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2012
PSYCHOPHARMACOLOGY UPDATE INSTITUTE
Child and Adolescent Psychopharmacology: Integrating Current Data into Clinical Practice

JANUARY 20–21, 2012
Laurence L. Greenhill, M.D. and Barbara J. Coffey, M.D., M.S., Co-Chairs
Sheraton New York Hotel and Towers – New York, NY

Register by December 16 at www.aacap.org/cs/psychopharm/2012 to get the Early Bird Rate.
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This photograph is my version of the playfulness of childhood. The picture was taken at my best friend's wedding. The girls on the right and left are the bride's baby sisters and the one in the middle is the bride and groom's daughter. The older of the two siblings was the maid of honor and the two little ones were flower girls. The girls all took their roles very seriously...but as soon as the ceremony was over they ripped off their shoes and jumped into the water – fancy dresses and all – oblivious to everyone else!
MISSION STATEMENT
Mission of the AACAP: Promote the healthy development of children, adolescents, and families through research, training, prevention, comprehensive diagnosis and treatment and to meet the professional needs of child and adolescent psychiatrists throughout their careers.

Amended and Approved by Council, June 27, 2010

FUNCTION 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. 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.
- Liaisons with other physicians and health care providers and collaborates with others who share common goals.

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My Presidential Initiatives

or those of you who were at my plenary talk in Toronto, you know that it was titled: “Yesterday, Today, and Tomorrow.” In it, I discussed the challenges that we, as a field, are faced with in the present and those which are being predicted for the future. My Presidential Initiatives, which will hopefully assist in meeting these challenges, are conveniently broken down into three categories – you guessed it: Yesterday, Today, and Tomorrow.

Presidential Initiatives: Yesterday

As a lover of history and a true believer that it should be an important aid in problem solving, I am checking into the feasibility of hiring a historian to write the history of the AACAP’s first 60 years. I would like this project to be done by our 2013 meeting at Disney World. Rather than a book, this history is envisioned as part of a new AACAP History website that will be created for this project. This website will be under the guidance of the AACAP History Committee and will be a venue for other key documents from our archives.

In addition, there will be a committee created, let’s call it “Project 60,” (n.b., the committee for our 50th anniversary was called “Project 50.”) that will be convened to organize and think through the AACAP’s overall celebration of its first 60 years in 2013. The committee has been tasked with working with the Development Committee to conceptualize and launch a fundraising campaign to coincide with the 60th anniversary celebration.

Presidential Initiatives: Today

It is my firm belief that the challenges we face as an organization are, in the large part, dealt with by the committee structure of the AACAP. As President-Elect, I created a review of committees (ROC) task force that included AACAP staff Earl Magee, Liz Goggin, Kristin Kroeger Ptakowski, Heidi Fordi, and Virginia Anthony, and me. Over the past year and half, this task force has reviewed the committees, their structures and procedures, and has made numerous suggestions that we hope have improved committee functioning. The changes include:

1. Streamlining definitions so there are now only committees and time limited task forces.
2. Assigning a staff person to each committee for support.
3. Increasing the number of times when committees report to Council from reporting once at the Annual Meeting to reporting at the Annual Meeting plus at the annual council retreat in June.
4. Enhancing the job of the Council Cluster Liaisons so that they have much more contact, knowledge, and input into the committees to which they are assigned.
5. Standardizing all reporting forms from the Committees, to the Council, and the Executive Committee, especially the budget reports, and putting everything online.
6. Improving the orientation process of all involved including the creation of a much enhanced policies manual.

The first task force has been sunssetted and replaced by a second task force that includes the council members that interface with the committee chairs as liaisons. Initial feedback from this new task force is positive and indicates that the committees have more support and are better able to meet their charges. The Beta testing of these quality improvement changes will continue for at least another year with midcourse corrections and further improvements as appropriate.

Presidential Initiatives: Tomorrow

To get a better hold on future challenges, we will look to the past, specifically an important AACAP 1983 document edited by Irving Philips, Norbert Enzer, and Richard Cohen entitled: “Child Psychiatry: A Plan for the Coming Decades.”
entitled: “Child Psychiatry: A Plan for the Coming Decades” (AACAP 1983). This publication was the culmination of a prior presidential initiative, “Project Future,” which was set in motion by George Tarjan, M.D., in 1978 when he appointed an eight-member committee. The charge to the committee was to examine our field’s, “knowledge base, manpower development, training content and educational structures, service focus, and delivery of care,” in light of rapid social and economic realities. The project eventually evolved into six task forces comprised of many professionals, including pediatricians, general psychiatrists, psychologists, nurses, social workers, educators, and lawyers. Its four major objectives were:

1. To explore and describe the current status of the profession of child psychiatry.
2. To estimate the future psychiatric needs of children, adolescents, and their families.
3. To develop a general concept of the knowledge and skills that will be needed by child psychiatrists over the next two decades.
4. To identify major issues faced by the profession, and to formulate recommendations for change and future directions.

The final document served as both a covert and an overt catalyst for many of the changes in the Academy and in our field for subsequent years.

I would like to set in motion a similar process with very similar objectives that should report to the Academy by our 2013 Annual Meeting in Orlando. I hope that this document, like its predecessor, will assist the AACAP in planning how to respond to changing social and economic realities that face us “today,” as well as in the future. I look forward to working with you on my Presidential Initiatives.

Reference

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Save the Dates for AACAP’s French River Cruise!

Immediately following the IACAPAP World Congress (July 21-25, 2012 in Paris), AACAP President, Martin J. Drell, M.D., leads a group of AACAP Members on a River Cruise, starting in Paris and traveling through the Normandy region of France. The cruise runs July 25-August 1, 2012.

More details will be forthcoming. If you are interested in being on the mailing list for more information, please contact meetings@aacap.org with your contact information.
Child Psychiatry in Libya: Helping Children in the Midst of Revolution

Child and adolescent psychiatrists, you are doing incredible things! When I first began my position as John Schowalter Resident Member to Council last October, I was amazed at the breadth of the AACAP’s work in advocacy, research, and education; and even more so at the myriad projects of our members. As coordinator for the Resident Columns this year, I hope to use this space to learn together about these inspiring and diverse projects, and to encourage our trainees to start getting involved. In this first column of my tenure, I am excited to present a medical student who inspires me. Hani Elwafi is already passionate about child and adolescent psychiatry and thinking big about how to improve the lives of our kids. His article moved me to learn more about the plight of children in war-torn countries and to think about how I, as a child and adolescent psychiatrist, can help. I hope you find it as inspiring as I did.

Ruth Gerson, M.D.,
John E. Schowalter Resident Member to Council

In February 2011, the pro-democracy movement that swept across the Middle East arrived in Libya. Emboldened by the success of their neighbors in Tunisia and Egypt, many Libyans took to the streets to demand an end to Colonel Muammar Qaddafi’s 42 years of tyranny. Qaddafi’s response was rapid and brutal, but the Libyan rebellion has continued unabated over the months and the opposition has finally wrested control over most of the country from Qaddafi’s iron grip.

My late father, Dr. Mohamed Elwafi, was a psychiatrist who fled from Libya to the United States in the 1970s. He left Libya in order to provide his children with the basic rights and freedoms that have been denied to Libyans for decades. I have watched with excitement as Libyans decided that the time had come to take their futures, and that of their children, into their own hands. Unfortunately, my initial elation gave way to horror and disgust as peaceful protests devolved into violence. Tens of thousands of Libyans have died in this conflict, and countless more have been injured.

Freedom has come at a considerable cost, particularly for Libya’s children. Despite the intense news coverage one could almost be forgiven for believing that Libya is devoid of children. Yet over one-third of Libya’s population, or 2.2 million people, is under the age of fifteen. They have witnessed untold horrors since the war broke out. Countless children have been rejected or destroyed altogether due to relentless urban battles. They have seen family members being taken from their homes to indefinite imprisonment and torture, or threatened with as much unless they fought for Qaddafi. They have been forced to watch as their mothers and sisters were subjected to sexual violence. The International Criminal Court in The Hague has investigated these “crimes against humanity,” and in May they issued a warrant for Qaddafi’s arrest.

Many children and what remains of their families are now living in refugee camps or temporary housing in liberated cities. Others have been trapped at home, sometimes for weeks at a time, while battles raged just outside their doors. At home, these children have been exposed to seemingly endless graphic images of violence on the television newscasts, and privy to disturbing conversations amongst frightened parents and relatives.

Schools, playgrounds, and athletic facilities closed their doors in February. Children lost access to safe places to play and learn and have had their normal routines disrupted. In April, one businessman, 38-year-old Mohammed Al-Ghaziri, decided that his three children had spent enough time hiding at home. Al-Ghaziri and his family live in Benghazi, Libya’s second largest city, which was the first to be liberated by the opposition in April. After the acute fighting subsided, Al-Ghaziri set about re-opening a school to provide children, including his own, somewhere safe to congregate and play outside of their apartments and homes. Many parents were afraid that their own anxieties and fears were affecting the children and wanted a place where the kids could feel happier.

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The school was initially set up to operate three hours per day, six days a week. As news of its existence spread, progressively more children arrived to the school. There they could participate in activities such as soccer and table tennis, card games, music, and art therapy. The psychological impact of the conflict was most vividly seen through the children’s drawings and paintings. At first, many coloredchaotically using dark colors. Some drew pictures of houses wrecked by bombs, men shooting at each other, bloody bodies, and families crying. One young girl drew a battle scene with tanks, helicopters, and ambulances, and said it shows “the crimes of Qaddafi killing his own people.” Another child made a drawing of a martyr’s funeral, with the casket draped in the flag adopted by the National Transitional Council, the temporary governing body of the opposition. Since then, many of the children have moved on to draw more gentle images such as rebel flags flying victoriously, sunshine, and flowers.

Fortunately, additional safe spaces and schools have been set up in Benghazi and surrounding towns. Nevertheless, many of these kids need continued psychosocial support to help them cope with the trauma they have experienced. Al-Ghaziri worries that his schools will not be able to help children fully cope with what they have seen and experienced unless they can enlist the help of mental health professionals. So far, this has been difficult to do.

In a country where psychiatric illness remains stigmatized, the dearth of professionals who can effectively deliver psychosocial interventions has become glaringly obvious under the strain of recent events. In a recent phone interview from Libya, a social worker working with children and families in Libya since the war began stressed repeatedly the dire need for mental health professionals with experience in treating post-traumatic stress disorder (PTSD), especially in the pediatric population. She worries about the more severe cases, children who have lost trust in all adults (especially males), some refusing to leave home or even to speak, and those who experience frequent nightmares and intrusive thoughts.

Unfortunately, these Libyan children are not unique in their plight. According to UNICEF, more than one billion children under the age of eighteen, as recently as 2009, were living in areas of armed conflict around the world or emerging from war; about three hundred million of these are under the age of five. Since 1990, almost 90 percent of global conflict-related deaths were civilians, and 80 percent of these were women and children. Over the past decade, conflicts have killed an estimated 2 million children, left 6 million disabled, 20 million homeless, and over 1 million separated from their parents. Growing up during wartime carries a threat of physical harm, but perhaps more devastatingly, it produces an irreversible alteration of the social fabric that supports healthy child development. Family members and friends are lost or separated. Schools, hospitals, playgrounds, and houses of worship may be damaged or even purposely destroyed.

Children may react to war-related traumatic experiences with symptoms of PTSD, grief, somatization, depression, and anxiety; and children exposed to such trauma are at increased risk for mental health and developmental problems stretching far into adulthood. Not all children exposed to war trauma experience these kinds of psychopathology, however, it is important to identify factors that increase risk or promote resilience. Risk factors that may predispose children in war zones to developing PTSD, include proximity to the areas of active combat, degree of life threat, displacement, pre-existing psychopathology, parental response, parental psychopathology, and economic hardship. Resilience factors, on the other hand, appear to form a ‘protective matrix’ around the child. Resilience factors include strong social and family support, promotion of healthy coping strategies, and availability of interventions aimed at providing safety, stability, and routine, such as those being implemented at Mr. Al-Ghaziri’s schools.

Libyan children will undoubtedly continue to feel the impact of this conflict for years to come. For those who are interested in helping, consider contacting Médecins Sans Frontières (MSF, Doctors without Borders), or MercyCorps. There are a number of different ways to help: donating money (via their websites), raising awareness of the issue among colleagues and friends, fundraising, and volunteering. Funds are needed to support the creation of safe spaces and facilities for children while schools and playgrounds are repaired or rebuilt. There is a need on the ground for mental health professionals who can help train Libyan mental health and non-mental health professionals, such as teachers, to respond to children with PTSD by promoting resilience factors. Help is needed to provide mental health support to parents, as well as psychoeducation aimed at removing the stigma associated with seeking out mental health services for themselves or their children. This war was fought to improve the future for Libyan children, but they need help now to make sense of it all.

Dr. Elwafi is a fourth year medical student at Yale School of Medicine and is excited to be pursuing a career in psychiatry. His father, Dr. Mohamed Elwafi, was a psychiatrist who returned to Libya in 2001 to work on modernizing the mental health system. “He passed away in 2007, but his dream of seeing improved access to mental health services in Libya will hopefully live on.”

Mr. Elwafi may be reached at hani.elwafi@yale.edu.
Well, sometimes they take 45 minutes, sometimes 60 minutes, occasionally 75 minutes. I noticed this in January (2011) while I was having a massage. I had been having stiffness in my neck. It was not going away. I could not or would not make time for a massage during the work week. Since I was going to be staying at a cross-country ski center on vacation, I would finally seek treatment. I had a choice of 30 minutes or 60 minutes, and signed up for the latter. About halfway through, I realized how happy I was that I had another 30 minutes. When all was said and done, it was closer to 75 minutes. I tipped appropriately, including an acknowledgement of the extra treatment, and scheduled a second massage to follow the cross-country ski event I was doing later in the week.

What does this have to do with the “Biological Roots of Child Psychiatry?” In part, it is about the myth that something that takes 45 minutes can be done equally well in 15 minutes. In part, it is about focusing on the procedure and not the care. In part, it is about confusing the part for the whole (Bateson 1972).

Is the analogy correct? Is massage biological? It certainly meets the criteria of being “somatic,” the definition of soma being “the body of an organism as contrasted with its germ cells.” A MEDLINE search using the terms “massage” and “pathophysiology” for the years 2009-11 reveals effects on chronic stress, hypertension, low back pain, connective tissue disorders, beta-endorphins, heart rate variability, diabetic neuropathy, fatigue, trigger point activity, and the parasympathetic nervous system.

In the context of that treatment alliance, psychiatrists who are skilled in the art of healing provide consultation with respect to child development, diagnosis, prognosis, individual counseling, parent counseling, psycho-education, specific non-pharmacological treatment approaches, specific pharmacological treatment approaches (Swann 2005), additional physician referrals, etc. With experience, such psychiatrists learn to guide the transference and countertransference (Reich 1960) in the service of the treatment alliance. With such experience, words such as “love” and “hate” enter the conversation more and more often (Harlow and Suomi 1970).

I mentioned “confusing the part for the whole” earlier. Bateson would also say, “The map is not the territory,” another error of logical types. Resecting the right colon is part of a surgical procedure that officially begins with general anesthesia and the initial incision, and officially ends with stapling the integument, but is always followed by talking with the patient and family – which is the real closing. More importantly, the whole event is preceded by and is in the context of a mutually respectful physician-patient relationship, within which there is a thorough explanation and discussion of alternatives. All of the above constitutes the whole of a surgical procedure, which is different than the part that is the resection.

Confusing any of the nine or more possible components of a psychiatric interview with psychiatric treatment is an error of logical types; specifically, confusion of the part for the whole. In the ongoing discussion with my friend comparing surgery to psychiatry, he said, “At the end of the procedure, I have the tonsils in my hand.” I countered, “At the end of a psychiatric interview, what matters is whether or not I have done the procedure well, and my friend, that is exactly what precedes you having the tonsils in your hand, doing the procedure well.”

Confusing an organ that evolved primarily in the context of selection pressure for social competence with the pathways, receptors, and neurotransmitters that underlie the mechanisms through which it achieves that competence is a grievous error of logical types.
The whole psychiatric interview, which cannot possibly be done well in much less than 45 minutes, and originates in a biologically based treatment alliance, is the essential foundation of psychiatric treatment. None of the parts can substitute for the whole, and thus a part cannot constitute a psychiatric procedure. Ignoring this is detrimental to the patient, the physician, the treatment, and the profession. A 15-minute massage might be worse than none at all, and oftentimes the same is true of a 15-minute psychiatric visit.

References

As always, conversations with friends and colleagues generate the ideas that are expressed in these columns. This particular column developed out of discussions with Ashley Anderson, M.D., at a UW-Madison basketball game; Peter Thurlow, M.D., while canoeing in northern Maine; and Peter Lake, M.D., at our monthly breakfasts.

Dr. Kramer is Clinical Professor Emeritus at the University of Wisconsin School of Medicine and Public Health. He is co-chair of the AACAP Family Committee. Comments on the biology of child psychiatry are always welcome: dakrame1@wisc.edu.

The mission of the Campaign for America’s Kids (CFAK) is to continually improve the lives of children affected by mental illnesses and their families through improved treatments and access to quality mental healthcare.

CFAK Connects: Research and educational program development are essential.
CFAK Advocates: Policies governing children must be effective and inclusive.
CFAK Recruits: Growing the workforce starts by mentoring medical students.
CFAK Educates: Mental illnesses in children are real, common, and treatable.
CFAK Supports: Innovative ideas are key to the field’s progress.

CFAK CARES!
Facilitating the Clinical Implementation of Pharmacogenomics

David Mrazek, M.D.

One of the top priorities of the National Institute of Health (NIH) is to encourage all of the NIH Institutes to promote translational research. One component of this major initiative is to consider possible barriers to implementation of genetic testing and to develop solutions that will improve the speed of translation. While there is exciting speculation about the future impact of sequencing entire genomes, there are only a few examples of genome sequencing being incorporated into clinical practice. In contrast, the utilization of pharmacogenomic genotyping to improve treatment outcomes using medication has been utilized for the past seven years.

