may or plan to become pregnant have yet another very good reason to stop.


Sleep, Depression, and Suicidal Ideation
The complex bi-directional relationship between sleep and health has become an increasingly interesting target for researchers. In January’s Sleep, Gangwisch et al. looked at sleep data culled from a national survey of over 15,000, 7th to 12th grade adolescents. They compared parental set bedtimes as a marker for adolescent sleep duration. They divided the families into those with parental set bedtimes 12 midnight or later and those that set 10 p.m. or earlier. They found that about 70% of the teens complied with the parental bedtimes and an additional 2/3 of the non-compliers reported being asleep within one hour. While acknowledging the limitations of this approach, they found that higher rates of depression (24%) and suicidal ideation (20%) in the shorter sleep group when compared to the longer sleep group. However, they did find that if they factored in the teens’ subjective sense of “getting enough sleep,” that while differences remained (about 10%) they no longer were statistically significant. They hypothesized that the negative impact of short sleep might be due to “inappropriate modulation of the emotional brain responses to aversive stimuli” that may occur during sleep or that fatigue might compromise coping skills or their judgment. While further study is needed, their findings suggest that clinicians should both take a more detailed sleep history (to identify patterns) and that this, coupled with the value of sleep on learning and academic performance, should lead to clear and strong advise for parents and patients on the value of getting enough sleep.


PANDAS Update
Since Swedo and Leonard’s first description of PANDAS, over a decade ago, controversy has swirled around the diagnosis. While the relationship of complex neuropsychiatric syndromes (Sydenham’s chorea, etc.) and streptococcal infection is clear, the same can not be said about streptococcal infections, obsessive compulsive disorder, Tourette’s Syndrome

continued on page 96
and tics. Schrag et al. studied the association of strep infection and the three disorders using the British data base, the Health Improvement Network, they identified 255 cases of OCD, TS, or tics. These cases were identified by scanning primary care records in 2-25 year olds for these specific diagnostic codes and then including all cases with a documented symptom onset. They then matched them to over 4,000 controls. Cases were scored positive when there was a documented strep infection within two years of the initial OCD, TS, or tic diagnosis. They found that “There was no overall increased risk of prior possible streptococcal infection in patients with a diagnosis of OCD, TS, or tics. Subgroup analysis showed that patients with OCD had a slightly higher risk than controls of having had possible streptococcal infections without prescription of antibiotics in the 2 years prior to the onset of OCD.” They concluded that there was no evidence of any type of strong association between strep infection and OCD, TS, or tics. However, they left the door slightly ajar on the question of whether there may be either a small sub-population who may be at risk or that there may be a very minor general association. In an accompanying editorial, Gilbert and Kurlan conclude, based upon this study and a literature review, that “current evidence indicates that for the ordinary TS/OCD phenotype of waxing and waning symptoms, GABHS infection does not seem to be an important etiologic factor and therefore not an appropriate target for assessment or therapy. Perhaps for other clinical presentations, the link to GABHS infection is more relevant.” For clinicians the evidence is increasingly clear; prophylactic antibiotics and blood monitoring should become a thing of the past.


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**Call for Exhibitors!**

Besides exhibiting at the Annual Meeting, you can also exhibit at each of our annual institutes. We offer tabletop exhibits to allow exhibitors the chance to connect with specific demographics within the child and adolescent psychiatry community. Approximately six tabletop exhibits are available at each of our annual institutes and are placed in high-traffic areas, providing exhibitors with the greatest opportunity to meet attendees. The vast majority of our attendees are practicing physicians. Exhibit opportunities are below:

**Lifelong Learning Institute**

Maintenance of Certification Module 6: Autism, Psychotic Disorders (Non-Affective), and Updates on Relevant Topics for Child and Adolescent Psychiatrists

Co-Chairs: Sandra B. Sexson, M.D., and Andrew T. Russell, M.D.

March 26-27, 2010

Seattle, Washington

Expected Attendance: 100

**35th Annual Review Course in Child and Adolescent Psychiatry and Training Session for the Oral Exams**

Co-Chairs: Melissa P. DelBello, M.D., M.S., and Robert A. Kowatch, M.D., Ph.D.

April 21-24, 2010

Cincinnati, Ohio

Expected Attendance: 200

The Exhibitor Prospectus for our 57th Annual Meeting, October 26-31, 2010, at the Hilton New York in New York City will be mailed in April.

For more information, please visit www.aacap.org/cs/root/meetings/exhibit.opportunities, or contact:

Lindsay Schlauch, AACAP Meetings Manager

Phone: 202.966.7300, ext. 104 • Fax: 202.966.5894 • E-mail: exhibits@aacap.org
According to the 56th Annual Meeting evaluations, the highest rated sessions in each presentation category were:

**Clinical Case Conference 9:** Sexual Solicitation of Minors on the Internet: Clinical and Legal Challenges in the Case of a 16-Year Old Runaway • Chair: Brett Schneider, M.D.

**Clinical Consultation Breakfast 1:** Master Clinician Gabrielle A. Carlson, M.D.

**Clinical Perspectives 16:** Sex and Gender Issues in Youth from the Atlantic to the Pacific • Chair: Richard R. Pleak, M.D.

**Honors Presentations 1:** Community-Based Participatory Research in Native American Communities • Chair: John T. Walkup, M.D.