It is widely recognized that there is great personal variability in how patients respond to medication. In child psychiatric practice, psychotropic medications are frequently a primary component of our treatment and provide striking examples of these differences. It has been recognized for decades that there is usually insufficient “evidence” to establish FDA-approved indications for children for many psychotropic medications. However, our patients often have debilitating problems which we know can sometimes be helped by psychotropic medication that can only be used on an “off label” basis (Baldwin and Koskey 2011).

Given the high frequency of the side effects of most psychotropic medications as well as the black box warning for all antidepressant medications when used in children and adolescents, it is prudent to systematically identify those pediatric patients who have an increased probability of having difficulty metabolizing specific psychotropic medications. Clearly, avoiding adverse events is in the best interest of our patients.

I have been a member of the National Institute of General Medical Science (NIGMS) Pharmacogenomic Research Network (PGRN) for the past seven years, and have been involved in many discussions about how to make it easier for clinicians to utilize pharmacogenomic testing. Working with one of my colleagues in the PGRN network, Caryn Lerman, Ph.D., we recently prepared a commentary outlining both the barriers for the implementation of pharmacogenomic testing as well as some solutions (Mrazek and Lerman, 2011).

At this point, there are two major barriers. The first major barrier is the cost of testing. It has not been demonstrated unequivocally that pharmacogenetic testing will decrease the cost of providing psychiatric care within the first year following testing despite the fact that in many cases the results are very helpful clinically. Furthermore, when we consider the treatment of children, it is critical to remember that their therapeutic horizons extend for many decades. Fortunately, as the cost of genotyping continues to drop and as more companies begin to provide these services, the cost of clinical pharmacogenomic testing will become more affordable. The second major barrier is the shortage of ongoing professional training opportunities for clinicians that are designed to teach them how to implement pharmacogenomic testing. While clear progress has been made, it is still disappointing to review some of the currently available clinical guidelines that do not include consideration of the appropriate use of pharmacogenomic testing.

Like so many issues in medicine, the ultimate solution will be to obtain more “evidence.” However, more evidence does not necessarily require funding expensive prospective trials. Given that each of us is different in our genetic makeup, research strategies that provide an opportunity to consider the implications of genetic variations in groups of subjects with the same variants is a far more efficient approach to a better understanding of the usefulness of clinical pharmacogenomic testing than traditional clinical trials.

It is also beginning to become more widely appreciated that the use of “pragmatic clinical trials” represents a reasonable alternative to expensive “randomized controlled clinical trials.” While pragmatic trials will not be able to clarify the influence of some confounding variables of interest, they can demonstrate different clinical outcomes that can be linked to genetic variations. Being able to more accurately predict positive outcomes is an important step forward in achieving modest improvements in practice.

It is encouraging that psychiatry and child psychiatry, along with oncology and cardiology, are among the first medical specialties that are using pharmacogenomic testing to guide treatment. Hopefully, these efforts will lead to the adoption of pharmacogenomic testing by more medical specialties in the near future.

References

Dr. Mrazek is Professor of Psychiatry and Pediatrics at the Mayo Clinic College of Medicine. Dr. Mrazek and his collaborators at the Mayo Clinic have developed intellectual property related to pharmacogenomic testing that the Mayo Clinic has licensed to AssureRx, which is a personalized medicine company that specializes in pharmacogenomic applications. Dr. Mrazek may be reached at mrazek.david@mayo.edu.
Releasing Information – Part III

Lee H. Haller, M.D.

Parts I and II on the topic of releasing information appeared in AACAP News March/April and July/August issues respectively. Failure to respond appropriately to a release of information request can cause harm to your patient and aggravation for you. Additionally, it could result in litigation. In my previous columns on this topic, I described the necessary elements that make a request for information valid. Sending any information in the absence of a valid release, i.e., one that comport with state and federal law, can be tantamount to releasing information without any authorization. Once you are satisfied that you have a valid release, the question becomes what information should you produce. This is the topic for this issue's column.

As a general rule, it is best to release the minimum amount of information necessary to accomplish the purpose stated in the release. For example, you may receive a request for your entire record from a subsequent psychiatrist, because your patient and family have moved. The doctor would want the information for continuity of care purposes.

You certainly will want to assist in your patient’s future care. Therefore, do not ignore the request. Instead, take time to cull through the chart for pertinent data and send a summary letter detailing such, along with the statement that if the doctor needs further information, he or she may contact you. If, instead, you send a copy of the chart, you may be sending information that is unnecessary and even potentially harmful to the patient. For example, suppose that patient had been the object of some embarrassing event, which you recorded in the medical chart, but which did not turn out to be relevant to the treatment. The patient might not want that information forwarded. If you are in doubt as to what to send, you can contact the patient (or legal guardian) for clarification. The same holds true for requests from insurance companies, i.e., do not automatically send the entire chart. Instead, contact the company to see what specific information is needed.

Once you are satisfied that you have a valid release, the question becomes what information should you produce. This is the topic for this issue's column.

If the request comes from a company doing security background checks for a potential employer and you have information about the patient which might be damaging, such information should not be sent without first contacting the patient (or legal guardian) for specific authorization. For example, a child who was involved in using drugs or was arrested for larceny may not want that information to go forward.

If you believe certain information would be relevant to the requesting party, you cannot just omit sending it as if the data did not exist. Rather, when sending a treatment summary, you can indicate that you are forwarding only the information that the patient or legal guardian has authorized. In short, releasing information requires a degree of both caring and thought on the part of a psychiatrist.

Dr. Haller is in private practice as a board certified child, adolescent, adult, and forensic psychiatrist. He is not an attorney. His statements should not be taken as legal advice.
DIVERSITY AND CULTURE

Keeping up with the Shahs and Patels: The Model Minority Mirage

Pooja Koolwal, Mohit Joshipura, Niraj Badhiawala, and Ayesha Mian, M.D.

Parents often talk about the younger generation as if they didn’t have anything to do with it.
~Haim Ginott

In the year 1965, the Immigration and Naturalization Act opened doors for professionals, scientists, and artists of “exceptional ability.” This proved to be a watershed moment in the history of Asian/South Asian immigration into the United States, and the model minority image was born. The 1990s, however, saw a change in the demographics of South Asians that entered the country, as the immigration process became harder for the “professional” category, and the extended family members of the earlier immigrants entered in waves. These came in the hopes of fulfilling the American dream, but found themselves taking entry level labor jobs like driving cabs, working at gas stations or retail stores, or working hard at starting small businesses.

The latter wave of immigrants suffer from greater acculturative stress; intergenerational conflict between their adolescents and the parents is fairly common as these youngsters strive to balance their family’s cultural bend towards interdependence and collectivism while asserting their independence—more commonly a Western concept learnt outside of the home environment. There is a paucity of literature on the above issues and their manifest psychiatric symptoms in the United States. However, multiple studies done in the United Kingdom show evidence of increased self-harm behavior and suicidal ideation in young South Asian girls, ages 16-24. One study indicated a 1.5 fold increase in risk of self harm in South Asian women of the above age range, compared to White women of the same age group (Cooper 2006). Evidence suggests that socio-cultural factors may have a great contribution in the higher rate of self harm in this population than psychiatric factors (Bhugra et al. 1999). Other reports have shown that suicide is the leading cause of death in South Asian girls 16-24 years of age.

Stigma against mental health illnesses, like depression and anxiety, causes these symptoms and disorders to be under-recognized in South Asian youth. Expressing symptoms of these disorders or thoughts about suicide are often considered signs of weakness or cowardice as per socio-cultural norms and mores. Small studies have also shown that South Asians tend to underutilize medical services related to mental health.

Stigma stops people from discussing such problems amongst friends, family, and even health professionals. People originating from many Eastern cultures may believe that diseases such as depression are not real, and that paradoxically, it is “all in the mind.” It is often assumed that youth who are depressed, anxious, or suicidal have gone astray into drug addiction, bad company, and the like, which may, at times, be the outward manifestation of the former, especially in adolescent males.

Often times the cultural gap between the South Asian immigrants and their US born children may be both the cause and the barrier to treatment for mental health issues. Many parents find it difficult to grasp the idea of adolescent depression, as this is not a familiar concept from their own youth.
Furthermore, in a culture that only rewards excellence and has little tolerance for mistakes, individuals with mental illnesses are quickly dismissed as “failures.” This is where the cultural fixation on upholding the family’s honor and “saving face” can be detrimental to the adolescent who is struggling to emotionally and psychologically cope with life changes. The fear of being labeled as “crazy” can create internal discord within the family unit. Instead of the strongly needed social support, troubled South Asian youth might find themselves rejected by their families or forced to cover up their mental health issues. Unfortunately, the South Asian youth is caught in the middle of cultural biases and is either denied the ability to seek appropriate care, or is forced to keep any psychiatric help a secret from others. It is important to focus on this growing population of South Asians, labeled as the model minority and laden with expectations of high achievement, to understand their psych-social and mental health needs as well as their specific risk factors and stressors.

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Pooja Koolwal is a third-year medical student at Baylor College of Medicine; Mohit Joshipura is a fourth-year medical student at Texas Tech University Health Sciences Center School of Medicine; Niraj Badhiawala is a third-year medical student at Baylor College of Medicine; and Ayesha Mian, M.D., is on the faculty at Baylor College of Medicine, and is the coordinator of the “Diversity and Culture” column in the AACAP News. Dr. Mian may be reached at mian@bcm.edu.

The Editorial Board of AACAP News is soliciting photographs from AACAP members to be published on its front page, inside standing alone, or accompanying relevant articles or stories. The published photographs should—in some artistic way—illustrate themes pertaining to children, childhood, parents and children, parenting, or families. All AACAP members are invited to submit up to two photographs every two months for consideration. A committee of five experienced photographers who are AACAP members—David Corwin, M.D., James Harris, M.D., Fred Seligman, M.D., Ludwig Szymanski, M.D., and Alvin Rosenfeld, M.D.—will select the photos to be used. Photos not selected will be included in the voting for the subsequent two issues, along with all newly submitted photos. Unused photos will be retained by the AACAP to be used if and when a story they might illustrate is to be published. The AACAP News may edit photos to enhance them or make them suitable for publication. If you would like your photo(s) considered, please send a high-resolution version to Dr. Rosenfeld, the AACAP News photo editor, at ARosen45@aol.com. Please include a description, 50 words or less, of the photo and the circumstances it illustrates.
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Mentorship Matters: Going Deeper: How I Chose a Career in Child and Adolescent Psychiatry

Jennifer M. O’Keeffe

Child psychiatry is one of the most underserved specialties in the world. The AACAP has taken a primary role in rectifying this, but what is it that really draws people to child psychiatry? For this issue of AACAP News I am excited to present another fantastic medical student, Jennifer O’Keeffe. Jennifer describes how her mentor, Rebecca Weis, M.D., provided that perfect balance of encouragement, supervision and freedom that allowed her to explore child psychiatry and find her niche.

Ruth Gerson, M.D., John E. Schowalter Resident Member to Council

I walked into the cafeteria. Most of the kids were joking around and listening to their MP3 players, a reward for good behavior on the Adolescent Psychiatry Inpatient Unit where I was doing an elective rotation. My eyes scanned the room to find David, sitting alone at a table, twirling headphones around his fingers and shaking his foot. He looked up at me with a slight half smile that was my signal to come over to his table. I asked him why he was not listening to his favorite songs like the rest of the kids. He replied, “I was waiting for you to come talk to me. You always come at this time.”

My first few sessions with David were difficult. It was nearly impossible to break through the barrier that 14 years of mistrust, separation, and anger had created. Sure, I was able to ask him questions about his favorite movie and what he liked to do with friends on weekends, but moving beyond these superficial conversations was much more of a challenge. My attending, Rebecca Weis, M.D., had encouraged me to try to learn why he ran away from home, why he was constantly fighting with his mother, and why there was such a sad look in his eyes every time we met. It was easy to speculate. He had been separated from his parents in infancy, constantly living in different locations, and had not had a stable parental figure in his life since he was born. I needed to find out how these past experiences were getting in his way now, and what could be done to get his life on track at such a crucial age.

It was around the third session when it happened. We were discussing comic books and his love for drawing when he reached under his bed and pulled out a drawing that his mother had sketched of his family several years ago. A smile swept across his face, but soon it morphed into an angry glare, and he chucked the picture across the room. I walked over and gently picked up the portrait. I gave him a quiet moment and then I asked him what the picture meant to him and why was he so angry. He took a few deep breaths and then started rattling off how he was upset at his mom for shipping him away when he was young, how he hated the way she treated his younger brother, and that he felt he needed to protect his family from his mom’s new boyfriend. We worked together from that point onward, talking about these and any other issues that came to his mind. As much as I held the physician role in his eyes, he also viewed me as a friend, mentor, and support system to let his pent up emotions loose. I was his advocate. With several family meetings, group and individual therapy, and the right recipe of medications he was able to leave the Unit with a new sense of hope and motivation that he could make his life better from this point forward.

A few weeks later, I heard from Ruth Gerson, M.D., the child and adolescent psychiatry fellow I worked with on this case, that she unexpectedly ran into David and his aunt at the drug store. They both said he was doing great. His grades in school had improved tremendously, he was no longer fighting with everyone, and he overall appeared to be a much happier teenager. It was evident that the team on the Unit had made a critical impact in this patient’s life, giving him hope that a new beginning was possible.

David was one of the many patients I had the pleasure of working with during my month on the Adolescent Inpatient Unit. Dr. Weis encouraged me to take a primary role on the team and to really get to know my patients. The satisfaction gained from working with David and the other teens on the unit played an enormous role in my decision to choose child and adolescent psychiatry. In addition to confirming my passion for pursuing the field, the rotation was essential for me as a fourth year medical student to clarify a misperception about psychiatry and child psychiatry. I was worried that if I chose psychiatry, I would not have the opportunity to use the “medicine and science” information I learned throughout medical school. However, to my fascination and relief,
this was not an issue; actually quite the opposite. For example, one of the patients on the Unit was diagnosed with a brain tumor as a young child and now, many years later, had to cope with the mental and social implications of this surgery at such a young age. A patient of mine suffered from a life-consuming eating disorder and was hospitalized at a measly 96 pounds. It was the psychiatric team’s responsibility to monitor her electrolytes, get her BMI back into normal range and make sure she had the physical and emotional strength to fight her illness. These are just a few of the examples that demonstrate how child and adolescent psychiatry allows us to take our medical knowledge and apply it to real, devastating mental disorders.

Psychiatry is fascinating. Although our treatment focuses primarily on the mind and brain, the entire person is affected. It is the one field of medicine that treats not only the biological components of the illness, but also explores deeper to improve the patient’s mind, emotions, and functioning in society. No aspect of life is neglected, including relationships, family and social wellbeing. Child and adolescent psychiatry is an investigation into not only the child’s mental state, but also their world. I embrace the opportunity to use my medical knowledge as a child advocate, providing the comprehensive care that these children and their families deserve.

Ms. O’Keeffe is a fourth year medical student at Albert Einstein College of Medicine.

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### Business is Business:

**A short history in malpractice insurance for child and adolescent psychiatrists.**

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<td>1986</td>
<td>AACAP, in an effort to address the needs of their growing membership, first approached the American Psychiatric Association about amending their malpractice insurance program to include risk differential premiums for child psychiatrists. This made sense as child psychiatrists experienced far fewer claims and payouts were significantly lower. Sadly the APA balked on the idea, leaving child psychiatrists to deal with high premiums and basic coverage.</td>
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*The very next year the APA offered 25% lower premiums for child psychiatrists.*

| 1987 | AACAP, working closely with dedicated members and staff created, crafted and developed their very own malpractice insurance program. Not only was the program tailor made to the specific needs of child psychiatrists, it was offered at 25% lower premiums! |

| 2009 | AACAP, always looking to improve their offerings, programs and services chose the American Professional Agency to manage its malpractice program, eventually being insured by Darwin/Allied World Assurance. |

| 2010 | The APA chose the American Professional Agency to manage their insurance program with Darwin/Allied World Assurance as the underwriter. |

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New Media and Mental Health Care: Frontiers of Interpersonal Communication

Part 1: Unusual Situations and Scary Anecdotes

A younger friend and former colleague moved from counseling to administration in a new and larger organization. She maintains a personal Facebook page where former clients—now grown and with children of their own—have found her on-line. Though geographically dispersed, they confide in her their woes and seek her advice. Similarly, a colleague from a program for homeless youth reports ongoing electronic communication via the program’s Facebook page for those who have left. For children who found stability and some measure of comfort in residential care, this remote contact may be the only sense of family they can maintain.

A female colleague became the object of obsession for a male patient. After a difficult termination, he found her address, and details of her life sufficient to threaten her children. A colleague reports that patients have told her it was easy to find photos of her and her family online that had been posted on sites by third parties, with a simple Google search.

The Yelp! Issue: A colleague who works with high-acuity patients found himself lambasted anonymously online. In deference to patient confidentiality, he could not reply. He subsequently discovered an online battle over his reputation, as other anonymous patients came to his defense.

While still in private practice, numerous patients told me they could not find me on-line. By ignoring the Internet, I thought it would not affect me. When I Googled my name, three commercial referral sites came up that listed an address and number that were 15 years old, while my current contact information (4-years old and available in the phone book) was nowhere to be seen. In order to update, I would need to become a paying subscriber.

An inexperienced yet stubborn therapist I once supervised insisted that it was acceptable to allow his young clients unlimited access to his computer during sessions. The net result was that little interaction was required and problems were easily avoided. On the other hand, many younger therapists and child and adolescent psychiatrists believe that the judicious use of videogames can facilitate trust and communication, and enhance their work.