**Institute 7:** Practical Pediatric Psychopharmacology for the Primary Care Clinician • Chair: Adelaide Robb, M.D.

**Media Theatre 9:** Whale Rider: The Odyssey of a Changing Traditional Childhood • Chair: Michael Storck, M.D.

**Special Interest Study Group 8:** Problem-Based Learning in Child and Adolescent Psychiatry • Chair: Norbert Skokauskas, M.D., Ph.D.

**Symposium 46:** Empirically Supported Psychotherapies for Preschoolers • Chair: Mini Tandon, D.O.

**Workshop 16:** Asperger’s Disorder: Diagnosis, Behavioral Interventions, and Social Skills Training • Chair: Martin Lubetsky, M.D.

Please note these rankings are determined by average overall ratings on session evaluations. The response rate and enrollment numbers did not influence ranking.

Congratulations to all the presenters!

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**Highest Rated Scientific Sessions at the 56th Annual Meeting**

**October 27-November 1, 2009  Honolulu, Hawai’i**

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**Special congratulations to the Most Highly Requested Speakers at the 56th Annual Meeting!**

Attendees at the 56th Annual Meeting in Honolulu last October completed evaluation forms that provided an opportunity to list speakers they would most like to hear present at future meetings.

The top 11 requested speakers included (listed alphabetically):

- Joseph Biederman, M.D.
- Gabrielle Carlson, M.D.
- Kiki D. Chang, M.D.
- Peter S. Jensen, M.D.
- John March, M.D., M.P.H.
- Mani N. Pavuluri, M.D., Ph.D.
- Sir Michael Rutter, M.D.
- Lenore Terr, M.D.
- Karen Dineen Wagner, M.D., Ph.D.
- John Walkup, M. D.
- Timothy Wilens, M.D.

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Thank you to all of the 56th Annual Meeting speakers for your contribution to the AACAP!
Hanna Smith
Development Manager

Since the first award 15 years ago, the Elaine Schlosser Lewis (ESL) Fund has granted more than $220,000 to 30 recipients, funded groundbreaking research on children and adolescents with attention deficit disorders, and launched the careers of much-needed researchers in ADHD.

More than 30 donors and guests gathered at the Tenth Annual Elaine Schlosser Lewis Award Luncheon in New York City on December 7, 2009, to learn about exciting advances in the field and the latest research in ADHD that they helped fund. These generous donors also contributed more than $50,000 in 2009 to continue expanding the research that leads to new treatments and help for families.

Three recent recipients of the Elaine Schlosser Lewis Pilot Research Award for Attention-Deficit/Hyperactivity Disorders who presented their research at the luncheon were:

- **Gholson J. Lyon, M.D., Ph.D.**, recipient in 2007 for *Improving Tic-Related Response Inhibition: The Effects of Dexamethasone in Children and Adolescents with ADHD and Chronic Tic Disorders*;
- **Yuhuan Xie, M.D.**, recipient in 2007 for *The Effectiveness of Videoconferencing on Teaching Parent Training Skills to Parents of Children with ADHD*;
- **Leslie Hulvershorn, M.D.**, recipient in 2009 for *An Examination of Corticolimbic Functional Connectivity in Children with ADHD with and without Severe Mood Dysregulation*.

Dr. Lyon’s research findings dispel the myth that stimulants, specifically, dexamethylphenidate, exacerbate tics. His findings are important for the treatment of children and adolescents with chronic tic disorders, many of whom are not prescribed stimulants due to the incorrect and largely held perception that they increased tics.

The Tourette Syndrome Association has awarded Dr. Gholson a $150,000 grant to continue the research he began with the initial support from the ESL fund.

Dr. Xie’s presentation explored the contributions of technology for ADHD research. She presented her findings on the potential for using videoconferencing as a means of training parents to effectively deal with their children with ADHD, as well as the importance of support services for those families.

Dr. Xie found that parent training through videoconferencing is as effective as face-to-face sessions in improving parent-child relationship and social skills in children with ADHD as rated by parents.

Dr. Hulvershorn’s research focused on the correlation between mood dysregulation and temper outbursts of children with ADHD. She will continue her
research in 2010 with additional funding from the Se evac Family Foundation and the National Alliance for Research on Schizophrenia and Depression (NARSAD).

The reports on ADHD advances continued with the keynote address from James McGough, M.D., a 2009 ESL Award recipient for his JAACAP article titled, Child Behavior Checklist (CBCL) Pediatric Bipolar Disorder Profile and ADHD: Comorbidity and Quantitative Trait Loci Analysis. Dr. McGough explained that his research suggests that certain genomes may distinguish a subset of ADHD patients with significant comorbidity and predisposition to severe psychopathology.

Jeffrey Newcorn, M.D., a former ESL awardee, and Harold Koplewicz, M.D., founder of the NYU Child Study Center, also spoke of recent developments in ADHD research. Dr. Newcorn focused on the neurodevelopmental course of ADHD research, while Dr. Koplewicz provided insight to the personal challenges faced by those with ADHD.