Part 2: Quotidian Reality

A survey of therapists and psychiatrists (from multiple settings, ages 30 to 80 years) revealed a more reassuring picture. Most practitioners do NOT use e-mail, although a few use it to good effect for scheduling. They all have their personal instructions to clients that e-mail is not necessarily confidential, that they cannot respond in a timely way, nor deliver the sensitivity they can offer in person. A few described incidents where patients revealed deeply personal information via e-mail, endangering their own confidentiality, but also introducing fruitful clinical material into the work. Very few practitioners over 50 years old maintain a Facebook page or even think about social media. Younger practitioners reported being invited to join their clients’ “friends list” or view their MySpace page. Some declined, some found it helpful. No one had problems with malicious stalking, although several reported that patients had indeed uncovered their personal and family information. (Few considered this to be a problem, although I predict this will change as patients become more skillful.) No one seemed troubled by the potential for negative reviews online, or used a service to track and counter this phenomenon, subscribing to the old adage, “If a tree falls in a forest and no one is there to hear it...” Most practitioners used computers in the therapy hour to facilitate case management or look up information. This can be especially important for patients who are demoralized, who have low literacy or no access to computers. Despite some present or potential problems, most practitioners and institutions appear to be negotiating this massive cultural shift without dreadful consequences.

Part 3: Need for Guidance

There are no formal guidelines from either the American Psychiatric Association (APA) or AACAP to navigate these uncharted and potentially perilous waters (Gabbard 2010). Conceptually, I see these falling into five basic, though related categories.

1) Therapist privacy.

Given the sometimes intense nature of therapy, the privacy and safety of the practitioner are non-negotiable if the clinician is to deliver his or her best work. This is no longer guaranteed. Without the constraints that arise naturally from being in the live presence of others, people on computers will indulge in behaviors (including bullying, child pornography, or virtual stalking), from which they would otherwise refrain (the Internet and e-communication may be dis-inhibiting). While this may increase therapist accountability by leveling the power balance between patient and doctor, it also may prevent practitioners from addressing important areas of conflict, or cause them to limit who they will treat.
2) Boundaries.
As with privacy issues, the ease with which individuals can now communicate or learn about each other increases the urgency to create clear rules about sharing of personal information and contact between visits. This can become an issue with teens who were raised with social media, and who may be displaying their lives on-line in ways that are uncomfortable and inappropriate for therapists.

3) Flow of information.
If patients and their families deliver too much information to us between sessions, we can find ourselves overwhelmed during session trying to address both the live issues and those that we received virtually. Our capacity to introduce method and order into lives that are habitually chaotic or confusing can be greatly reduced, diminishing our effectiveness. Particularly troubling is the issue of suicidal thoughts expressed online, but never delivered to the therapist. If your patient has invited you to a site where his suicidal intent is expressed and you never see it, what is your responsibility? If not legally, than in your own mind, where “what if” will probably be a refrain for a long time.

4) Dilution of the therapeutic relationship.
Neuroscience has revealed that one of the most effective aspects of therapy is the sharing of affective states, including the activation of mirror neurons and the process of intersubjectivity that is engendered in the therapeutic hour. Obviously, this is lost when we are not sitting with our patients.

5) Hitting “Send” too soon.
One accidental motor movement can have drastic consequences! Impulsive communications and loss of confidentiality can undo months of painstaking work. No matter how many times you or your institution send reminders to save messages and re-read before you send, it is easy to mess up, or even hit “send” when you are aiming for “delete”!

Part 4: The Changing Context of Psychotherapy
The last ten years have seen the establishment of time-limited, focused, effective therapies such as dialectical behavior therapy (DBT), interpersonal therapy (IPT), cognitive behavioral therapy (CBT), and time limited dynamic psychotherapy (TLDP). Economic factors also have spelled an end to multi-year, open-ended dynamic psychotherapies for all but the wealthy. Ideally, this should allow therapists to move from the psychological stance of sage, to that of technical expert, altering the dynamics of therapy to one of collaboration and focused transparency. This should relieve us of some of the pressures of transference and countertransference, thus making it less likely that patients will harbor mysterious feelings about us, and making it easier for us to set guidelines for boundaries and the sharing of personal information.

Because the new media are neurologically potent, novel (and abnormal) sensory inputs that pervade human interactions, they will necessarily alter our biologically-based human relations. The unanswered question is how much an evolutionary system—that of attachment, emotional communication, and social cohesion—can be impacted before its function declines. Increased access to information, for example, clearly has a democratizing effect on oppressed populations or provides a lifeline to isolated and suffering teens. It may even be that the diminution of affect that occurs as we move from face-to-face, to virtual communication decreases destructive, emotionally-driven behavior. (We move from “I’m gonna kill you!” to “Whatever.”) On the other hand, because our brains evolved to share affect, it is possible that decreasing our sensory contact with each other may decrease our neurological and emotional resilience, for example leading to increased anhedonia or avoidance of painful affect. I have already discussed disinhibition as another behavioral effect.

These larger issues, still in the philosophical and speculative realm, appear to me to be important concerns, in which psychiatrists can naturally contribute. In the meantime, the five areas listed above present resolvable issues that will provide some measure of relief as we move forward.

The AACAP Media and Ethics Committees are initiating a task force to create guidelines, and members will be welcome to submit commentary. If you are interested, please contact Michael Brody, M.D., (Media Committee) or Arden Dingle, M.D., before the next annual conference.

Acknowledgements: Thank you to all the anonymous members of the AACAP Media Committee, the North Carolina Regional Organization of Child and Adolescent Psychiatry Executive Committee, and colleagues who so promptly returned my survey and contributed anecdotes.

Reference
Gabbard G (2010), Ask the expert: email in communication with patients. FOCUS, VII 1:43

Dr. Burke is at Sutter Pacific Medical Foundation, Pediatric Environmental Health Specialty Unit at the University of California San Francisco. She may be reached at docmol@pacbell.net.
The Advocacy Group of the Regional Council for Eastern Pennsylvania and Southern New Jersey has been actively involved in advocating for children and adolescent mental health care throughout the year. We had one of the largest representative groups for AACAP’s Advocacy Day in Washington, DC, this past April. We also had strong representation from our partner organizations. Carol Caruso, executive director of National Alliance for the Mentally Ill (NAMI) PA Montgomery County; Marie Paxton, president of our local Children and Adolescents with Attention Deficit Disorder (CHADD) chapter; adolescent patients and their families; as well as resident representation, including Matthew Prowler, M.D., who is AACAP’s 2011-2012 Mary Crosby Congressional Fellow on Capitol Hill.

During April, in the shadow of a government shutdown over the budget, we met with Congressional representatives and their staffs from our own districts to try to protect our most vulnerable youths from further cuts in funding. We argued that loss of federal funding to The National Institutes of Mental Health (NIMH), National Institute of Drug Abuse (NIDA), Substance Abuse and Mental Health Services Administration/Center for Mental Health Services (SAMHSA/CMHS), Center for Disease Control (CDC), or National Center for Birth Defects and Developmental Disabilities (N CBDD) would damage early intervention, prevention, and treatment for children suffering from mental illness. We emphasized that a small investment will yield big savings in the long run.

We then moved across the Capitol to the Senate. Senator Bob Casey (D-PA), a tremendous advocate for the Patient Protection and Affordable Care Act (ACA), also sits on the Subcommittee on Children and Families of the Health, Education, Labor, and Pensions Committee. He has been supportive of continued funding for mental health research and treatment as well as Section 5203 of the ACA, which authorizes a loan repayment program for those who specialize in pediatric psychiatric training to help alleviate access to care issues in child psychiatry. Our discussions with Senator Casey were very productive.

Our next stop was a meeting with the Junior Senator from Pennsylvania, Pat Toomey (R-PA). Senator Toomey is known to be a fiscal conservative and an opponent of the ACA so we were anticipating some resistance to our message. However, we were pleasantly surprised by Senator Toomey’s Legislative Aide for Health Issues, Tessie Abraham. She assured us of the Senator’s interest in children’s health issues and confided that this was one of the reasons she had decided to work for the Senator. She explained that the Senator was sympathetic to our causes but budgeting concerns were of paramount importance. Showing the long term cost savings as being at least fiscally neutral would be essential to gaining his support.

Throughout the spring and summer, we formed a “Collaboration of Care Committee,” enlisting pediatricians and advocacy groups, such as NAMI and CHADD, to discuss improving access to child and adolescent mental health care. We have looked at various models, including the Massachusetts Plan and current plans in Oregon and New Jersey. Collaboration with all of our health partners has been key to broadening our horizons on new and innovative methods to ensure the best care, given the current shortage in funding and in child and adolescent psychiatrists. Our committee will continue to work on a comprehensive plan that will most likely be uniquely Pennsylvania.

Following Congress’s debt ceiling compromise, a 12 member “Super Committee” was named and charged with cutting 1.5 trillion dollars from the federal deficit. This committee has the ability to recommend broad changes in government spending and restructuring government entitlement programs (Medicare, Medicaid, and Social Security) as well as the Tax Code. Senator Pat Toomey is one of the 12 members of Congress serving on the committee. We felt it was important to advocate our position that the deficit not be reduced on the backs of children who can ill afford decreases in necessary services.

Our own Regional Council’s “Super Committee” of Fayez El-Galawi, M.D., (current president), Randy Gurak, M.D., (president-elect), Rao Gogineni, M.D., (past president), Carol Caruso (NAMI), and Valerie Oulds-Dunbar (program manager of Philadelphia Compact from the City’s Department of Behavioral

Randall Gurak, M.D.
AACAP Advocacy Liaison
Health) met with Senator Toomey’s Southeast Regional Manager, James Fitzpatrick, at the Senator’s Philadelphia office on September 9, 2011. Carol and Valerie gave personal stories about dire shortages in child and adolescent psychiatrists and the toll it takes on their members and families.

Members of Regional Council provided the workforce shortage maps for Pennsylvania and emphasized that Section 5203 of the Affordable Health Care Act was authorized but not appropriated. We gave firsthand accounts of how great the need is for suffering children and how important early intervention is in saving lives and money.

Mr. Fitzpatrick asked pertinent questions and was quite surprised by the answers demonstrating the severity of the problems. Although Senator Toomey is against the Affordable Health Care Act, he assured us that he is in favor of retaining several provisions, including children continuing on their parents’ health insurance coverage until the age of 26. He also thought that the Senator would be in favor of funding Section 5203, given the cost savings as explained by our members and the materials we left him. We assured him that we will continue to watch the work of Senator Toomey and the Super Committee and follow up with our input and concerns throughout the process.

Our Regional Council’s advocacy efforts could not be possible without the significant support from the AACAP staff, especially Liz DiLauro, assistant director of Grassroots Advocacy, whose input and guidance helped prepare us to be effective advocates for our patients. We are also indebted to Karen Davis, legislative coordinator, and Michael Linskey, assistant director of Federal Government Affairs, whose persistence over several months and numerous e-mails and phone calls resulted in our meetings with the Senator’s staff.

Dr. Gurak is an associate clinical professor in the department of psychiatry at Drexel University College of Medicine. He serves as a representative to the assembly and advocacy liaison for the Regional Council of AACAP for Eastern Pennsylvania and Southern New Jersey. Dr Gurak has a private practice in Cherry Hill, New Jersey and Philadelphia, Pennsylvania. Dr. Gurak may be reached at rgurak@aol.com.

PITTSBURGH REGIONAL COUNCIL OF CHILD AND ADOLESCENT PSYCHIATRY

Resolution: Controlling Children’s Misuse of Prescription Drugs

The misuse of psychoactive prescription drugs is a rapidly growing problem among the youth of our country. Efforts now underway by health plans and pharmacy benefit managers to decrease pharmacy costs and improve administrative efficiency are instituting policies encouraging, and in some instances requiring, the prescribing and dispensing of all medications through a 90-day prescription process. The prescribing of Drug Enforcement Administration Schedule II, III, and IV medications in a 90-day supply puts larger quantities of these medications in homes where they will be difficult to control, making larger quantities more available to children and adolescents. The Resolution, authored by Alan A. Axelson, M.D., president of the Pittsburg Regional Council of Child and Adolescent Psychiatry, was presented to the Pennsylvania Medical Society House of Delegates in October, and will be presented to the American Psychiatric Association in November. The Resolution asks that there be a “90 day prescribing/30 day dispensing rule” imposed on these medications. This modification to the 90-day mail order will preserve cost savings while preserving physician medication management options.
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Identifying Risk—The Role of “Non-Suicidal Self Injury”

Identifying risk factors for adverse clinical outcomes has been the focus of many studies, particularly around identifying those at greatest risk for suicide. Efforts at differentiating suicide ideators, from suicide attempters and completers, have been challenging and certain factors (prior attempts, substance abuse, the presence of firearms) have been clearly identified. But what constitutes an “attempt” and is their predictive value in differentiating types of self-injury? In this context the term non-suicidal self-injury (NSSI) has emerged as a relatively new descriptor. The name reflects its construct, that is self-harm, that is believed to not be suicidal. With this definition it has been estimated that NSSI occurs in approximately 10%+ of the adolescent population which is in contrast to the 6.3% (morbidity and mortality weekly report, Center for Disease Control 2009) that attempt suicide and the 0.01% of adolescents that complete suicide. The roots of the term NSSI derive from the increasingly common occurrence of self-injurious behaviors, the need to differentiate those at greatest risk from those at lesser or even no risk, and the necessity to judiciously use our scarce mental health resources only as needed. Clearly, not all self-harm events are equivalent and not all those who self-harm need to be hospitalized, but is NSSI really not as “worrisome” as it is sometimes treated or does it have some real importance? Increasingly it appears that common practice has inadvertently evolved to almost normalize this concerning behavior or at least to dismiss or minimize it as a significant risk factor for more serious self-harm. But what is the data? In the two studies cited below adolescents with moderate to severe depression (Great Britain’s ADAPT-the Adolescent Depression Antidepressants and Psychotherapy Trial ) and adolescents with refractory depression (USA-TORDIA-Treatment of Resistant Depression in Adolescents), rigorously look at the data and both show that NSSI is powerful risk factor for future suicide attempts.

In May’s American Journal of Psychiatry, Wilkinson and his colleagues report on over 160 adolescents followed in their Adolescent Depression Antidepressant and Psychotherapy Trial (ADAPT). In their study 36% of the adolescents had had a NSSI occurrence in the month prior to enrolling in the program. During the 28 weeks of the intervention (multiple arms including medications and psychotherapy alone and in combination) 37% of their cohort had a subsequent self-injurious event. It should be noted that the proportion dropped steadily (in each group-including medication alone) with time of participation. They found that along with pre-baseline suicide attempts (which are by far the most potent predictor), endorsing suicidal items on a checklist, poor family functioning, and NSSI all were significantly correlated with suicide attempts during the 28 weeks of the study. However, when looking at an increase in Odds Ratio (OR), only family functioning (OR 2.11) and NSSI (OR 3.20) reached statistical significance. Looking further at the data, self-injury in the month prior to initiating care was the single most powerful predictor. The authors go on to conclude: “Suicidal and non-suicidal self-harm are both significant risks for depressed adolescents treated in the clinic. The presence of family dysfunction, high levels of suicidality, and recent self-harm (suicidal or non-suicidal) should alert us to a high risk for future suicide attempts…. The lack of positive results to date from trials that offered specific treatments focused on self-injury indicates the need for the development and testing of new treatments.”

In August’s Journal of the American Academy of Child and Adolescent Psychiatry, Asarnow and her colleagues present data on recent findings that undercut (pun respectfully intended) any notion that NSSI is not serious. Their study population was a unique one in that their follow-up was on the 334 adolescents in the TORDIA (Treatment of Resistant Depression in Adolescents) study. These were adolescents, identified as having been treatment resistant to prior treatment with an SSRI and included both teens who received or did not receive CBT. They were then randomized and had a switch in antidepressants to either another SSRI or venlafaxine, and then followed for 24 weeks. In this unique group, they found that 37% of the group had NSSI in the month prior to entry into the study. In follow up, they found that NSSI was a powerful predictor of suicide with a hazard ratio of over 5. They go on to conclude that “NSSI is a common problem among youths with treatment-resistant depression and is a significant predictor of future SAs and NSSI, underscoring the critical need for strategies that target the prevention of both NSSI and suicidal behavior.”

The authors in both studies are unclear as to the mechanism(s) at work here. Wilkinson, in the ADAPT paper, speculate that: “According to Joiner’s interpersonal-psychological theory of suicidal behavior, people make serious suicide attempts only if they have the combination of a wish to die and the capability to act on that wish. Joiner’s group has stated that repeated non-suicidal self-injury may result in higher pain tolerance and reduced fear of death, increasing the capability to cross the boundary between suicidal ideas and acts. Our study (ADAPT) is the first longitudinal study to demonstrate that self-injury is associated with future suicide attempts, independent of depressive symptoms.” Whether this is
the mechanism at work or there is some other, clinicians who identify adolescents with so-called NSSI should be alerted to see it as a significant indicator for future risk and act accordingly. Perhaps a better acronym would be NISSI: Non-Immediately Suicidal Self-Injury, reflecting the clinical importance of this finding.


Identifying Risk—Bullying and Suicidal Behaviors

There is more than ample evidence that bullying is a major public health problem. High profile cases of suicide associated with bullying have captured the public eye and some states and locales have revised policies to take a more protective and proactive stance. Their efforts are applauded. While undoubtedly bullying is bad for all involved (bullies do poorly, too), more systematic study of the relationship and mechanisms between bullying and mental health, particularly suicide, is both critical and challenging to carry out. In Klomek et al.’s 2008 study, cited below, they initially presented their findings on a self-report survey of over 2300 13-18 year olds. They found that: “Regression analyses indicated that frequent exposure to all types of peer victimization was related to high risk of depression, suicidal ideation, and attempts compared to students not victimized. Infrequent victimization was also related to increased risk, particularly among females. The more types of victimization, the higher the risk for depression and suicidality among both genders.” They went on to recommend that screening teens for bullying should become part of the routine evaluation of all patients.