The luncheon concluded in a discussion panel that explored “ADHD Then and Now: 15 Years of ADHD Research.” Audience members had the opportunity to ask questions and learn directly from the ADHD experts; Drs. McGough, Newcorn, and Koplewicz. The questions: “Is ADHD a gift?” and “How do we define success?” resonated deeply with guests and initiated a lively discussion overcoming the negative stigma often associated with attention disorders.

The ESL Fund honors Elaine Schlosser Lewis, a special education teacher, child advocate, and mother of Owen Lewis, M.D. Since 1994, Dr. Lewis has been the driving force behind the ESL Fund’s success and growth. For more information on ways to support the ESL Fund, please contact Hanna Smith, AACAP Development Manager at hsmith@aacap.org or 202.966.7300, ext. 130.

UPCOMING EVENTS AND DEADLINES

**March 26-27, 2010**
AACAP Lifelong Learning Institute
Module 6: Autism, Psychotic Disorders (Non-Affective), and Updates on Relevant Topics in CAP
Seattle, Washington
www.aacap.org

**April 7-10, 2010**
31st Annual Meeting of the Society of Behavioral Medicine
Seattle, Washington
www.sbm.org/meetings/2010

**April 21-24, 2010**
35th AACAP Annual Review Course
Cincinnati, Ohio
www.aacap.org
meetings@aacap.org

**May 4-7, 2010**
Association of Psychology & Psychiatry for Adults & Children (A.P.P.A.C.)
15th International Conference
Athens, Greece

**May 6-8, 2010**
AACAP Advocacy Day
(contact k.davis@aacap.org)

Assembly of Regional Organizations
(contact l.goggins@aacap.org)
Washington, D.C.

**May 12-15, 2010**
12th Biennial Conference of the European Association for Research on Adolescence
Vilnius, Lithuania
www.eara2010.eu

**May 20-22, 2010**
9th Annual International Meeting for Autism Research 2010 (IMFAR)
Philadelphia, Pennsylvania
www.autism-insar.org

**May 22-26, 2010**
American Psychiatric Association 2010 Annual Meeting
New Orleans, Louisiana
www.psych.org

**May 26-29, 2010**
3rd International Congress on ADHD 2010
Berlin, Germany
www.adhd-congress.org

**May 29-30, 2010**
Korean Academy of Child and Adolescent Psychiatry Annual Meeting
Seoul, Korea
www.kacap.or.kr or mompeian@yahoo.co.kr

**June 2-6, 2010**
The International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP)
The 19th World Congress
Beijing, China
www.iacapap2010.org

**June 6-10, 2010**
International College of Neuropsychopharmacology (CINP)
Hong Kong, China
www.cinp.org

**October 26-31, 2010**
AACAP 57th Annual Meeting
New York, New York
www.aacap.org
meetings@aacap.org

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The AACAP would like to thank the following members for their tenure and celebrate their elevation to Life Member:

Richard Barrett, M.D., Houston, Texas
Shashi Bhatia, M.D., Omaha, Nebraska
Elly Bhuyan, M.D., Saint Louis, Missouri
Anthony A. Bottone, M.D., Seattle, Washington
John B. Burns, M.D., Boise, Idaho
William J. Chambers, M.D., New York, New York
Colette Chiland, M.D., Paris, France
James C. Cooper, M.D., Boise, Idaho
Mohsen Emami, M.D., Pittsford, New York
Leon Fajerman, M.D., Chula Vista, New York
Harvey H. Falit, M.D., Ann Arbor, Michigan
Ralph Gemelli, M.D., Washington, DC
Larry Goodlund, M.D., La Crosse, Wisconsin
James C. Harris, M.D., Baltimore, Maryland
Theodore Hoffman, Jr., M.D., Davis, California
Patrick Holden, M.D., San Antonio, Texas
Michael A. Kalm, M.D., Salt Lake City, Utah
Joan Evelyn Kinlan, M.D., Washington, DC
Jerome H Liebowitz, M.D., Scarsdale, New York
Rita Lum, M.D., Meridian, Mississippi
Robert MacDonald, M.D., Denver, Colorado
James C. MacIntyre, II, M.D., Charlotte, North Carolina
Marvin Mathews, M.D., Kailua, Hawai‘i
Beverly Myers, M.D., Warwick, Rhode Island
Karim Olson, M.D., Traverse City, Michigan
L. Marlene Payne, M.D., McLean, Virginia
Solomon Perlo, M.D., Los Angeles, California
Richard Pesikoff, M.D., Houston, Texas
Alvin F. Poussaint, M.D., Boston, Massachusetts
George Realmuto, M.D., Minneapolis, Minnesota
Baird S. Ritter, M.D., Ardmore, Pennsylvania
Gary B. Rosenberg, M.D., Summit, New Jersey
Boris Rubinstein, M.D., Hastings On Hudson, New York
James A. Ruggles, M.D., Stockton, California
Laurence R. Saben, M.D., El Cajon, California
Nora Smith, M.D., Brooklyn, New York
Jorge Srabstein, M.D., Potomac, Maryland
Jaime Suarez, M.D., Bradenton, Maryland
Jay Tarnow, M.D., Houston, Texas
Howard Toff, M.D., Tucson, Arizona
Joan Trachtenberg, M.D., New York, New York
Robert L. Tyson, M.D., Seattle, Washington
Henry Katsuo Watanabe, M.D., Reno, Washington
Harvey Weintraub, M.D., Harveys Lake, Pennsylvania
Donald Wilkerson, M.D., Salt Lake City, Utah