Their initial paper was based upon self-reports gathered at the time of assessment and was vital both for its findings and as a call to action for both communities and practitioners. For patients, parents, and clinicians the longer term or lasting impact is also of great concern. Simply put, are there downstream effects after victimization and if so what is their nature? In Klomek’s July 2011 paper, they report on two subsets of the initial study group and how they fared four years later. One group was an at-risk group identified by having had recent (to the initial evaluation) depression, suicidality, or impairment from substance abuse. Of this group of over 300, just fewer than 100 reported frequent bullying either as victims, bullies, or both. The second group, of almost 240, was involved in bullying as well, but was deemed low-risk by not having had a history of depression, suicidality, or impairment by substance abuse. They found that psychiatric problems in all groups had diminished. Additionally: “Youth who only reported frequent bullying behaviors (as bullies, victims, or both) did not develop later depression or suicidality and continued to have fewer psychiatric problems than students identified as at-risk (history of depression or suicidality). Students who experienced bullying behaviors and depression or suicidality were more impaired 4 years later than those who had only reported depression or suicidality.”

Taken together, the two studies found that while bullying did have a proximal (to the event) impact on depression and suicidality, bullying in and of itself did not confer significant future risk if at the time of the occurrences those bullied did not have concomitant risk factors (depression, suicidality, substance abuse). Additionally, they found that those at risk continued to be at risk, albeit with some improvement, regardless of bullying. Finally, and quite importantly, they found that those at risk, who also were involved in bullying, were at the highest risk of all, i.e., bullying moderates future difficulties for those at risk. For clinicians, the implications are clear, screening for bullying should be part of every evaluation and for those of our patients at risk, bullying can significantly moderate prognosis.


AACAP’s 2011 Mary Crosby Congressional Fellow

AACAP is pleased to announce that Matthew Prowler, M.D., is the Mary Crosby Congressional Fellow for 2011-2012. Dr. Prowler is working in the office of Senator Bob Casey from Pennsylvania. Senator Casey is known as an advocate for children’s issues and serves on the crucial Health, Education, Labor and Pensions Committees, the committee which oversees many of AACAP’s top legislative priorities. Over the next 11 months Matt will be working to educate policymakers and Congressional staff about child and adolescent psychiatry, and increasing awareness of children’s mental health issues within the public policy arena.

AACAP would like to thank its 2010-2011 Irving Berlin, M.D. Congressional Fellow Scott Palyo, M.D., who completed his internship with Senator Debbie Stabenow of Michigan. Dr. Palyo had the opportunity to work directly with Senator Stabenow on issues including Medicaid block grants, establishing a single office of children’s health within the White House, and electronic medical records. We thank Scott for his excellent work and dedication.

To support the Mary Crosby Congressional Fellow contact development@aacap.org.

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Please see Brief Summary of Full Prescribing Information on the following page.

INTUNIV® (guanfacine) Extended-Release Tablets

Rx Only

BRIEF SUMMARY: Consult the Full Prescribing Information for complete product information.

INDICATIONS AND USAGE
INTUNIV® is indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) as monotherapy and as an adjunctive therapy to stimulant medications. The efficacy of INTUNIV® was studied for the treatment of ADHD in two controlled monotherapy clinical trials (3 and 6 weeks in duration) and one controlled adjunctive trial with psychostimulants (9 weeks in duration) in children and adolescents ages 6-17 who met DSM-IV criteria for ADHD (see Clinical Studies in Full Prescribing Information). The effectiveness of INTUNIV® for longer-term use (more than 9 months) has not been systematically evaluated in controlled trials. INTUNIV® is indicated as an integral part of a total treatment program for ADHD that may include other measures (psychological, educational, and social) for patients with this syndrome. Drug treatment may not be indicated for all patients with this syndrome.

CONTRAINDICATIONS
Patients with a history of hypotension to INTUNIV®, its active ingredients (see Description in Full Prescribing Information), or other products containing guanfacine (e.g. TENDRIL®) should not take INTUNIV®.

WARNINGS AND PRECAUTIONS
Hypotension, Bradycardia, and Syncope
Treatment with INTUNIV® can cause decreases in blood pressure and heart rate. In the monotherapy, pediatric, short-term (3-9 weeks), controlled trials, the maximum mean change from baseline in systolic blood pressure, diastolic blood pressure, and heart rate were -15 mm Hg, -13 mm Hg, and -0.4 beats per minute, respectively, for all doses combined (generally one week after reaching target doses of 1 mg/day, 2 mg/day, 3 mg/day, or 4 mg/day). These changes were dose dependent. Decreases in blood pressure and heart rate were usually modest and asymptomatic; however, hypotension and bradycardia can occur. Hypotension was reported as an adverse event for 7% of the INTUNIV® group and 3% of the placebo group. The most common dose-related orthostatic hypotension, which was reported for 1% of the INTUNIV® group and none of the placebo group. In the adjunctive trial, hypotension (3%) and bradycardia (2%) were observed in patients treated with INTUNIV® as compared to none in the placebo group. In long-term, open-label studies, (mean exposure of approximately 10 months), maximum decreases in systolic and diastolic blood pressure occurred in the first month of therapy. Decreases were less pronounced over time. Syncope occurred in 1% of pediatric subjects in the clinical program. The majority of these cases occurred in the long-term, open-label studies. Measure heart rate and blood pressure prior to initiation of therapy, following dose increases, and periodically while on therapy. Use INTUNIV® with caution in patients with a history of hypotension, heart block, bradycardia, or cardiovascular disease, because it can decrease blood pressure and heart rate. Use caution in treating patients who have a history of syncope or may have a condition that predisposes them to syncope, such as hypotension, orthostatic hypotension, bradycardia, or dehydration. Use INTUNIV® with caution in patients treated concomitantly with antihypertensives or other drugs that can reduce blood pressure or heart rate or increase the risk of syncope. Advise patients to avoid becoming dehydrated or overheated.

Sedation and Somnolence
Sedation and somnolence were commonly reported adverse reactions in clinical studies (3% for INTUNIV® vs. 3% for placebo in monotherapy studies and 16% for INTUNIV® vs. 7.1% for placebo in the adjunctive study) in children and adolescents with ADHD, especially during initial use (see Adverse Reactions). Before using INTUNIV® with other centrally active depressants (such as phenothiazines, barbiturates, or benzodiazepines), consider the potential for additive sedative effects. Caution patients against operating heavy equipment or driving until they know how they respond to treatment with INTUNIV®. Advise patients to avoid use with alcohol.

Other Guanfacine-Containing Products
Guanfacine, the active ingredient in INTUNIV®, is also approved as an antihypertensive. Do not use INTUNIV® in patients concomitantly taking other guanfacine-containing products (e.g., Tenex).

ADVERSE REACTIONS
Monotherapy Trials
The most commonly observed adverse reactions (incidence ≥ 5% and at least twice the rate for placebo) in the monotherapy trials with INTUNIV® were: somnolence, fatigue, nausea, lethargy, and hypotension. Twelve percent (12%) of patients receiving INTUNIV® discontinued from the monotherapy clinical studies due to adverse events, compared to 4% in the placebo group. The most common adverse reactions leading to discontinuation of INTUNIV®-treated patients from the studies were somnolence/sedation (6%) and fatigue (5%). Less common adverse reactions leading to discontinuation (occurring in approximately 1% of patients) included: hypotension, headache, and diziness. Adjuvantative Trials
The most common adverse reactions (incidence ≥ 5% and at least twice the rate for placebo) in the adjunctive trials with INTUNIV® were: somnolence, fatigue, insomnia, dizziness, and abdominal pain. Three percent of patients receiving INTUNIV® discontinued from the adjunctive clinical study due to adverse events, compared to 1% in the placebo group.

Clinical Trial Experience
Short Term Monotherapy Clinical Studies
Common Adverse Reactions - Two short-term, placebo-controlled, double-blind pivotal trials (Studies 1 and 2) were conducted in children and adolescents with ADHD, using fixed doses of INTUNIV® (1 mg, 2 mg, 3 mg, and 4 mg/day). The most commonly reported adverse reactions (occurring in ≥2% of patients) that were considered drug-related and reported in a greater percentage of patients taking INTUNIV® compared to patients taking placebo were: somnolence, headache, fatigue, abdominal pain, hypotension, nausea, lethargy, dizziness, irritability, decreased appetite, dry mouth, and constipation.

Short Term Adjunctive Clinical Study
A 9-week, placebo-controlled, double-blind, dose-optimized pivotal study (Study 3) was conducted in children and adolescents aged 6-17 years with a diagnosis of ADHD who were identified as having a sub-optimal response to psychostimulants. Patients received INTUNIV® (1 mg, 2 mg, 3 mg, and 4 mg/day) or placebo, dosed in the morning or in the evening, in combination with their morning dose of psychostimulant. The most commonly reported adverse reactions (occurring in ≥2% of patients in the overall INTUNIV® group) that were reported in a greater percentage of patients taking INTUNIV® compared to patients taking placebo were: headache, somnolence, insomnia, fatigue, abdominal pain, decreased appetite, nausea, diaphoresis, hypertension, effect of liability, bradycardia, constipation, and dry mouth.

Effects on Height, Weight, and Body Mass Index (BMI)
Patients taking INTUNIV® demonstrated similar growth compared to normative data. Patients taking INTUNIV® had a mean increase in weight of 0.5 kg (1 lb) compared to those receiving placebo over a comparative treatment period. Patients receiving INTUNIV® for at least 12 months in open-label studies gained an average of 8 kg (17 lbs) in weight and 8 cm (2 in) in height. The height, weight, and BMI percentile remained stable in patients at 12 months in the long-term studies compared to when they began receiving INTUNIV®.

Laboratory Tests
In short- and long-term studies, no clinically important effects were identified on any laboratory parameters.

Effects on Heart Rate and QT Interval
The effect of two dose levels of immediate-release guanfacine (4 mg and 8 mg) on the QT interval was evaluated in a double-blind, randomized, placebo- and active-controlled, cross-over study in healthy adults. A dose-dependent decrease in heart rate was observed during the first 12 hours, at time of maximal concentrations. The mean change in heart rate was -13 bpm at 4 mg and -22 bpm at 8 mg. An apparent increase in mean QTc was observed for both doses. However, guanfacine does not appear to interfere with cardiac repolarization of the form associated with propafenone drugs. This finding has no known clinical relevance.

Other Adverse Reactions
Observed in Clinical Studies
Additional adverse reactions observed in short-, placebo-controlled and long-term, open-label clinical studies not included elsewhere in this section include: atrioventricular block, sinus arrhythmia, dyspnea, stomach discomfort, vomiting, asthma, chest pain, hypersensitivity, increased alanine aminotransferase, increased blood pressure, increased weight, convolution, postural dizziness, syncope, agitation, anxiety, depression, hypertension, nightmares, increased urinary frequency, urticaria, asthma, hypertension and pallor.

DRUG INTERACTIONS
CYP3A4/5 inhibitors Use caution when INTUNIV® is administered to patients taking ketoconazole and other strong CYP3A4/5 inhibitors, since elevation of plasma guanfacine concentration increases the risk of adverse events such as hypotension, bradycardia, and sedation.

CYP3A4 Inducers
When patients are taking INTUNIV® concomitantly with a CYP3A4 inducer, an increase in the dose of INTUNIV® within the recommended dose range may be considered.

Valepropic Acid
Co-administration of guanfacine and valproic acid can result in increased concentrations of valproic acid.

Antihypertensive Drugs
Use caution when INTUNIV® is administered concomitantly with antihypertensive drugs, due to the potential for additive pharmacodynamic effects (e.g., hypotension, syncope) [see Warnings and Precautions].

CNS Depressant Drugs
Caution should be exercised when INTUNIV® is administered concomitantly with CNS depressant drugs (e.g. alcohol, sedative/hypnotics, benzodiazepines, barbiturates, and antipsychotics) due to the potential for additive pharmacodynamic effects (e.g., sedation, somnolence) [see Warnings and Precautions].

USE IN SPECIFIC POPULATIONS
Pregnancy: Pregnancy Category C
There are no adequate and well-controlled studies of guanfacine in pregnant women. INTUNIV® should be used during pregnancy only if the potential benefit to the mother outweighs the potential risk to the fetus.

Nursing Mothers:
It is not known whether guanfacine is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when INTUNIV® is administered to a nursing woman.

Pediatric Use:
The safety and efficacy of INTUNIV® in pediatric patients less than 6 years of age have not been established. For children and adolescents 6 years and older, efficacy beyond 9 weeks and safety beyond 2 years of treatment have not been established.

Geriatric Use:
The safety and efficacy of INTUNIV® in geriatric patients have not been established.

Use in Patients with Renal or Hepatic Impairment:
Dose reduction may be required in patients with clinically significant impairment of renal or hepatic function.

OVERDOSAGE
Symptoms:
Two cases of accidental overdose of INTUNIV® were reported in clinical trials in pediatric ADHD patients. These reports included adverse reactions of sedation and bradycardia in one patient and somnolence and dizziness in the other patient. Post-marketing experience with guanfacine overdose indicate that, hypotension, drowsiness, lethargy, and bradycardia have been observed following overdose. Initial hypotension may develop early and may be followed by hypotension.

Treatment:
Consult a Certified Poison Control Center by calling 1-800-222-1222 for up to date guidance and advice.

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IN THE PSYCHOTROPICAL SUN

By Rajneesh Mahajan, M.D.

Lean limbs girdle his thin frame,
Oversized shirt and shorts,
Cover the body-vehicle,
Running on dopaminergic fuel,
Stimulants sustain;
A smile belies the bullied pupil,
Pupa – not yet imago,
Pupils letting in, the fluorescent haze of the
Windowless office with the pale clinical walls.
“Can I draw?” he asks, stammering.
“Sure, why not?” I reply,
As I take out crayons and paper;
Smile widens, face brightens,
Thin fingers start moving –
Transformer, Optimus Prime – strong, powerful,
Noble alien, a robot,
Only a hint though in the scrawny sketch,
As only a hint of what he could be – transformed,
Sunburned in the psychotropical sun,
An artist par excellence,
Or a bully with no pulpit,
A stray wanderer, astray in life’s windings;
“Am I good?” He asks.

Dr. Mahajan is a child and adolescent psychiatrist on the faculty of Kennedy Krieger Institute (KKI) and the Johns Hopkins University School of Medicine in Baltimore, Maryland. His area of focus is Autism Spectrum Disorders. He provides clinical care at KKI’s Center for Autism and Related Disorders and in the Psychiatry clinic.
THE AUDIENCE
By Chuck Joy, M.D.

1. it’s all about the audience
to whom we are speaking

in these pages, our newsletter
we address ourselves
us, members, child psychiatrists

a literate venue
specialized, subspecialized
perhaps destined to disappear
but isn’t everything in 2012?

2. anyone
intelligent enough
to fit words together
recognizes the neurobiological sureshot
is a good fit, to about thirty-four per cent
of a typical child psychiatry practice

as if
there were such a typical practice,
every child psychiatry practice
is unique but might we agree
we have certain skills
beyond pharmacotherapy?

3. let’s share our experiences
practicing these skills, honing them
reflecting upon them
in these pages
here, our News

less formal than the Journal
more private than in other venues
our website say, where we encourage parents
or a coffeehouse where all may enter

here, in this newsletter
for us, members, child psychiatrists
the audience

Individuals interested in submitting poetry should e-mail
Poetry Coordinator Charles Joy, M.D., at crjoy1@gmail.com.
When invited to write this Lifer’s column I relished the prospect of targeting gadgetry and check lists - the digitalization of medicine; and the fading of Donald Winnicott’s message: the need to “hold the family” so the family can “hold the child.” I was primed to lash out against the waning teaching of dynamic psychotherapy, the near elimination of adequate treatment stays in mental hospitals, and the trend for mentally ill behavioral problems of all ages to end up in jails.

But as I took a deep breath to start my outburst I realized that it would be totally unnecessary in the AACAP News; for the AACAP is both the major forum where all these issues are discussed, and an organization that mobilizes political and educational action to effectively address the problems. More to the point, it publishes Martin Drell, M.D.’s priceless psychotherapy notes.

So instead, I will summarize my professional history from age four onward and explain how the AACAP has been a gift in my life as I believe it is to a majority of its members.

My allegiance to medicine began at age four when I announced to an approving family that I chose “doctor” from the standard career list of “Tinker, tailor, soldier, sailor, doctor, lawyer, beggar man, thief.” Thus, I have been committed to medicine for 83 years. The origins of my commitments to psychiatry (65 years); to child psychiatry (55 years); and to the AACAP (44 years), will be noted below.

It took 17 years of waiting and three years in the United States Navy before I entered medical school. Our class was part of the national wave of veterans returning on the GI Bill. We were so glad to be back that we studied everything with enthusiasm and without complaint, loving it all, whether or not we understood it.

Five classmates and I got jobs as interns at the Northampton State Hospital in the break between our second and third years (1948). It was an intense immersion in the world of chronic psychiatric problems treated in a state hospital. I date my commitment to psychiatry to that summer. But the appeal of internal medicine remained through graduation and internship, and I delayed deciding so long to apply for a psychiatry residency that I was lucky to be accepted at the Boston Psychopathic Hospital (later called MMHC) in 1951. There my fascination with psychiatric illness was intensified by fabulous supervision opening up the world of developmental theory exploring the underpinnings of all that we deal with. There I became a disciple of Elvin Semrad.

In my third residency year, I was fortunate enough to persuade my wife to marry me and we went to London, where I had a clerkship in neurology at Queen Square and she worked at the Maudsley Hospital. We returned with our one month old son.

Following two years of running adult inpatient wards and supervising residents, I started my fellowship in child psychiatry with Gregory Rochlin, M.D., in 1956. He had just opened a ten beds, five-nights-per-week, locked ward for children up to age 13 years and I was put in charge. I directed it until 1973 when I was appointed director of the 60 bed, full-care Gaebler Children’s Unit (for children through age 15 years) at Metropolitan State Hospital. I became superintendent when Gaebler became a Department of Mental Health (DMH) State Hospital in its own right. I continued there until retirement from DMH in 1989. During those 33 years, I was responsible for the hospital care and treatment of hundreds of children from as young as four to the 16th birthday, with the full range of serious mental illnesses and concomitant behavioral problems, including juvenile murderers.

The 60 beds at Gaebler were the only public beds for children in Massachusetts and the pressure to gain admission was constant. The 16th birthday as the absolute age limit was essential because otherwise obligatory court referrals of 16-18 year olds would have wiped out beds for younger patients and longer term treatment.

One judge demanded that I admit an adolescent over the age limit. I had to refuse the demand in order to protect the hospital’s mission. He threatened to cite me for contempt and I might well have been jailed but for the intervention of the Commissioner and his legal counsel. When I stopped running the hospital, my extra systoles dropped from 22/minute to 0.

With this population I was an explorer in the “universe of Childhood Schizophrenia” – a pre-DSM-III comprehensive label that comprised dozens of competing diagnostic concepts – the most durable of which has been Autism. There were intense debates between proponents of different diagnostic theories, as well as about the role of psychotherapy.

Severe behavior problems – assaultive and self-destructive – were frequent. As with the great majority of psychiatric hospitals, pragmatic management required restraint – primarily locked seclusion. I was frequently called on to defend and explain the use of seclusion and restraint. I was also a member of the American Psychiatric Association (APA) task force on the subject. My general comment to critics was (and is) that they regard any restraint as abuse rather than...
recognizing that restraint (which includes hospitalization itself) may be properly used or may be abusively used.

I was always impressed with the deep level of caring and understanding the nursing staff, both at MMHC and Gaebler, had for all of the children, including those that were the most difficult, e.g., assaultive, spitting, and biting. The quality of reacting to the child with compassion allowed the need for restraint to lessen. It was common for children to come to trusted staff when they felt they were near losing control and ask to be put in a room, even to have it locked, to help them maintain control. Virginia Merritt (2011) wrote of the staff’s closeness years later:

“They still meet once a year, the people from that hospital, now a ghostly place, the driveway chained, tall grass filling in the paths to the picnic grounds where the kids went in the spring. A social worker told me, and it’s been 10 years or more now, ‘I would still trust me life to any of those people I worked there with’.”

In 1967, the greatest surprise and gift of my professional life appeared: the invitation to Fellowship in the Academy of Child Psychiatry. I had thought it was a pantheon of professors; not an organization that a journeyman in the field would aspire to. I reveled in this inexplicable honor, which came as Lawrence Stone, M.D., a friend and colleague in Boston, was leading a group negotiating with Sidney Berman, M.D., president of the Academy, to open up the Academy to membership by application. At my second meeting George Gardner, M.D., (a founder of the Academy) was sitting next to me while Dr. Berman was arguing for opening up. He whispered in my ear, “Some of these old fogeys want to keep the Academy as a private club.” I remained quiet. But the historic change became a second birth for the field.

Membership in the Academy makes me feel more a part of the profession than does my Child Boards Diploma. At meetings, we are colleagues with both leaders and peers. It is like being in a continuing residency, a true place of learning and sharing. Gordon Harper, M.D., and I for years chaired lively meetings of children’s ward directors throughout the country. The commonality of our problems (such as conflicts about restraints) and similarity of our admiration for our ward personnel nourished our morale.

One of the major impediments to productive discussion about conflictual issues in the field is orthodoxy or dogmatic beliefs. I offer the following aphorism: Truth is the fragile child of skepticism, Dogma the brutal spawn of certainty (Gair 1988).

Dogma and orthodoxy are not the way of the Academy. Its only orthodoxy is commitment to the collaborative and ethical pursuit and exchange of knowledge helpful to children, adolescents, and their families in their development and in their disorders.

The Academy holds the field, its members, its patients, and its allies in a Winnicottian embrace. This Lifer is content that child and adolescent psychiatry is in good hands. ■

References


Dr. Gair has reached the age of aphorisms and is professor emeritus of Psychiatry at Boston University School of Medicine. He was the third chair of the Assembly of Regional Organizations of Child/Adolescent Psychiatry of the Academy and served, with Norbert Enzer, M.D., Robert Stubblefield, M.D., Elissa Benedek, M.D., and Tom Haizlip, M.D., on the committee that produced the Academy’s Code of Ethics (~1981). He received the 2005 APA’s Agnes Purcell McGavin Award for Distinguished Career Achievement in Child and Adolescent Psychiatry. Dr. Gair can be reached at gair33@verizon.net.
Reflections on a Visit to Tokyo (It’s a Small World, After All)

Leoneen Woodard-Faust, M.D.

“Y”ou should go to Tokyo Disneyland,” I remembered my sister advised. However, for me, the invitation to do “Rounds” with my husband’s friend, Yasuo Aihara, M.D., Ph.D., the only pediatric neurosurgeon at Tokyo Women’s Medical University (so named because it was founded to train only women physicians) clearly trumped our plans to visit with Mickey and Minnie.

My husband and I entered the hospital and confidently approached the Information Desk, following the signs in Japanese and English. As we waited for Dr. Aihara, I looked around the room and studied people’s faces for signs of their feelings. I found none. “Constricted affect,” I assessed. No sign that they were a nation in mourning or that they were dealing with illness; their own or a loved one. Unlike the people’s faces and atmosphere of the hospitals in Chicago where I work, there was a sense of calm here. However, as I thought about it, in this city of thirteen million people, there was a general sense of calm that one would not expect, especially given the circumstances.

Being in Tokyo post-disaster was fascinating and somewhat overwhelming, and I considered the convergence of events that had led to my visit today. My son, an Asian Language and Biology major at Amherst College, had planned to go to Sophia University in Tokyo for a semester abroad the spring of his junior year. On March 11, 2011, two weeks before he was to leave, the earthquake and tsunami occurred, and the nuclear reactor problems ensued. Initially, the program was put on hold, but then the decision was made to continue as scheduled. Never having been to Japan, I had insisted that my husband and I plan our vacation around visiting our son and touring Tokyo (ignoring his snipes about “helicopter parents”) and we had booked our trip back in January.

While in Chicago for a fellowship eight years ago, Dr. Aihara became tennis buddies with my husband, and they have kept in touch. My many questions about his work during dinner after our arrival in Tokyo resulted in his invitation to visit the hospital.

My thoughts were interrupted as Dr. Aihara hurried over to greet us. We exchanged hellos, and he took us through the medical center and up to his unit. In contrast to the lack of emotion that I felt downstairs, the patients and mothers on the unit were smiling and engaging. Dr. Aihara had told them he was bringing a child and adolescent psychiatrist from Chicago to visit and they greeted us with reverence and enthusiasm.

“No HIPAA here?” I wondered, as we were ushered into the rooms of a half-dozen boys and girls with neurofibromatosis, tumors, and moyamoya disease who had undergone various neurosurgical procedures over the past days to months.

Dr. Aihara handed the first patient a Rubik’s Cube and told him to solve it, as he explained that the boy had undergone a resection of an astrocytoma a few weeks prior and was now receiving chemotherapy. The boy had experienced some speech problems and motor deficits on his right side, but was improving and could solve the Rubik’s Cube in two minutes. This was one of Dr. Aihara’s ways of tracking patients’ motor and cognitive functions. We watched in awe as the boy worked the puzzle with lightning speed and accurately matched all of the colors.

Dr. Aihara explained that Japan’s social insurance system enables his patients to stay in the hospital days to months through their course of medical treatment. However, while they have physical therapy to help with recovery of motor functions post-surgery, there is no Consultation-Liaison team from psychiatry to address emotional adjustment to the patient’s illness and treatment issues. Currently, at his hospital, there is no neuropsychological testing available to evaluate patients’ cognitive functioning; no educational services to help them keep up with their schoolwork while they are hospitalized; no protocol for helping with family issues and to provide support to parents. In fact, there is no child psychiatry at the hospital. The developmental and psycho-social needs of the patients are basically not...
recognized as important. They are not considered within the context of the medical necessities of the patients: except by Dr. Aihara.

Many patients are “fixed” surgically, then discharged home, leaving one parent to remark, “Dr. Aihara, you saved my child, but he’s not so good.” Dr. Aihara says there is no acknowledgement that the patients, parents, and families often need emotional support and psychiatric treatment. He translated for a mother, who recounted how she became very depressed, and felt scared and hopeless when first told her child had a brain tumor and needed surgery. Although she was doing better as her daughter was improving after surgery, she wondered how mothers like her are helped in the United States. I responded that we have a team of doctors and others who work hard to help the child and the parents deal with feelings related to the child’s illness. Unable to offer the same, Dr. Aihara hesitated before translating, and said half-jokingly that he might not want to tell her that.

The level of care and concern for each of his patients is evident, and it is touching to watch Dr. Aihara in action. He affectionately scoops up one little girl from her wheelchair and gives her a hug, as her mother watches with amusement and admiration. A little boy stands in his bed at attention and meets Dr. Aihara and us with a disciplined greeting, and a grin. Dr. Aihara states the boy is learning English and teasingly orders him to count to ten in English. The boy happily complies. We applaud along with his mother at the end.

He knows their story, he knows their brains, and he pretty much knows their future. For the young college student with a brainstem glioma that went undiagnosed for several years until he found his way to Dr. Aihara, who removed as much as he could, the future is grim. But, even in his semi-comatose state, the teen makes great effort to respond with respect.

When the little girl with moyamoya disease asked, “What kind of doctor are you?” we described to her that I am a “feelings doctor,” which seemed to satisfy her. She then turned to my husband and asked, “What kind of doctor are you?” Dr. Aihara chucked as he translated, and he told her that my husband is in business. The product of a thirty-year relationship with a child and adolescent psychiatrist, my husband responded to us, “Poor dear, she thinks everyone that she meets now must be a doctor.” Dr. Aihara paused, as did I, as we appreciated the profoundness of his observation. “Yes. Exactly,” said Dr. Aihara.

The compassion and hope for a future for all of these children is evident in Dr. Aihara. As lucky as unlucky children can be, they are fortunate to have the benefit of the unbelievable skills of this brilliant, talented, and charismatic neurosurgeon. But the trauma and sadness of their experiences was not lost as we appreciated Dr. Aihara’s work. He feels for these children and their parents, and he wants to treat them as a whole. The response and obvious approval that I received from the mothers on the unit made me feel that they, and mothers like them, will advocate for additional services that address the mental health needs of their children and families. Dr. Aihara has already recruited a nurse and a psychologist, and is working to develop a team to help him toward that goal. Their appreciation of a few minutes of discussion about my experiences with pediatric consultation-liaison was inspiring, and left me wondering about the possibilities of a cross-pacific collaboration.

On our way off the unit, Dr. Aihara pointed to several windows that were cracked. “That’s from the earthquake,” he told us. I saw just a trace of the memories from that day in his face, and I thought “PTSD” as he described the earthquake, the fear (but not panic), and the calm evacuation of all of the children from the building to a newer and safer part of the hospital complex.

As he walked with us to catch a taxi, Dr. Aihara bowed and said, “It was an honor for you to visit us here. Thank you for coming.” “Are you kidding,” I thought, but responded, “I am honored that you allowed me to come. This was a privilege and an unbelievable experience that I will always remember. Arigato gozaimasu.”

My husband and I got into the taxi and neither of us spoke for a few minutes. How to describe what I had seen; the importance of what Dr. Aihara is doing? “He’s a rock star!” I blurted. My husband knew what I was trying to say, and replied, “Yeah. He is.”

Sorry, Sis. This was way better than Disneyland.

Dr. Woodard-Faust is a clinical associate in the child and adolescent section of the Department of Psychiatry and Behavioral Neurosciences at the University of Chicago. She is also the medical director of the Child and Adolescent Program in the Mental Health Center at Mercy Hospital and Medical Center in Chicago, Illinois. She may be reached at lwoodard@yodabsd.uchicago.edu.
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Challenges and Opportunities in ADHD: A Conversation with the Experts

SPEAKERS INCLUDE:

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Columbia University
New York, NY

Howard B. Abikoff, Ph.D.
NYU Langone Medical Center
New York, NY

Gabrielle A. Carlson, M.D.
Stony Brook University
School of Medicine
Stony Brook, NY

James J. McGough, M.D.
University of California, Los Angeles
Los Angeles, CA

Timothy E. Wilens, M.D.
Harvard Medical School
Boston, MA

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Membership CORNER

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<td><strong>To Progress.</strong> Utilize awards and grants to support research, training, and to foster the professional development of early career psychiatrists.</td>
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Log on to [www.aacap.org](http://www.aacap.org) for more information and frequently asked questions about this new feature.

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

- Denis M. Donovan, M.D., Treasure Island, Florida
- Robert Harmick, M.D., Springs, New York
- Subhash Inamdar, M.D., New York, New York
- Steven Shulruff, M.D., Johnson City, Tennessee

In Memoriam

**Herbert S. Sacks, M.D.**, President of the American Psychiatric Association (1997-1998) and a renowned clinical professor of child and adolescent psychiatry at Yale School of Medicine, died on August 30, 2011, in New Haven, Connecticut. He was 84 years old.

**Ulrich “Uli” Schoette, M.D.**, a staunch advocate for child psychiatry, worked on both the state and federal level on issues such as workforce, parity and most recently, led the charge against psychologists prescribing medication. He was a key player on the Work Group on Quality Issues, was shepherd to numerous Practice Parameters, and served as the liaison with Maintenance of Certification coordinating module topics and parameter development. In addition to all of that he was a fixture on the Washington State Assembly, having served as delegate for over a decade.
Welcome New AACAP Members

Patricia M. Abbott, M.D., Newton, MA
Joshua R. Ackerman, M.D., New York, NY
Manish Aggarwal, M.D., Strongsville, OH
Arpit Aggarwal, M.D., Columbus, MO
Efosa Airehui, M.D., Columbia, MO
Oyindamola Ajibade-Akonai, M.D., Coralville, IA
Ashley Jade Albarado, M.D., New Orleans, LA
Joseph Alimasuya, M.D., Fresno, CA
Firuzali Aliev, M.D., Chicago, IL
Nanette Allison, M.D., Fort Worth, TX
Nicole Almeida, M.D., Miami, FL
Dinara Amanbekova, M.D., New York, NY
Robert A. Anderson, M.D., Palmyra, PA
Erin Anderson, M.D., Minneapolis, MN
Jitendra Reddy Annapareddy, M.D., Hershey, PA
Emily Aron, M.D., New York, NY
Gurvinder Arora, M.D., Newark, NJ
Rania Attia, M.D., New York, NY
Amna Aziz, Lubbock, TX
Melanie Baca, Albuquerque, NM
Cynthia Basiz, M.D., Saint Louis, MO
Smitha Battula, M.D., Olathe, KS
Estela A. Beale, M.D., Southampton, NY
Aniruddh Behere, M.D., Springfield, IL
Aaron Besterman, Valhalla, NY
Melissa Blessing, Flagstaff, AZ
Elizabeth Botts, M.D., Saint Louis, MO
Brady Bradshaw, M.D., Kansas City, MO
Kjersti Braunstein, M.D., Flushing, NY
Kristie Boyce, M.D., Atlanta, GA
Ahmar Butt, M.D., Buffalo, NY
Crystal Bullard, M.D., Lexington, SC
Ahmar Butt, M.D., Flushing, NY
Christine Carrejo, M.D., Johnson City, TN
Anthony Cavalieri, M.D., Ann Arbor, MI
Monica Cavanagh, M.D., Saskatoon, SK, Canada
Lill Chamorro, M.D., Syracuse, NY
Prakash Chandra, M.D., Kansas City, MO
Michelle Chaney, Gainesville, FL
Rebecca Chauhan, M.D., Ancaster, ON, Canada
Jatinder Chawla, M.D., New York, NY
Jeffrey Chen, M.D., Atlanta, GA
Steve Chennankara, D.O., Mesquite, TX
Pascale Chrisphonte, M.D., New Haven, CT
Weiming Chu, M.D., Orange, CA
Peter Clark, M.D., Buffalo, NY
Adrienne Cropey, M.D., Candler, NC
Megan Crochet, M.D., New York, NY
Tracy Das, M.D., Peachtree City, GA
Kelly Davidson, M.D., Pittsburgh, PA
Crystal De Weese, M.D., Sherwood, AR
Margaret Dejong, M.D., London, United Kingdom
Anthony Joseph Deo, Ph.D., Pittsburgh, PA
Namita Dhiman, M.D., Omaha, NE
Andrea Diaz-Stransky, Nuevo Leon, Mexico
John J. DiAllo, Jr., M.D., Dobbs Ferry, NY
An Dinh, Ozone Park, NY
Louis Doan, Coppell, TX
Jennifer Downs, M.D., Providence, RI
Henry P. Driscoll, M.D., Pittsburgh, PA
Thomas Driscoll, Jr., West Orange, NJ
Neeta S. Duggal, Kansas City, MO
Stacy Eagle, M.D., New York, NY
Zhuanna Elberg, M.D., Amherst, NY
Paul Elizondo, III, San Francisco, CA
Jeremy Ernst, Sacramento, CA
Saeed Esraghi, M.D., Wilmington, DE
Devon Fagel, Redding, CT
Lance Feldman, M.D., Hummelstown, PA
Cheryl Ferero, M.D., St. Maarten, Netherlands
Tara-Willow Ferren, M.D., Winston Salem, NC
Vicente Figueroa, M.D., Rockville, MD
Juliana Finelli, New Orleans, LA
Jennifer Fischer, M.D., Richmond, VA
Joshua Fitzgerald, Las Vegas, NV
Carl Fleisher, M.D., Los Angeles, CA
Joan M. Flood, M.D., Toronto, ON, Canada
Kathryn Fort, M.D., Baltimore, MD
Jessica Fuhr, Simsbury, CT
Tamer M. Gaber, M.D., Morgantown, WV
Mary T. Gabriel, M.D., Shaker Heights, OH
Amber Gaither, Atlanta, GA
Zindadi Gandhi, M.D., Cherry Hill, NJ
Sherry Gergis, M.D., Manvel, TX
Bardia Gholami, M.D., Ann Arbor, MI
Jenee’ Gibson, M.D., Greenville, NC
Elizabeth Gilbert, Providence, RI
Aramdeep Gill, M.D., Morgantown, WV
Ingrid Gindin, M.D., Pittsburgh, PA
Shanti Lila Gooden, M.D., New York City, NY
Monika Goyal, M.D., Columbia, MO
Sharon Grundland, M.D., Greenwich, CT
Wei Guan, M.D., Roanoke, VA
Swapnil Gupta, M.D., Brooklyn, NY
Nidhi Gupta, M.D., Hummelstown, PA
Aida Hadziahmetovic, M.D., Phoenix, AZ
Brian Haigh, M.D., Broomfield, CO
Cliff Hamilton, M.D., New York, NY
Jennifer Hardwick, M.D., Springfield, IL
Bahar Hashemi, M.D., San Francisco, CA
Kathleen Hecksel, M.D., Minneapolis, MN
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Ingrid Hernandez, M.D., Webster, NY
Aisha Hines, D.O., Wichita, KS
Rachel Anya Hnatowich, M.D., Boston, MA
Pamela Hoffman, M.D., Glen Oaks, NY
Jordan Howard, Fresno, CA
Austin Hu, Dallas, TX
Kurt Humphrey, M.D., Denver, CO
Nga Thu Huynh, M.D., Shreveport, LA
Michael Hwang, M.D., New Orleans, LA
Roya Ijabi-Maghsoodi, M.D., Los Angeles, CA
Leanna Isserlin, M.D., London, ON, Canada
Sabeen Javaid, M.D., Ridgeland, MS
Aaron Jeckell, Tampa, FL
Shama Halvarshahgan, M.D., Omaha, NE
Jay D. Johnson, D.O., Anchorage, AK
Jeanne Johnson, M.D., Portland, OR
Gwendolyn Jones, M.D., Honolulu, HI
Lourens J. Kalverdijk, M.D., Grolloo, Netherlands
Sangeetha Kandan, New Orleans, LA
Peter Kang, M.D., Cape Elizabeth, ME
Faresh Kanga, M.D., Lexington, KY
Arun Kantamneni, M.D., Buffalo Grove, IL
Muhammad Kashi, MBBS, Surrey, BC, Canada
Emilia Kaufman, M.D., Westwood Hills, KS
Moira Kessler, M.D., Chicago, IL
Andrew R. Keyes, M.D., San Diego, CA
Joelle Kezarian, M.D., Chicago, IL
Zishan Khan, M.D., Wichita, KS
Shabana Khan, M.D., Pittsburgh, PA
Farah Khan, M.D., Edison, NJ
Manpreet Khemka, M.D., Ridgeland, MS
David Kim, M.D., W Hartford, CT
Ah Young Kim, M.D., Buffalo, NY
Eugene Kinn, M.D., Los Angeles, CA
Jennifer King, M.D., Menomonee Falls, WI
Shawn Kohler, Urbana, IL
Antigone Kostas, M.D., Buffalo, NY
Gaurav Kulkarni, M.D., Columbia, MO
Jacquelyn LaGrone, M.D., Dallas, TX
Jody Langford, M.D., Milwaukee, WI
Tonya Lawrence, M.D., Elkins Park, PA
Sophia Le, D.O., Fresno, CA