In Memoriam
David Templeton Armitage, M.D., J.D.
Silver Spring, Maryland
Donna B. Burke, M.D.
Elm Grove, Wisconsin
Herbert Cline, M.D.
Chestnut Hill, Massachusetts

Congratulations to our new AACAP Fellows:
Muhammad W. Azeem, M.D.
Rocky Hill, Connecticut
Laurence Eric Dopkin, M.D.
New York, New York
Edgardo J. Menvielle, M.D.
Washington, DC
Steven Shulruff, M.D.
Johnson City, Tennessee
Poonam Soni, M.D.
Salt Lake City, Utah
L. Read Sulik, M.D., F.A.A.P.
Saint Paul, Minnesota

2010-2011 Membership Directory
Every two years the AACAP prints and distributes a Membership Directory to all members. The directory is a great resource to connect with colleagues, rediscover AACAP products and services, become familiar with your AACAP leadership and regional organizations, and use as a source for referrals.

Prepare for the 2010-2011 AACAP Membership Directory:
- Make sure you renew for 2010.
- Update your information on www.aacap.org.
- Watch your mail for the Membership Directory Update form.

Renew Your AACAP Membership and Stay in the Know with AACAP News
Maintain all of your AACAP member benefits by paying your 2010 dues. The AACAP News that you are reading right now is an example of one of your many member benefits.

Time is running out to renew for 2010! You can pay your dues in three easy ways: online at www.aacap.org, by fax, or by mail.

Contact AACAP Member Services if you have any questions on your benefits or your dues renewal notice. Renew your membership and keep your AACAP News coming!
Visit the Members-Only Section of the AACAP Web site
Did you know that the Members-Only section of the AACAP provides invaluable information regarding member issues and gives you access to the tools to manage your account?

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- Purchase publications
- View reports from Council, the Executive Committee and the President
- View the Staff Directory and so much more!

How Can I Reach the Member Services Department?
If you have questions pertaining to your membership, member benefits, or to update your contact information, please contact the Member Services Department:

Rob Grant
Director of Communications & Member Services
800.333.7636 x 119
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You may also e-mail us at membership@aacap.org or dues@aacap.org.

Pay Your Dues Online
If you have not yet paid your 2010 AACAP membership dues, save time by renewing online at the AACAP.org Web site in three easy steps!

1) Log in to the AACAP Web site.
2) Click on the Pay Dues Online under Online Services at the bottom of the Home page.
3) Submit your payment information.

Have you forgotten your login information? You can retrieve your username and password by clicking on “Login” at the top of the Home page and selecting the “Forgot your username or password?” link. From there, you will enter either your username or e-mail address to have your login information sent to you.

AACAP Launches New Online Community for Life Members

Life Members of AACAP now have a new vehicle for communicating with each other and voicing their opinions on professional issues and AACAP projects. The “Life Members Online Community” is the multi-faceted communications network launched in January solely for Life Members. The online system allows Life Members to:

- Initiate or join online discussions
- Respond to surveys or questions from the Life Member Subcommittee or AACAP to participate in decision making
- Share information such as journal articles, reports, papers, photos or graphic images
- Receive notices of upcoming events, or check permanently posted calendars;
- Find contact information for Life Members
- And much more.

“This Online Community will be a terrific means of enabling Life Members to communicate on professional and social levels, as well as to take part in the planning of Life Member projects,” said John Schowalter, M.D., Life Member Subcommittee chair. “This is another example of Life Members continuing to lead our profession; this time with cutting edge technology.”

The network is available only to AACAP Life Members, those who are at least 65 years old and have been an AACAP member for at least 30 years. To participate in the Online Community, Life Members must log in to the section of the dedicated section of the AACAP web site using their AACAP password. If you are a Life Member and have questions about the Online Community, please e-mail a message to development@aacap.org.

Once you log in, you’ll find reasons to return regularly and make your voice heard.
As AACAP President, I invite you to become active in one of AACAP’s many components. It is our dedicated member volunteers serving on committees, work groups and task forces that enable AACAP to accomplish our goals. If you are interested in becoming a member of a component, contact the chair listed below to learn more about current projects, or contact the AACAP National Office to receive a copy of the component’s charge and most recent annual report.

To be considered for appointment to an AACAP component, please send an e-mail of interest along with your CV to lgreenhill@AACAP.org or by mail to the national office at 3615 Wisconsin Ave., NW, Washington, DC 20016, attn: Liz Goggin. If you have questions regarding this process, please contact Liz Goggin at lgoggin@aacap.org.

A few items to remember:

- To be considered for appointment to a committee, you must be a member of AACAP.
- Send a copy of your e-mail of interest to the appropriate chair(s).
- Component meetings are open to all members and you are welcome to attend at any time.

I will be making appointments in the summer based on available openings.