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New Members (continued from page 329)

Benjamin Lederer, M.D., Providence, RI
Lloyd Lee, D.O., Torrance, CA
Ruby Lee, M.D., Providence, RI
Jessica J. Lee, M.D., Brooklyn, NY
Joshua Leo, M.D., Boston, MA
Stephanie Lichtor, M.D., Providence, RI
Morgan Liddell, Hershey, PA
Cindy Lim, M.D., San Diego, CA
Joseph Llinas, M.D., Birmingham, AL
Raj Loungani, West Palm Beach, FL
Roy Lubit, M.D., New York, NY
Nicholas Lynch, M.D., Brooklyn, NY
Susan Mackenzie, M.D., Toronto, ON, Canada
Sharon Maddock, M.D., New York, NY
Huma Mahmood, D.O., Philadelphia, PA
Nasuh Malas, M.D., Pittsburgh, PA
Kaaya Malhotra, D.O., Philadelphia, PA
Natalie March, M.D., East Hartford, CT
Tatiana Maric, M.D., Huntington, NY
Elliott Martin, M.D., North Haven, CT
Lady Martinez, M.D., Charlottesville, VA
Maria Master, M.D., Hoboken, NJ
Jill McCaill, Metairie, LA
Molly McCarthy, D.O., Nashville, TN
Dawn McCartney, M.D., Winchester, MB, Canada
Cristin McDermott, Farmington, CT
Caitlin McKeever, M.D., Toronto, ON, Canada
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Tracy McNamara, Akron, OH
Jonathan Thomas Megerian, M.D., Ph.D., Littleton, MA
Mira A. Merker, M.D., Denver, CO
Isabella Michna, M.D., Saint Louis, MO
Dale Miller, M.D., Tampa, FL
Sohyou Min, M.D., Oakville, ON, Canada
Paul Mitran, M.D., Rego Park, NY
Adebowale Motifoya, M.D., Burlington, VT
Kimberly Mollot, M.D., Milton, ON, Canada
Hermann A. Moreno, M.D., Laramie, WY
Manasa Musunuri, M.D., Staten Island, NY
Meredith Naidorf, M.D., New Haven, CT
Maya Nair, Atlanta, GA
Bushra Naz, M.D., Albany, NY
Sarah Neely, M.D., Atlanta, GA
Marina Nesterenko, M.D., New Hartford, NY
Tan Ngo, M.D., Portland, OR
Saadia Nosheen, M.D., Ann Arbor, MI
Kiyoko Ogake, M.D., Bronx, NY
Brenda Ojeda Arce, M.D., San Juan, PR
Kristine Olivier, M.D., New Orleans, LA
Judith Outt, M.D., Phoenix, AZ
Stephen Pannel, M.D., Birmingham, AL
Anusheer Parashar, M.D., Royal Oak, MI
Hy Gia Park, M.D., Fulton, CO
Charlene Patenaude, M.D., Amherst, MA
Anne Penner, M.D., Pittsburgh, PA
Erlan Perdoxck, D.O., Iowa City, IA
Brian Pham, M.D., Los Angeles, CA
Tammi-Marie Phillip, New Haven, CT
Blake Andrew Phillips, M.D., Nashville, TN
Justyna Piasecka, M.D., New Haven, CT
Usha Pirzani, M.D., Buffalo, NY
Priti Purushothaman, M.D., Cleveland, OH
Adeel Rahbani, M.D., M.P.H., Mobile, AL
Rahim Rahemtulla, M.D., Philadelphia, PA
Anjela K. Ramirova, M.D., Roanoke, VA
Dhanrendran Ramar, M.D., Omaha, NE
Onelia Ramirez-Cook, M.D., Teaneck, NJ
Sonal Rana, M.D., Santa Monica, CA
Abner Rayapati, M.D., Lexington, KY
Jagan S. Reddy, M.D., Arlington, TX
Alison Reed, Hershey, PA
Katherine Revoredo, M.D., Los Angeles, CA
Maria Pia Rognes Velo, M.D., Ph.D., West Newton, MA
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Diana Sabagh, M.D., Milford, CT
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Mariana Schmajuk, Corona Del Mar, CA
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Norman E. Segal, M.D., Arlington Heights, IL
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Snehal Shah, M.D., Hartford, CT
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Ayesha Silman, M.D., Louisville, KY
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Shih Tan, New Orleans, LA
Haiwang Tang, M.D., Edmond, OK
Patrick Tapia, M.D., Birmingham, AL
Pradeep Tatagari, M.D., New Berlin, WI
Cortney Taylor, Vancouver, WA
Jerome Taylor, Jr., M.D., New Haven, CT
Shannon Terkell, M.D., Glen Oaks, NY
Melinda Thiam, M.D., Fairfax, VA
Tanya Thomas, M.D., Warwick, RI
Megan Thompson, D.O., New Orleans, LA
Lesia M. Trickett, San Antonio, TX
Terri Turner, M.D., Philadelphia, PA
Shuja Uddin, M.D., Syracuse, NY
Dan Udrea, M.D., Pittsburgh, PA
Michelle A. Venantius, M.D., Ancaster, ON, Canada
Rekha Vijayan, M.D., Omaha, NE
Lan Chi Le Vo, Keller, TX
Ngoc Tran Vo, M.D., Anaheim Hills, CA
Christoph V. Von Andreea, M.D., Wynnewood, PA
Charles J. Von Rose, D.O., Temple, TX
Anupama Wadhwa, M.D., Chicago, IL
Shannon Wagner, M.D., M.P.H., Chicago, IL
Oshrit Wano, M.D., Toronto, ON, Canada
Ashaki Warren, Atlanta, GA
Joshua Wilson, Houston, TX
Frederic Wilson, M.D., Austin, TX
Victoria Winkeller, M.D., Pittsburgh, PA
Dirk Winter, M.D., New York, NY
Daniel Witter, Gainesville, FL
Lilian Wong, M.D., Salem, VA
Benjamin D. Wood, M.D., Yarmouth, ME
Matthew Wright, M.D., New Haven, CT
Qun Wu, M.D., Chicago, IL
Arundithi Xantus, M.D., Miami, FL
John Zaharopoulos, III, D.O., Mesa, AZ
Daniel Zak, Jr., D.O., Brighton, MI
Elizabeth Zaleski, M.D., Los Angeles, CA
Hanna Zembrzuska, M.D., Silver Spring, MD
Janet Zock, M.D., Houston, TX
Catchers in the Rye Award to a Committee

Life Members Subcommittee
Under the leadership of John Schowalter, M.D., the Life Members Subcommittee develops initiatives for Life Members to support a variety of programs to support younger child and adolescent psychiatrists during the beginning of their careers. Since 2009, the Life Members Fund raised over $60,000 in donations from Life Members and relies on these funds to run many of its activities including, in 2011, funding 8 resident travel awards and 7 medical students travel awards to the Annual Meeting.

Catchers in the Rye Award to an Individual

Simon Davidson, M.D.
Dr. Davidson is currently the Regional Chief of the Specialized Psychiatric and Mental Health Services for Children and Youth (Children’s Hospital of Eastern Ontario (CHEO)/Royal Ottawa Mental Health Centre (ROMHC)), Medical Director of the Mental Health Patient Service Unit at CHEO and Chief Strategic Planning Executive of the Ontario Centre of Excellence for Child and Youth Mental Health. He is a Professor in the Department of Psychiatry at the University of Ottawa, where he is also Chairman of the Division of Child and Adolescent Psychiatry. Dr. Davidson is the Chair of the Child and Youth Advisory Committee for the Mental Health Commission of Canada and former president of the Canadian Academy of Child & Adolescent Psychiatry (CACAP).

Catchers in the Rye Award to a Regional Organization

New Jersey Council of Child and Adolescent Psychiatry
The New Jersey Council of Child and Adolescent Psychiatry (NJCCAP) was established in September 1972 by a group of child and adolescent psychiatrists with the avowed support of maintaining a liaison with AACAP. Since 2009, NJCCAP has taken the lead in organizing an annual forum on children’s health, which brings together health care providers, parent advocates, and policymakers committed to addressing access to care issues for children in New Jersey with mental health needs. NJCCAP’s commitment to advocating for children with mental illness has served as a catalyst in improving children’s mental health care at the state level.

Submissions to AACAP News
All AACAP members are encouraged to submit articles, announcements, poems, cartoons, photographs, and drawings to the News. Especially encouraged are short news worthy pieces of 250 words or less; i.e., Kudos (highlighting member achievements), Committee and ROCAP activities, and Letters to the Editor.

If you are interested in writing an Opinion piece or a column for forensics, ethics, youth culture, or diversity and culture, we will put you in touch with the appropriate column coordinator. E-mail your request to pjutz@aacap.org.

The “Instructions for Authors” is available online at www.aacap.org/galleries/default-file/instructions_for_authors_201110.pdf.
Amendments to the AACAP Bylaws – PASSED!

In a voting period that launched on August 8, and ended August 31, AACAP members voted to approve amendments to the AACAP Bylaws. The vote resulted in 94 percent of voters electing “Yes” to approve all amendments far surpassing the two-thirds majority needed to pass a vote. Nearly 20 percent of all eligible voters returned ballots with the majority of those submitted online.

The result to pass the amendments followed AACAP Council’s recommendations to approve all changes to the Bylaws (both major and minor). The major changes to the Bylaws include:

**Article II – Purposes**
- Add the AACAP Mission Statement to Article II.

**Article III – Membership**
- Add two new categories of Trainee Members—Triple Board Trainee members and Post-Pediatric Portal Program Trainee members.

**Article VIII – Assembly of Regional Organizations**
- Require all members of Regional Organizations to also be members of AACAP (i.e., eliminate a previous “grandfather clause” for members prior to January 1, 1991).
- Change the status of Life Members to Distinguished Life Members.
- Change the status of Life Fellows to Distinguished Life Fellows.
- Add a new status titled “Retired” status.

**Article XI – Website**
- Add a new Article XI describing the Academy’s website and the Website Editorial Board.

For more information on AACAP Bylaws, the recent Bylaws vote, or other AACAP projects and programs, please contact the AACAP Communications Department at communications@aacap.org or 202-966-7300 ext.: #154.

Call for Papers

The 2012 AACAP Annual Meeting takes place October 23-28, 2012, at the Hilton San Francisco Union Square in San Francisco, California. Abstract proposals are prerequisites for acceptance of any presentation. Topics may include any aspect of child and adolescent psychiatry: clinical treatment, research, training, development, service delivery, or administration.

Abstract proposals must be received at AACAP by Wednesday, February 15, 2012, or by Friday, June 15, 2012 for (late) New Research Posters. The online Call for Papers submission form will be available on www.aacap.org starting in December 2011, and all submissions must be made online. Questions? Contact AACAP’s Meetings Department at 202.966.7300, ext. 2006 or meetings@aacap.org.
Call for Exhibitors!

Reserve your space now to exhibit at each of AACAP’s four annual Institutes.

We offer tabletop exhibits that are placed in high-traffic areas, providing exhibitors with the greatest opportunity to meet attendees and to allow exhibitors the chance to connect with specific demographics within the child and adolescent psychiatry community. The vast majority of our attendees are practicing physicians. Exhibit opportunities are below:

2012
Psychopharmacology Update Institute
Child and Adolescent Psychopharmacology: Integrating Current Data into Clinical Practice

Co-Chairs: Laurence L. Greenhill, M.D., and Barbara Coffey, M.D.

January 20-21, 2012
Sheraton New York Hotel and Towers
New York, NY

Expected Attendance: 400

Douglas B. Hansen, M.D.
37th Annual Review Course in Child and Adolescent Psychiatry and Training Session for the Oral Exams

Chair: Boris Birmaher, M.D.
March 21-24, 2012
Westin Convention Center
Pittsburgh, PA

Expected Attendance: 200

Lifelong Learning Institute: Clinical Practice Update and Lifelong Learning Module 8: Modalities of Non-Pharmacological Treatments and Relevant Updates for Child and Adolescent Psychiatrists

Co-Chairs: Sandra B. Sexson, M.D., and Andrew T. Russell, M.D.
February 10-11, 2012
Omni San Diego Hotel
San Diego, CA

Expected Attendance: 125-150

59th Annual Meeting
The Exhibitor Prospectus for our 59th Annual Meeting, October 23-28, 2012, at the Hilton San Francisco, San Francisco, CA, will be mailed in May 2012. Please contact exhibits@aacap.org to be added to the mailing list.

For more information, please visit, http://www.aacap.org/cs/exhibit_and_sponsorship_opportunities or contact:

Lauren Kokernak
AACAP Meetings and Exhibits Manager
Phone: 202.966.7300, ext. 104
Fax: 202.966.5894
E-mail: exhibits@aacap.org

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Upcoming Events

November 18-20, 2011
International Federation of Families
Washington, DC
www.ffcmh.org

January 20-21, 2012
AACAP Psychopharmacology Update Institute
New York, NY
www.aacap.org

February 10-12, 2012
AACAP Lifelong Learning Institute
San Diego, CA
www.aacap.org

February 19-23, 2012
American College of Psychiatrists Annual Meeting
Grand Hyatt
San Antonio, TX

March 21-24, 2012
AACAP Douglas B. Hansen, M.D. 37th Annual Review Course in Child and Adolescent Psychiatry and Training Session for the Oral Exams
Pittsburgh, PA
www.aacap.org

April 2-6, 2012 (choice of day)
ABPN MOC In Child and Adolescent Psychiatry
www.abpn.com

May 5-9, 2012
American Psychiatric Association Annual Meeting
Philadelphia, PA
www.psych.org

May 11, 2012
AACAP Advocacy Day
Washington, DC
www.aacap.org

May 15-18, 2012
17th International APPAC Conference (Association of Psychology and Psychiatry for Adults and Children)
Athens, Greece
congress@appac.gr
www.appac.gr

July 21-25, 2012
IACAPAP World Congress
Paris, France
www.iacapap.org

July 25-August 1, 2012
AACAP Paris River Cruise
www.aacap.org

October 23-28, 2012
59th AACAP Annual Meeting
Hilton San Francisco Union Square
San Francisco, CA
www.aacap.org

November 2-3, 2012
1st Asian Congress on ADHD
Seoul, Korea
www.2012adhdseoul.org

November 2-4, 2012
ABPN Part II (Oral) Examination
In Child and Adolescent Psychiatry
San Antonio, TX
www.abpn.com

November 9-11, 2012
ABPN Part II (Oral) Examination
In Child and Adolescent Psychiatry
Houston, TX
www.abpn.com

April 15-19, 2013 (choice of day)
ABPN MOC In Child and Adolescent Psychiatry
www.abpn.com

October 22-27, 2013
60th AACAP Annual Meeting
Walt Disney World
Dolphin Hotel
Orlando, FL
www.aacap.org
FOR YOUR INFORMATION

Thank You for Supporting AACAP

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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Every effort was made to list names correctly. If you find an error, please accept our apologies and contact Hanna Smith at 202.966.7300, ext. 130 or hsmith@aacap.org.

AACAP’s Newest Lifelong Learning Module Now Available

The AACAP is proud to announce the release of Lifelong Learning Module 8: Modalities of Non-Pharmacological Treatments and Updates on Relevant Topics for Child and Adolescent Psychiatrists. With the purchase of this module you will have the opportunity to earn 30 AMA PRA Category 1 Credits™ toward your lifelong learning and self-assessment activity requirements.

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- Call 202.966.7300 ext. 139 to place your order over the phone.

For questions on Module 8 or maintenance of certification, please contact Quentin Bernhard III, CME Coordinator, at 202.966.7300 ext. 139 or at qbernhard@aacap.org.

Order Module 8 when you pay your 2012 membership dues by January 31, 2012, and save 50% off the cover price (a $100 savings). Orders received after this date will not qualify for this promotion. Please indicate this selection on your dues notice.
AACAP Donor Spotlight: Why I Give

Jack McDermott, M.D., is professor and chair emeritus, Department of Psychiatry, University of Hawaii School of Medicine. Currently a member of the Life Members Subcommittee, he is a former editor of the Journal of the American Academy of Child and Adolescent Psychiatry.

What motivates you as a philanthropist?

I think what motivates me is the wish to give back some of what I’ve gotten in my life from the communities I live in. Take the larger community, for example. I support the arts in the community I live in because of what it gives to us—and it can’t exist without contributions. Next, at a more personal level, I feel an obligation to give back to the communities that have helped me develop professionally.

What was the most important factor in your decision to donate to AACAP? And specifically to the Life Members Fund?

Our professional community is important because that is where we receive our ongoing education and support. I tell our child residents as they enter their careers that they are going to belong to several professional communities (e.g., American Psychiatric Association, American Medical Association), but their professional home is the AACAP. It is a relatively small professional community, the one they will grow up in. Here they can join committees and programs, sometimes out of reach in the larger organizations. I joined AACAP in the 1960s and it was so friendly then because it was so small. Now it is has grown from a village to a mid-sized community, but it still has that small town feel. AACAP gives its members research, new techniques, new practices, and whole new fields. We give something back because dues and contributions are its life blood.

The Life Members Fund appeals to me because it renews that AACAP life blood through scholarships to the Annual Meeting for residents in training and medical students. They are our future. The Life Members Fund re-circulates the dues you give back after retirement.

Seeing it bring these younger people to the meeting is rejuvenating, to us as well as to AACAP.

Is there an aspect of AACAP’s activities that interests you the most?

The Annual Meeting and the Journal interest me the most. The Journal is the moving front of new research and translating that into practice techniques keeps us alive as practitioners. I was fortunate enough to be editor for 10 years—I learned a lot on the job and found connections with people all over the world through that experience. Seeing it now as a subscriber and reader I can appreciate how the Journal is always moving forward—and has risen to whole new heights with subsequent editors.

Do you have any advice for others who are considering supporting AACAP?

Sure, pick an aspect of the Academy that is of special interest to you and think about how your money might be used. Consider the particular projects that you would like to support and see to what degree you can specify them. There will be more positive feedback this way. Indeed, it will more than double that good feeling you get just from giving!

Attention Life Members!

Stay involved in all Life Members activities, programs, and photos by reading the Life Members e-Newsletter distributed quarterly via email. Did you receive the latest Life Member e-Newsletter in October? If not, contact the Development Office at development@aacap.org or 202.966.7300, ext. 140.

Make a donation to the Life Members Fund and support Life Members’ activities such as Education and Outreach Awards for Child and Adolescent Psychiatry Residents, Mentorship Grants for Medical Students, and the Life Members events during the 58th Annual Meeting in San Francisco.

Visit http://www.aacap.org/cs/giving to donate.
AACAP Policy Statement Requirements

Policies should:

- Be a statement regarding an important policy issue,
- Be well written, as briefly 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.

*revised 1/2009

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 3/2005
ILLONOIS

CHILD/adoLESCENt PSYCHIATRIST
Crystal Lake, IL

Looking for PT or FT Child psychiatrist needed for outpatient private practice mainly in our Crystal Lake office but open to add Schaumburg or Vernon Hills office as well. Provide psychiatric evaluations and medication management for strictly outpatient private practice. On call for weekend coverage every 11 weeks. Practice consists of 10 psychiatrists currently and about 28 therapists that offers full spectrum of services.

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Schaumburg, IL 60173
847-240-2211 x224
Fax: 847-240-2418
E-mail: pmc@prapsych.com
www.prapsych.com

ASSISTANT PROFESSOR OF
CLINICAL PSYCHIATRY
Springfield, IL

The Department of Psychiatry of Southern Illinois University School of Medicine is seeking to hire a full-time faculty member to fill the position of Assistant Professor of Clinical Psychiatry in the Department of Psychiatry, Division of Child Psychiatry. The primary responsibility for the incumbent will be to provide child and adolescent psychiatric services, including outpatient clinics and inpatient duties at the child psychiatry hospital. The incumbent will also be responsible for instruction of students, residents, fellows and other allied health professionals as well as participation in clinical and research services. SIU SOM is an EEOC employer.

Qualified applicants will have an M.D. or D.O. degree, must have completed five years of approved residency training in general psychiatry and child psychiatry. The incumbent must be board certified in general psychiatry within four years of hire and board certified in child and adolescent psychiatry within five years of hire and maintain certifications. Applicants must be eligible for licensure in the State of Illinois. This position has been designated as security sensitive and employment is contingent upon the result of a criminal background investigation. Deadline for receipt of applications will be August 31 or until filled.

Please send Curriculum Vitae and three letters of recommendation to:
Radmila Bogdanich, MA
Chief Administrator
SIU School of Medicine Department of Psychiatry
217/545-7670
P.O. Box 19642,
Springfield, IL 62794-9642
rbogdanich@siumed.edu

MARYLAND

CHILD AND ADOLESCENT
PSYCHIATRIST
SHEPARD PRATT PHYSICIANS, P.A.
DIRECTOR, AUTISM CLINIC,
OUTPATIENT NEUROPSYCHIATRY
PROGRAM
Towson, MD

Board certified, child and adolescent psychiatrist sought for an exciting position combining the best of private practice and academic psychiatry. Sheppard Pratt Health System, one of the top psychiatric health care systems in the country, is seeking a child and adolescent psychiatrist with expertise in developmental disabilities to focus on the treatment of psychiatric disorders from a neuropsychiatric perspective.

Elements of the Program are grant-supported, so there are opportunities for academic work as well as teaching and training residents. The Outpatient Neuropsychiatry Program is located on Sheppard Pratt’s historic Towson campus, approximately 20 minutes north of the Inner Harbor in Baltimore, Maryland.

Qualified candidates must possess a current license to practice in Maryland at the time of appointment and have completed a child and adolescent fellowship. Extensive clinical experience with autism and other developmental disabilities is required. Leadership experience preferred. Sheppard Pratt offers a generous compensation package and comprehensive benefits and is an equal opportunity employer.

If you would like to explore these options, please contact our Director for Professional Services:
Ms. Barbara Magid
410-938-3460
bmagid@sheppardpratt.org

MASSACHUSETTS

DIRECTOR, OUTPATIENT
PSYCHIATRY SERVICES
Boston, MA

The Department of Psychiatry at Children’s Hospital Boston is seeking a child and adolescent psychiatrist with exceptional leadership and clinical skills to serve as Medical Director of Outpatient Psychiatry Service (OPS). Charged with overseeing the quality and effective organization of the Department’s outpatient mental health care, this individual must be able to envision current and future needs for mental health treatment and outcome assessment as they relate to children and their families and to the strategic goals of the Department and Hospital. This individual must be an experienced physician with strong leadership and management skills as well as expertise in evidence-based treatments. Excellent teaching ability is critical as the OPS is the primary venue where our child psychiatry, psychology, and social work trainees learn evidence-based approaches to the treatment of psychiatric disorders. This individual must be intellectually engaged in scholarly academic endeavors and an effective collaborator with Hospital and community partners as well as an able administrative manager who is skilled in managing people and resources. It is anticipated that this position will evolve into a broader clinical and administrative leadership role in the Department.

The applicant must be board-certified in child and adolescent psychiatry and have 5-15 years of relevant clinical experience, demonstrated ability in scholarly/research projects, and program management experience. Salary is competitive and commensurate with experience and accomplishments. The position carries a Harvard Medical School faculty appointment.

A letter of interest along with a curriculum vita should be sent to the attention of:
David R. DeMaso, MD
Psychiatrist-in-Chief and Chairman of Psychiatry, Children’s Hospital Boston
300 Longwood Avenue
Boston, MA 02115
617-355-6724
or (preferably)
david.demaso@childrens.harvard.edu

Children’s Hospital Boston is an Affirmative Action/Equal Opportunity Employer
NEW YORK

INPATIENT CHILD PSYCHIATRY POSITIONS
Bronx, New York

Full time New York State, Office of Mental Health, positions for Board eligible or Board Certified Child Psychiatrists on a pre-adolescent and a younger adolescent inpatient unit, treating youngsters who require intermediate length of stay treatment for symptoms of severe psychiatric disorders that cannot be managed in outpatient, day hospital, residential and short term inpatient settings.

The Child Psychiatrist is the clinical leader of a treatment team consisting of three clinicians (Psychologists and Social Workers) who are the patient therapists, nursing staff, therapy aides, teachers and activity therapists. The Child Psychiatrist directly supervises the treatment team, manages the psychopharmacological and medical treatment of the patients on the adolescent unit and is responsible for the treatment plan developed by the clinical team.

Bronx Children’s Psychiatric Center is an 86 bed New York State OMH Child and Adolescent Psychiatric facility that is affiliated with the Albert Einstein College of Medicine, Division of Child Psychiatry, and the position includes faculty appointment to the Albert Einstein College of Medicine. Child Psychiatry fellows, Psychiatry residents, Psychology externs and Social Work interns may rotate on the unit as part of the clinical team. Teaching in the AECOM Child Psychiatry Fellowship Program is encouraged, as well as research opportunities with this patient population.

The position is on a New York State OMH line with the full New York State benefit package. Salary range for Board eligible Child Psychiatrist is up to $148,421 and for Board Certified Child Psychiatrist is up to $157,736.

Submit Applications To:
Harvey N. Kranzler, M.D.
Clinical Director, Bronx Childrens Psychiatric Center, Professor of Clinical Psychiatry and Behavioral Sciences, Director, Division of Child and Adolescent Psychiatry
Albert Einstein College of Medicine
718-239-3624
Fax: 718-239-3669
harvey.kranzler@omh.ny.gov

PSYCHIATRIST and PSYCHIATRIC CRNP
Moon Township, Pennsylvania

Staunton Clinic, a member of Heritage Valley Health System, located 12 miles from downtown Pittsburgh, PA, is actively recruiting for a full time Psychiatrist and an Outpatient Psychiatric Certified Registered Nurse Practitioner (CRNP). We are a comprehensive behavioral health clinic offering a wide range of private and public mental health and mental retardation services. Locations served include Allegheny and Beaver counties.

PSYCHIATRIST—Must be licensed to practice medicine in the state of PA, board certified or eligibility in psychiatry with 2 yrs. of direct clinical experience. A fellowship in child and adolescent psychiatry is preferred. Ideal for a self-starter who desires a busy practice with a guaranteed referral base and work in a multi-disciplinary setting with other mental health specialists. Call will be shared on a one in six rotation.

PSYCHIATRIC CRNP—Responsible for providing care to Psychiatric patients from children through geriatrics under the direct medical supervision of the Psychiatric Director. Must be State licensed to provide care as a nurse practitioner. At least 2 yrs. of experience in specialty & ANA certification in Psychiatric/Mental Health Nursing strongly preferred. CPR certification. Valid driver’s license.

We offer a competitive salary, flexible benefits, on site parking, generous paid time off, 403b match and much more. Interested candidates should submit curriculum vitae along with salary requirement to:

Heritage Valley Health System
HR Department
420 Rouser Road, Suite 102
Moon Township, PA 15108-3090
fax to: 412-749-7428
e-mail to: hvhsvh@hvhs.org
or apply on line at www.heritagevalley.org
EOE

WEST VIRGINIA

CHILD PSYCHIATRY
Charleston, West Virginia

West Virginia University–Charleston Division, Department of Behavioral Medicine & Psychiatry is seeking a full-time academic BC/BE child psychiatrist for evaluation and treatment of child outpatients, coverage of child intakes, follow-ups with residents/medical students, and coverage of pediatric consults. The opportunity involves teaching and supervisory responsibilities. Students include more than 20 residents in either a general psychiatry track or a med/psych track, 30+ medical students, and three PhD psychology interns. Scholarly activity is strongly encouraged and supported. The position includes seeing your own panel of patients which in some instances will be in collaboration with child psychology faculty. Duties include supervision of residents/medical students on adult services on a regular basis, predominately in resident clinics and others on an as needed basis as when on weekend third call. You will also give lectures on child psychiatry topics and serve as a discussant for case presentation. Administrative duties may develop as academic career progresses. The successful candidate will join a diverse and interdisciplinary faculty, including general psychiatrists, child and adolescent psychiatrists, addiction psychiatrist, geriatric psychiatrists, medicine/psychiatrist clinicians, child psychologists, and neuropsychologist. West Virginia University–Charleston Division is the oldest regional medical campus in the United States with approximately 400 clinical faculty providing training and educational oversight to more than 80 medical students and 140 residents. We are affiliated with Charleston Area Medical Center, a non-profit, 838-bed, tertiary referral center. Appointment will be at a level commensurate with experience and qualifications. The position will remain open until filled.

Qualifications: MD or DO. Recent inpatient experience. Ability to obtain an unrestricted West Virginia medical license. BC/BE Child Psychiatry.

Submit Applications To:
Carol Wamsley, CMSR
511 Brooks Street
Charleston, WV 25301
304-388-3347
Fax: 304-388-6297
Carol.Wamsley@camc.org
Web Site Address: www.camc.org

EOE
Lifelong Learning Institute

CLINICAL PRACTICE UPDATE AND LIFELONG LEARNING MODULE 8:
Modalities of Non-Pharmacological Treatments and Relevant Updates for Child and Adolescent Psychiatrists

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INDICATIONS AND USAGE

KAPVAY™ is a centrally acting alpha-, -adrenergic agonist indicated for the treatment of attention deficit hyperactivity disorder (ADHD) as monotherapy or as adjunctive therapy to stimulant medications. (1)

The efficacy of KAPVAY is based on the results of two clinical trials in children and adolescents. (14) Maintenance efficacy has not been systematically evaluated, and patients who are continued on longer-term treatment require periodic reassessment. (1)

This extended-release formulation of clonidine hydrochloride is also approved for the treatment of hypertension under the trade name JENILOGA. (1)

CONTRAINdications

KAPVAY should not be used in patients with known hypersensitivity to clonidine.

WARNINGS AND PRECAUTIONS

Hypotension/Bradycardia

Treatment with KAPVAY can cause dose related decreases in blood pressure and heart rate. In patients who completed 5 weeks of treatment in a controlled, fixed-dose monotherapy study in pediatric patients, during the treatment period the maximum placebo-subtracted mean change in systolic blood pressure was -4.0 mmHg on KAPVAY 0.2 mg/day and -8.8 mmHg on KAPVAY 0.4 mg/day. The maximum placebo- subtracted mean change in diastolic blood pressure was -4.0 mmHg on KAPVAY 0.2 mg/day and -7.3 mmHg on KAPVAY 0.4 mg/day. The maximum placebo-subtracted mean change in heart rate was -4.0 beats per minute on KAPVAY 0.2 mg/day and -7.7 beats per minute on KAPVAY 0.4 mg/day.

During the taper period of the fixed-dose monotherapy study the maximum placebo-subtracted mean change in systolic blood pressure was -3.4 mmHg on KAPVAY 0.2 mg/day and -5.6 mmHg on KAPVAY 0.4 mg/day. The maximum placebo-subtracted mean change in diastolic blood pressure was -3.3 mmHg on KAPVAY 0.2 mg/day and -5.4 mmHg on KAPVAY 0.4 mg/day. The maximum placebo- subtracted mean change in heart rate was -0.6 beats per minute on KAPVAY 0.2 mg/day and -3.0 beats per minute on KAPVAY 0.4 mg/day.

Measure heart rate and blood pressure prior to initiation of therapy, following dose increases, and periodically while on therapy. Use KAPVAY with caution in patients with a history of hypotension, heart block, bradycardia, or cardiovascular disease, because it can decrease blood pressure and heart rate. Use caution in treating patients who have a history of syncope or may have a condition that predisposes them to syncope, such as hypertension, orthostatic hypotension, bradycardia, or dehydration. Use KAPVAY with caution in patients treated concomitantly with antihypertensives or other drugs that can reduce blood pressure or heart rate or increase the risk of syncope. Advise patients to avoid becoming dehydrated or overheat.

Sedation and Somnolence

Somnolence and sedation were commonly reported adverse reactions in clinical studies. In patients who completed 5 weeks of treatment in a controlled fixed-dose pediatric monotherapy study, 51% of patients treated with 0.4 mg/day and 38% treated with 0.2 mg/day vs 7% of placebo treated patients reported somnolence as an adverse event. In patients that completed 5 weeks of therapy in a controlled fixed-dose pediatric adjunctive to stimulants study, 19% of patients treated with KAPVAY+stimulant vs 8% treated with placebo+stimulant reported somnolence. Before using KAPVAY with other centrally active depressants (such as phenothiazines, barbiturates, or benzodiazepines), consider the potential for additive sedative effects. Caution patients against operating heavy equipment or driving until they know how they respond to treatment with KAPVAY. Advise patients to avoid using alcohol.