LIST OF COMPONENTS, CHAIRS AND E-MAIL ADDRESSES

**Adolescent Psychiatry Committee**
Lois Flaherty, M.D.
LFlaher770@aol.com

**Adoption and Foster Care Committee**
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geofou@sbcglobal.net

**Arts Committee**
Stuart Copans, M.D.
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Charles Joy, M.D.
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**Autism and Intellectual Disability Committee**
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**Building Committee**
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**Child Maltreatment and Violence Abuse and Neglect Committee**
Judith Ann Cohen, M.D.
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**Committee on Collaboration with Medical Professions**
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**David DeMaso, M.D.**
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**Committee on Medical Students and Residents**
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**Financial Planning Committee**
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An Invitation to Become Active in an AACAP Component from President Laurence L. Greenhill, M.D.
Members & the NEWS

Child and adolescent psychiatrists can extend their reach and educate a wide audience by working with the news media. The AACAP Communications Office connects journalists with AACAP members. If you would like to work with the news media, please contact the Communications Office with your area of interest at communications@aacap.org.

Additionally, if you do work with the media, please share your work for publication in this section of the AACAP News. The following is a snapshot of AACAP members’ recent work with the news media.

- Steven Adelsheim, M.D., contributed to the article “Project Tries to Identify First Signs of Psychosis,” which appeared in Psychiatric News on December 18, 2009.
- L. Eugene Arnold, M.D., contributed to the article “Study may show whether neurofeedback helps people with ADHD and other disorders,” which appeared in the Washington Post on December 15, 2009.
- William Arroyo, M.D., connected with Anna Sussman from Nation Public Radio for an article on access to mental health care for low income youth in California on January 7, 2010.
- Michael Brody, M.D., contributed to the article “Changing roles,” which appeared in The National on December 21, 2009.
- Gabrielle Carlson, M.D., contributed to the article “Poor Children Likelier to Get Antipsychotics,” which appeared in New York Times on December 11, 2009.
- Judith A. Cohen, M.D., and Stephen P. Herman, M.D., were connected with Rick Montgomery from the Kansas City Star for an article on inter-generational sexual abuse on November 16, 2009. Dr. Herman also contributed to the article “Children of Mentally Ill Parents at Increased Mortality Risk,” which appeared in Medscape Today on December 3, 2009.
- David O. Conant-Norville, M.D., contributed to the article “Psychiatrist Continues His 200-Mile Commute,” which appeared in the East Oregonian on December 14, 2009.
- Martin J. Drell, M.D., and Paramjit Joshi, M.D., connected with Julie Dubin from Time.com for an article on telepsychiatry on December 15, 2009.
- Rachel M. Fleissner, M.D., connected with Rebecca Sweat from 2010 Kitten USA for an article on kids and kittens on December 18, 2009.
- Eric Fombonne, M.D., contributed to the article “Autism: Kids put at risk,” which appeared in the Los Angeles Times on December 7, 2009.
- Rama Roa Gogineni, M.D., contributed to the article “Lawsuits filed over drug side effects,” which appeared in the Philadelphia Inquirer on January 8, 2010.
- Nitin Gogtay, M.D., contributed to the article “Science Advances Begin to Reveal Schizophrenia’s Early Brain Changes,” which appeared in Psychiatric News on December 18, 2009.
- Peter S. Jensen, M.D., contributed to the article “More Toddlers, Young Children Given Antipsychotics,” which appeared in HealthDay.com on January 4, 2010.
- Tord S.I. Ivarsson, M.D., contributed to the article CBT Goes Home to Benefit Children With OCD,” which appeared in Psychiatric News on December 18, 2009.
- Glenn J. Kashurba, M.D., contributed to the article “Synergistic Effect of Prenatal Tobacco and Early Lead Exposure on ADHD,” which appeared in Medscape Today on November 26, 2009.
- Joan Luby, M.D., contributed to the article, “Neonatal Scale Predicts Developmental Delays in Early Childhood,” which appeared in Medscape Today on December 17, 2009.
- Judith L. Rapoport, M.D., was featured in the article “Childhood Schizophrenia Q&A,” which appeared on Oprah.com in December 2009.
- Nancy Rappaport, M.D., was featured in the article “Recommended Reading for a Healthy New Year,” which appeared in the Wall Street Journal on December 4, 2009.
The AACAP has well established guidelines for the submission of Policy Statements for consideration and periodically publishes those guidelines for your information. Please keep this information for your future reference.

AACAP POLICY STATEMENT REQUIREMENTS

Policies should:

- Be a statement regarding an important policy issue,
- Be well written, as brief as possible,
- Identify the target audience, and
- Have the potential of having some specific impact.
- Include ideas for distribution.

In formulating the Policy Statement, the author(s) should keep in mind the criteria as stated above. Platitudinous statements supporting “Apple Pie” and “Motherhood” or condemning the multitude of actions, behaviors, social events, or cultural patterns which may have some negative effect on children and families are not likely to serve the AACAP well and may, ultimately, undermine the credibility of AACAP efforts in other areas.

The final draft policy statement should be submitted by an individual author(s) or body (e.g., component or Assembly) to the Policy Statement Advisory Committee via the National Office. In formulating the policy statement, the authors should keep in mind the criteria as stated above. Statement must include ideas for distribution. If the authors wish to have the statement on the next Executive Committee or Council agenda, they must have the draft statement in to the National Office eight weeks in advance.

AACAP POLICY STATEMENT PROCEDURES

- Once a final draft policy statement is submitted to the Policy Statement Advisory Committee (PSAC), the PSAC Chair directs that:
  - the author(s) is told of what major revisions or minor edits are necessary. After the author(s) has revised the statement, they may resubmit to the PSAC;
    OR
  - the author(s) is informed that the statement does not meet the criteria for a policy statement.

- After the PSAC approval, the Executive Committee reviews the statement to decide whether it should be placed on Council agenda or sent to Council via mail ballot.

- Council members can opt to accept the statement as written or place on the Council agenda for deliberation. If even one member requests deliberation, the policy statement is placed on the next Council agenda.

If Council approves the statement, the author(s) is alerted to any minor changes recommended. Statement is printed in AACAP News and distributed to the recommended sources then placed on the AACAP Web site. If Council does not approve the statement, the author(s) may be requested to rewrite and resubmit to the PSAC.

- Every two years, the PSAC reviews all policy statements for necessary revisions or updates. Revisions are made by the original author(s), if available, or by known specialists in that area of expertise. The revising author(s) is given a 3-month period to make changes and resubmit to the PSAC for final approval.

*revised 1/2009

*revised 3/2005
Family and Youth Participation in Clinical Decision-Making

Authored by the Work Group on Community-Based Systems of Care
Approved by Council, October, 2009

Families and youth, as developmentally appropriate, must have a primary decision-making role in their treatment. The Institute of Medicine indicates that health care system redesign needs to involve “care customized according to patient needs and values,” with “the patient (as) the source of control” (1). The promotion of family participation and empowerment is referred to as “family-driven care,” with the family recognized as an equal partner with mental health and other human service professionals. Taking into account the need for active youth participation as well, care should be “family-driven and youth-guided.” The concept of family-driven, youth-guided care is further endorsed in the report of the President’s New Freedom Commission (2). There is evidence that outcomes improve when family and youth participate actively in treatment (3) (4). Family and youth engagement and subsequent commitment to treatment are heightened when they have leadership roles in clinical decision-making.

Families, youth and professionals have different sets of knowledge, experience and beliefs. All parties involved thus bring their unique expertise to the treatment team, without which the clinical decision-making process would be less productive. Family perspective is based on a family’s experience with their child and an understanding of their child and family’s strengths, needs, community, and culture. Youth perspective is based on the youth’s lived experience and priorities. Professional perspective is based on training, cumulative clinical experience, and the ability to listen carefully and respectfully to others. Mutual respect for each perspective promotes decision-making in the best interest of the child.

Family and youth involvement is essential at each phase of the treatment process, including assessment, treatment planning, implementation, monitoring, and outcome evaluation. Family and youth partnership also needs to inform decision making at the policy and systems level. Family priorities and resources must be identified and should drive care. Throughout the treatment process families and youth must:

• have the right to be involved in making decisions regarding providers and others involved in the treatment team;
• be encouraged to express preferences, needs, priorities, and disagreements;
• collaborate actively in treatment plan development and in identifying desired goals and outcomes;
• be given the best knowledge and information to make decisions;
• make joint decisions with their treatment team; and
• participate actively in monitoring treatment outcomes and modifying treatment.

Child psychiatrists should always work towards consensus among all parties in the clinical decision process. However, under extreme situations, legal mandates or safety concerns may need to take precedent.

Working together, family, youth, and professionals can collaborate effectively in support of individualized, strengths-based, culturally competent treatment.

(1) Institute of Medicine (2001): Crossing the Quality Chasm: A New Health System for the 21st Century
Sexual Orientation and Gender Identity Issues Committee Revision of the Gay, Lesbian and Bisexual Parents Policy Statement, Adopted 1999
Approved by Council October 30, 2009

Gay, Lesbian, Bisexual, or Transgender Parents Policy Statement

All decisions relating to custody and parental rights should rest on the interest of the child. There is no evidence to suggest or support that parents who are lesbian, gay, bisexual, or transgender are per se superior or inferior from or deficient in parenting skills, child-centered concerns, and parent-child attachments when compared with heterosexual parents. There is no credible evidence that shows that a parent’s sexual orientation or gender identity will adversely affect the development of the child.

Lesbian, gay, bisexual, or transgender individuals historically have faced more rigorous scrutiny than heterosexual people regarding their rights to be or become parents. The American Academy of Child and Adolescent Psychiatry opposes any discrimination based on sexual orientation or gender identity against individuals in regard to their rights as custodial, foster, or adoptive parents.

Sexual Orientation and Gender Identity Issues Committee revision of the Sexual Orientation and Civil Rights Policy Statement, Adopted 1992
Approved by Council October 30, 2009

Sexual Orientation, Gender Identity, and Civil Rights Policy Statement

The American Academy of Child and Adolescent Psychiatry rejects all public and private discrimination based on sexual orientation or gender identity of persons of any age particularly in the areas of employment, military service, housing, public accommodations, membership, licensing, promotion or assignment, education, training, marriage, adoption, parenting, foster care, or qualification as an expert in a court of law. The AACAP affirms the right of all people to their orientation and identity without interference or coercive interventions attempting to change sexual orientation or gender identity.

Further, the AACAP condemns any restriction on employment or service based on sexual orientation or gender identity in positions involving the delivery of services or treatments to children and adolescents.
Thank You for Supporting the AACAP

The AACAP is committed to the promotion of mentally healthy children, adolescents, and families through research, training, advocacy, prevention, comprehensive diagnosis and treatment, peer support, and collaboration. Thank you to the following donors for their generous financial support of our mission.

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BE/C CHILD AND ADOLESCENT PSYCHIATRIST
Essex/New London, CT

Private non-profit mental health agency serving children, adolescents and families in the beautiful shoreline towns of Southeastern CT seeks a Board Eligible/Certified Child and Adolescent Psychiatrist. This part-time position offers the candidate ample opportunities for private practice since this is a highly underserved area of CT. This area has good schools, plenty of recreational opportunities and is within a couple of hours of New York and Boston.

Submit applications to:
Personnel
Personnel Department Child & Family Agency
255 Hampstead Street
New London, CT 06320
Phone: 860.443.2896
Fax: 860.442.5909
E-mail: personnel@cfapress.org
www.cfapress.org

PSYCHIATRIST
Hartford, CT

Provide direct client services in either an inpatient or partial hospital setting. Services include admission evaluations, psychotherapy and pharmacotherapy.

Nearby: University of Connecticut; Hartford; within driving distance to Boston, Providence and New York City. Close to the mountains and the seashore.

Qualifications: The successful candidate will be a board-certified psychiatrist with experience in child or adolescent inpatient and evaluation services. He/she must have experience with multidisciplinary team treatment work with experience/training in addiction psychiatry, pharmacotherapy and psychotherapy.

Submit applications to:
Deborah Weidner, MD, MBA
P.O. Box 260
Natchaug Hospital
189 Storrs Road
Mansfield Center, CT 06250
Phone: 860.456.1311
Fax: 860.450.0165
E-mail: dweidner@natchaug.org
www.natchaug.org

Kansas

CIVILIAN CHILD/ADOLESCENT PSYCHIATRIST
Manhattan, KS

Work as a civilian Child and Adolescent Psychiatrist at Irwin Army Community Hospital and help serve those who serve our country! Trustaff hires healthcare professionals to work as civilians at military and VA hospitals nationwide. We are currently seeking qualified Child and Adolescent Psychiatrists for immediate full-time opportunities at Irwin Army Community Hospital, which is located at Fort Riley near Kansas State University in the greater Manhattan, KS area. Working as a part of the hospital’s Behavioral Health Team, you will have the rewarding opportunity to care for active duty military and their dependents. As a company we are offering: extremely competitive compensation ($270,000 - $300,000 salary); $25,000 sign-on bonus; $20,000 yearly retention bonuses; relocation assistance; yearly continuing education assistance; stable schedule allowing for great work/life balance (Monday - Friday, 7:30am - 4:30pm, minimal on-call); long term career opportunity (5 years); malpractice 100% covered; any state license is acceptable to work at this facility; rewarding opportunity to work with active duty military and their dependents.

Nearby: Irwin Army Community Hospital is a 250-bed army hospital at Fort Riley. It offers acute care, chronic care, and high quality health maintenance to soldiers, families and retirees of Fort Riley and the surrounding community. The hospital has three primary care clinics for family practice, pediatrics and internal medicine. Additionally, it offers OB/GYN, physical therapy, behavioral health, preventive medicine and pharmacy services. Fort Riley is located 120 miles west of Kansas City between Junction City (town of approximately 17,000) and Manhattan (college town of 45,000 residents). Manhattan is home to Kansas State University, a university of over 23,000 students. Fort Riley is also 60 miles west of Topeka and 115 miles north of Wichita. The local area has two large freshwater lakes for fishing, swimming, boating or camping. There are many other opportunities, Big XII Kansas State Wildcats football; Milford Lake Wetlands; hiking on the Konza Prairies; or golf at a nationally ranked course.

Qualifications: 1.1 EDUCATION: The psychiatrist is required to be a Doctor of Medicine. 1.2 LICENSURE: The psychiatrist is required to hold a valid license to legally practice the specialty of Psychiatry in one of the 50 states in the United States, the District of Columbia, the Commonwealth of Puerto Rico, or a U.S. Territory. 1.3 RESIDENCY: The psychiatrist shall have completed a psychiatric residency and child and adolescent fellowship training approved by the Accreditation Council for Graduate Medical Education. 1.4 EXPERIENCE: The psychiatrist shall have sufficient experience to effectively provide psychiatric medical services for patients and family members as it relates to family therapy. Shall have worked at least one of the past three years with children and adolescents. The psychiatrist shall be competent to treat children and adolescents for crisis intervention and ongoing psychotherapy/medical management. 1.5 CERTIFICATION: The psychiatrist shall have and maintain a current Basic Cardiac Life Support (BCLS) certificate.

Submit applications to:
Christine Fuka
4270 Glendale Milford Road
Cincinnati, OH 45242
Phone: 877.880.0346 ext 1105
Fax: 866.546.3115
E-mail: government@trustaff.com
www.trustaffgovernmenthealthcare.com

Maryland

CLINICAL RESEARCH FELLOWSHIP
Bethesda, MD

The Department of Health and Human Services (DHHS), National Institutes of Health (NIH), National Institute of Mental Health (NIMH) is recruiting child psychiatrists, pediatricians, pediatric neurologists, neuropsychologists, and developmental psychologists for research fellowship positions in the Pediatrics and Developmental Neuroscience Branch (PDN) in Bethesda, MD. This multi-disciplinary clinical research program is focused on understanding the etiology and pathophysiology of autism spectrum disorders (ASD), obsessive-compulsive disorder (OCD), and related conditions. Specific research interests include the regressive subtype of autism, medical comorbidities of ASD, and evaluation of novel therapies for autism, OCD, and other psychiatric disorders. Fellows will have excellent mentoring and comprehensive training in all areas of clinical research, including descriptive studies, clinical trials, and neuroimaging studies. Fellows are encouraged to design their own research investigations, including collaborative studies with scientists inside and outside of NIMH. The research fellowship is 2-5 years in duration, with positions available in Spring/Summer 2010. Applications will be accepted until the positions are filled. Active medical licensure in a United States state or territory is required. DHHS and NIH are Equal Opportunity Employers. For further information, or to make application, please contact Susan Swedo, M.D., Chief, Pediatrics & Developmental Neuroscience Branch, 10 Center Drive-MSC1255, Bethesda, MD; phone 301.496.5323 and e-mail: swedos@mail.nih.gov

Submit applications to:
Patricia Andrews
National Institute of Mental Health Pediatrics and Developmental Neuropsychiatry Branch
Building 10, Room 4N208-MSC 1255
Bethesda MD 20892
Phone: 301.435.6650
Fax: 301.402.8497
E-mail: andrewsp@mail.nih.gov
http://intramural.nimh.nih.gov/pdn/

New York

2 OPENINGS FOR ASSISTANT OR ASSOCIATE PROFESSOR
Buffalo, NY

Our Division of CAP is seeking two psychiatrists at the Assistant or Associate Professor level with demonstrated academic interest and experience. The Division ethos includes comprehensive care and attention to children and their families, and the Division fosters the growth and development of academic faculty.

The first position is for a person interested in pursuing a career on the clinical educator track. This position will involve primary clinical responsibilities in our outpatient resident training clinic. There will be significant time/effort allocated to medical student and resident supervision and...
teaching. Persons with a strong clinical background in psychopharmacology will be highly competitive for this position. Clinical research opportunities are plentiful, including exploration of diagnosis and treatment of children with affective disorders, PDD, and other psychiatric illnesses.

The second position is on the research scholar track. This is an academic position with protected time for research and teaching activities within the Division. Clinical duties will vary according to the candidate’s interests and research objectives. Candidates must have significant experience in clinical research, ideally with formal research training and/or a track record of extramural funding. We are particularly interested in clinical scientists with established research programs in neuroscience, clinical trials research, psychoneuroimmunology, clinical/genetic epidemiology, PTSD/mood disorders, or other relevant domains of translational research.

The University at Buffalo Department of Psychiatry has a strong standing in the medical school and a prominent teaching program for medical students. The residency programs in general psychiatry and child/adolescent psychiatry are nationally recognized. The Division Chief and Department Chair are committed to expanding research productivity and scholarship among the faculty. The Division of Child and Adolescent Psychiatry, the Department of Psychiatry and the School of Medicine have outstanding resources. The School of Medicine and Biomedical Sciences has a newly developed Clinical and Translational Research Center (CTRC). There is an organized consortium of affiliated hospitals and community mental health centers offering a wide range of clinical settings. Department faculty treat patients in many of these settings, which provide a rich and diverse source of potential participants for research programs. In addition, the Department maintains relationships with a number of other research and health centers that provide opportunities for collaborative research, including the Buffalo Center of Excellence in Bioinformatics, the Roswell Park Cancer Institute, the Research Institute on Addictions, the VA Western New York Healthcare System, and the Women and Children’s Hospital of Buffalo.

Qualifications: The successful candidate must be eligible for NY State medical licensure, board eligible (preference board certified) in child and adolescent psychiatry and have a proven record of academic achievement. Salary and benefits are competitive and commensurate with qualifications. The University at Buffalo is an Equal Opportunity/Affirmative Action Employer, M/F/D/V.

Submit applications to:
Bruce D. Miller, M.D.
Women & Children’s Hospital of Buffalo
219 Bryant Street
Buffalo, NY 14222
Phone: 716.878.7645
Fax: 716.888.3935
E-mail: brumill@buffalo.edu

West Virginia
CHILD AND ADOLESCENT PSYCHIATRIST
Mid-Ohio Valley/Parkersburg, WV
Westbrook Health Services, a Comprehensive Community based, not for profit behavioral health center located in the Mid-Ohio Valley is recruiting a Child and Adolescent Psychiatrist (J-1 slot available).

Metro area of 150,000. A great place to raise a family. Good schools, including colleges and universities. Very low crime rate. Practice where you are wanted and appreciated. For details, call or send your CV to:
Dr. Amelia McPeak, Medical Director
Westbrook Health Services
2121 Seventh Street
Parkersburg, WV 26101
Phone: 304.485.1721 ext 273
Fax: 304.422.0908
E-mail: amcpeak@westbrookhealth.com

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Register by March 30, at www.aacap.org to get Early Bird Rates! Plus, SAVE $25 by registering online!

For more information about this meeting, visit www.aacap.org or contact AACAP at meetings@aacap.org or 202.966.7300, ext. 2006.
Save the Dates

AACAP 57th Annual Meeting
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New Research Poster submission deadline:
June 15, 2010