Abrupt Discontinuation

No studies evaluating abrupt discontinuation of KAPVAY in children with ADHD have been conducted. In children and adolescents with ADHD, physicians should gradually reduce the dose of KAPVAY in decrements of no more than 0.1 mg every 3 to 7 days. Patients should be instructed not to discontinue KAPVAY therapy without consulting their physician due to the potential risk of withdrawal effects. In adults with hypertension, sudden cessation of clonidine hydrochloride extended-release formulation treatment in the 0.2 to 0.6 mg/day range resulted in reports of headache, tachycardia, nausea, flushing, warm feeling, brief lightheadedness, tightness in chest, and anxiety. In adults with hypertension, sudden cessation of treatment with immediate-release clonidine has, in some cases, resulted in symptoms such as nervousness, agitation, headache, and tremor accompanied or followed by a rapid rise in blood pressure and elevated catecholamine concentrations in the plasma.

Allergic Reactions

In patients who have developed localized contact sensitization to clonidine transdermal system, continuation of clonidine transdermal system or substitution of oral clonidine hydrochloride therapy may be associated with the development of a generalized skin rash.

In patients who develop an allergic reaction from clonidine transdermal system, substitution of oral clonidine hydrochloride may elicit an allergic reaction (including generalized rash, urticaria or angioedema).

Patients with Vascular Disease, Cardiac Conduction Disease, or Renal Failure

Clonidine hydrochloride should be used with caution in patients who have severe coronary insufficiency, conduction disturbances, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

Other Clonidine-Containing Products

Clonidine, the active ingredient in KAPVAY, is also approved as an antihypertensive. Do not use KAPVAY in patients concomitantly taking other clonidine-containing products, (e.g. Catapres®).

ADVERSE REACTIONS

Clinical Trial Experience

Two KAPVAY ADHD clinical studies evaluated 256 patients who received active therapy, in one of the two placebo-controlled studies (Studies 1 and 2) with primary efficacy end-points at 5-weeks.

Study 1: Fixed-dose KAPVAY Monotherapy

Study 1 was a multi-center, randomized, double-blind, placebo-controlled study with primary efficacy endpoint at 5 weeks, of two fixed doses (0.2 mg/day or 0.4 mg/day) of KAPVAY in children and adolescents (6 to 17 years of age) who met DSM-IV criteria for ADHD hyperactive or combined/subtypes. KAPVAY was initiated at 0.1 mg/day and titrated up to 0.4 mg/day over a 3-week period. Most KAPVAY treated patients (75.5%) were escalated to the maximum dose of 0.4 mg/day.

Commonly observed adverse reactions (incidence of ≥ 2% in the treatment group and greater than the rate on placebo) during the treatment period are listed in Table 3.

Study 2: Flexible-dose KAPVAY as Adjunctive Therapy to Psychostimulants

Study 2 was a multi-center, randomized, double-blind, placebo-controlled study, with primary efficacy endpoint at 5 weeks, of a flexible dose of KAPVAY as adjunctive therapy to a psychostimulant in children and adolescents (6 to 17 years) who met DSM-IV criteria for ADHD hyperactive or combined/subtypes. KAPVAY was initiated at 0.1 mg/day and titrated up to 0.4 mg/day over a 3-week period. Most KAPVAY treated patients (75.5%) were escalated to the maximum dose of 0.4 mg/day.

Commonly observed adverse reactions (incidence of ≥ 2% in the treatment group and greater than the rate on placebo) during the treatment period are listed in Table 4.

Table 2 Common Adverse Reactions in the Fixed-Dose Monotherapy Trial- Treatment period (Study 1)

<table>
<thead>
<tr>
<th>Preferred Term</th>
<th>Percentage of Patients Reporting Event</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>KAPVAY 0.4 mg/day N=78</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Somnolence*</td>
<td>31%</td>
</tr>
<tr>
<td>Headache</td>
<td>19%</td>
</tr>
<tr>
<td>Upper Abdominal Pain</td>
<td>13%</td>
</tr>
<tr>
<td>Fatigue*</td>
<td>13%</td>
</tr>
<tr>
<td>Upper Respiratory Tract Infection</td>
<td>6%</td>
</tr>
<tr>
<td>Irritability</td>
<td>6%</td>
</tr>
<tr>
<td>Throat Pain</td>
<td>6%</td>
</tr>
<tr>
<td>Nausea</td>
<td>6%</td>
</tr>
<tr>
<td>Intolerance</td>
<td>9%</td>
</tr>
<tr>
<td>Dizziness</td>
<td>3%</td>
</tr>
<tr>
<td>Insomnia</td>
<td>6%</td>
</tr>
<tr>
<td>Emotional Disorder</td>
<td>5%</td>
</tr>
<tr>
<td>Constipation</td>
<td>6%</td>
</tr>
<tr>
<td>Dry Mouth</td>
<td>5%</td>
</tr>
<tr>
<td>Nasal Congestion</td>
<td>5%</td>
</tr>
<tr>
<td>Body Temperature Increased</td>
<td>1%</td>
</tr>
<tr>
<td>Gastrointestinal Viral</td>
<td>0%</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>1%</td>
</tr>
<tr>
<td>Ear Pain</td>
<td>0%</td>
</tr>
<tr>
<td>Nasopharyngitis</td>
<td>3%</td>
</tr>
<tr>
<td>Abnormal Sleep-Related Event</td>
<td>1%</td>
</tr>
<tr>
<td>Aggresive</td>
<td>1%</td>
</tr>
<tr>
<td>Asthma</td>
<td>1%</td>
</tr>
<tr>
<td>Bradycardia</td>
<td>4%</td>
</tr>
<tr>
<td>Enuresis</td>
<td>4%</td>
</tr>
<tr>
<td>Inflame like illness</td>
<td>3%</td>
</tr>
<tr>
<td>Tarry</td>
<td>3%</td>
</tr>
<tr>
<td>Thirst</td>
<td>3%</td>
</tr>
<tr>
<td>Tremor</td>
<td>3%</td>
</tr>
<tr>
<td>Epistaxis</td>
<td>0%</td>
</tr>
<tr>
<td>Lower Respiratory Tract Infection</td>
<td>0%</td>
</tr>
<tr>
<td>Poliakura</td>
<td>0%</td>
</tr>
<tr>
<td>Sleep Tetter</td>
<td>0%</td>
</tr>
</tbody>
</table>

* Taper Period: 0.2 mg dose, week 8; 0.4 mg dose, weeks 6-8; Placebo dose, weeks 6-8

Table 3 Common Adverse Reactions in the Fixed-Dose Monotherapy Trial- Taper period* (Study 1)

<table>
<thead>
<tr>
<th>Preferred Term</th>
<th>Percentage of Patients Reporting Event</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>KAPVAY 0.4 mg/day N=78</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Abdominal Pain Upper</td>
<td>6%</td>
</tr>
<tr>
<td>Headache</td>
<td>2%</td>
</tr>
<tr>
<td>Gastrointestinal Viral</td>
<td>5%</td>
</tr>
<tr>
<td>Somnolence</td>
<td>3%</td>
</tr>
<tr>
<td>Heart Rate Increased</td>
<td>3%</td>
</tr>
</tbody>
</table>

* Taper Period: 0.2 mg dose, week 8; 0.4 mg dose, weeks 6-8; Placebo dose, weeks 6-8
Thirteen percent (13%) of patients receiving KAPVAY discontinued from the pediatric monotherapy phase were upper abdominal pain and gastrointestinal virus.

Most common adverse reactions, defined as events that were reported in at least 5% of drug-treated patients and at least twice the rate in the placebo group and greater than the rate on placebo during the taper period are listed in Table 5.

Table 4 Common Adverse Reactions in the Flexible-Dose Adjunctive to Stimulant Therapy Trial- Treatment Period (Study 2)

<table>
<thead>
<tr>
<th>Preferred Term</th>
<th>KAPVAY+STM (N=102)</th>
<th>PBO+STM (N=96)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somnolence</td>
<td>19%</td>
<td>8%</td>
</tr>
<tr>
<td>Fatigue</td>
<td>16%</td>
<td>4%</td>
</tr>
<tr>
<td>Abdominal Pain Upper</td>
<td>12%</td>
<td>7%</td>
</tr>
<tr>
<td>Nasal Congestion</td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td>Throat Pain</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>Decreased Appetite</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>Body Temperature Increased</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>Dizziness</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>Insomnia</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>Epistaxis</td>
<td>3%</td>
<td>0</td>
</tr>
<tr>
<td>Rhinorrhea</td>
<td>3%</td>
<td>0</td>
</tr>
<tr>
<td>Abdominal Pain</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>2%</td>
<td>0</td>
</tr>
<tr>
<td>Pain in Extremity</td>
<td>2%</td>
<td>0</td>
</tr>
</tbody>
</table>

1. Somnolence includes the terms: “somnolence” and “sedation”.
2. Fatigue includes the terms “fatigue” and “lethargy”.

Commonly observed adverse reactions (incidence of ≥ 2% in the treatment group and greater than the rate on placebo) during the taper period are listed in Table 5.

Table 5 Common Adverse Reactions in the Flexible-Dose Adjunctive to Stimulant Therapy Trial- Taper Period* (Study 2)

<table>
<thead>
<tr>
<th>Preferred Term</th>
<th>KAPVAY+STM (N=102)</th>
<th>PBO+STM (N=96)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nasal Congestion</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>Headache</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Irritability</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Throat Pain</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Gastroenteritis Viral</td>
<td>2%</td>
<td>0</td>
</tr>
<tr>
<td>Rash</td>
<td>2%</td>
<td>0</td>
</tr>
</tbody>
</table>

Taper Period: weeks 6-8.

Most common adverse reactions, defined as events that were reported in at least 5% of drug-treated patients and at least twice the rate in the placebo patients, during the treatment period were somnolence, fatigue, upper respiratory tract infection, irritability, throat pain, insomnia, nightmares, emotional disorder, constipation, nasal congestion, increased body temperature, dry mouth, and ear pain. The most common adverse reactions that were reported during the taper phase were upper abdominal pain and gastrointestinal virus.

Adverse Reactions Leading to Discontinuation

Thirteen percent (13%) of patients receiving KAPVAY discontinued from the pediatric monotherapy study due to adverse events, compared to 1% in the placebo group. The most common adverse reactions leading to discontinuation of KAPVAY monotherapy treated patients were from somnolence/sedation (5%) and fatigue (4%). Less common adverse reactions leading to discontinuation (occurring in approximately 1% of patients) included: vomiting, urticaria, and rash. In the pediatric adjunctive treatment to stimulants, study, one patient discontinued from KAPVAY + stimulant group because of bradycardia.

Effects on Laboratory Tests, Vital Signs, and Electrocardiograms

KAPVAY treatment was not associated with any clinically important effects on any laboratory parameters in either of the placebo-controlled studies. Mean decreases in blood pressure and heart rate were seen [see Warnings and Precautions (5.1)].

There were no changes on ECGs to suggest a drug-related effect.

DRUG INTERACTIONS

No drug interaction studies have been conducted with KAPVAY in children. The following have been reported with other oral immediate release formulations of clonidine.

Interactions with CNS-depressant Drugs

Clonidine may potentiate the CNS-depressant effects of alcohol, barbiturates or other sedating drugs.

Interactions with Tricyclic Antidepressants

If a patient is receiving clonidine hydrochloride and also taking tricyclic antidepressants the hypotensive effects of clonidine may be reduced.

Interactions with Drugs Known to Affect Sinus Node Function or AV Nodal Conduction

Due to a potential for additive effects such as bradycardia and AV block, caution is warranted in patients receiving clonidine concomitantly with agents known to affect sinus node function or AV nodal conduction (e.g., digitalis, calcium channel blockers and beta-blockers).

Use with other products containing clonidine

Do not use KAPVAY concomitantly with other products containing clonidine (e.g. Catapres®).

Antihypertensive Drugs

Use caution when KAPVAY is administered concomitantly with antihypertensive drugs, due to the potential for additive pharmacodynamic effects (e.g., hypotension, syncope) [see Warnings and Precautions (5.2)].

USE IN SPECIFIC POPULATIONS

Pregnancy

Pregnancy Category: C. Oral administration of clonidine hydrochloride to pregnant rabbits during the period of embryofetal organogenesis at doses of up to 80 mcg/kg/day (approximately 3 times the oral maximum recommended daily dose [MRHD] of 0.4 mg/day on a mg/m² basis) produced no evidence of teratogenic or embryotoxic potential. In pregnant rats, however, doses as low as 15 mcg/kg/day (1/3 the MRHD on a mg/m² basis) were associated with increased resorptions in a study in which dams were treated continuously from 2 months prior to mating and throughout gestation. Increased resorptions were not associated with treatment at the same or at higher dose levels (up to 3 times the MRHD) when treatment of the dams was restricted to gestation days 6-15. Increases in resorptions were observed in both rats and mice at 500 mcg/kg/day (10 and 5 times the MRHD in rats and mice, respectively) or higher when the animals were treated on gestation days 1-14; 500 mcg/kg/day was the lowest dose employed in this study. No adequate and well-controlled studies have been conducted in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should not be used during pregnancy unless clearly needed.

Nursing Mothers

Since clonidine hydrochloride is excreted in human milk, caution should be exercised when KAPVAY is administered to a nursing woman.

Pediciatric Use

A study was conducted in which young rats were treated orally with clonidine hydrochloride from day 21 of age to adulthood at doses of up to 300 mcg/kg/day, which is approximately 3 times the maximum recommended human dose (MRHD) of 0.4 mg/day on a mg/m² basis. A slight delay in onset of preputial separation was seen in males treated with the highest dose (with a no-effect dose of 100 mcg/kg/day, which is approximately equal to the MRHD), but there were no drug effects on fertility or on other measures of sexual or neurobehavioral development.

KAPVAY has not been studied in children with ADHD less than 6 years old.

Patients with Renal Impairment

The impact of renal impairment on the pharmacokinetics of clonidine in children has not been assessed. The initial dosage of KAPVAY should be based on degree of impairment. Monitor patients carefully for hypotension and bradycardia, and titrate to higher doses cautiously. Since only a minimal amount of clonidine is removed during routine hemodialysis, there is no need to give supplemental KAPVAY following dialysis.

Adult Use in ADHD

KAPVAY has not been studied in adult patients with ADHD.

DRUG ABUSE AND DEPENDENCE

Controlled Substance

KAPVAY is not a controlled substance and has no known potential for abuse or dependence.

OVERDOSAGE

Symptoms

Clonidine overdose: Hypertension may develop early and may be followed by hypotension, bradycardia, respiratory depression, hypothermia, drowsiness, decreased or absent reflexes, weakness, irritability and miosis. The frequency of CNS depression may be higher in children than adults. Large overdoses may result in reversible cardiac conduction defects or dysrhythmias, apnea, coma and seizures. Signs and symptoms of overdose generally occur within 30 minutes to two hours after exposure.

Treatment

Consult with a Certified Poison Control Center for up-to-date guidance and advice.

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Last modified 06/2011
When added to a stimulant, extended-release Kapvay™ demonstrated statistically significant improvement of ADHD symptoms compared with a stimulant alone at the end of 5 weeks of treatment, as measured by the ADHD RS-IV total score.

**Indication**

Kapvay™ (clonidine hydrochloride) extended-release tablets are indicated for the treatment of attention deficit/hyperactivity disorder (ADHD) as monotherapy or as adjunctive therapy to stimulant medications in children and adolescents ages 6-17. The efficacy of Kapvay™ is based on the results of 2 clinical trials in children and adolescents.

Kapvay™ is indicated as an integral part of a total treatment program for ADHD that may include other measures (psychological, educational, and social) for patients with this syndrome.

The effectiveness of Kapvay™ for longer-term use (more than 5 weeks) has not been systematically evaluated in controlled trials; therefore, the physician electing to use Kapvay™ for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient.

**Important Safety Information**

- Kapvay™ should not be used in patients with known hypersensitivity to clonidine.
- Kapvay™ can cause dose-related decreases in blood pressure and heart rate. Use caution in treating patients who have a history of syncope or may have a condition that predisposes them to syncope, such as hypotension, orthostatic hypotension, bradycardia, or dehydration. Use with caution in patients treated concomitantly with antihypertensives or other drugs that can reduce blood pressure or heart rate or increase the risk of syncope.
- Somnolence/Sedation were commonly reported adverse reactions in clinical studies with Kapvay™. Potential for additive sedative effects with CNS-depressant drugs. Advise patients to avoid use with alcohol. Caution patients against operating heavy equipment or driving until they know how they respond to Kapvay™.
- Patients should be instructed not to discontinue Kapvay™ therapy without consulting their physician due to the potential risk of withdrawal effects.
- In patients who have developed localized contact sensitization or other allergic reaction to clonidine in a transdermal system, substitution of oral clonidine hydrochloride therapy may be associated with the development of a generalized skin rash, urticaria, or angioedema. Use cautiously in patients with vascular disease, cardiac conduction disease, or chronic renal failure; Monitor carefully and up titrate slowly.
- Clonidine may potentiate the CNS-depressive effects of alcohol, barbiturates or other sedating drugs.
- Use caution when Kapvay™ is administered concomitantly with antihypertensive drugs, due to the additive pharmacodynamic effects (e.g., hypotension, syncope).
- Kapvay™ should not be used during pregnancy unless clearly needed. Since clonidine hydrochloride is excreted in human milk, caution should be exercised when Kapvay™ is administered to a nursing woman.
- Caution is warranted in patients receiving clonidine concomitantly with agents known to affect sinus node function or AV nodal conduction (e.g., digitalis, calcium channel blockers and beta-blockers) due to a potential for additive effects, such as bradycardia and AV block.
- Clonidine, the active ingredient in Kapvay™, is also approved as an antihypertensive. Do not use Kapvay™ in patients concomitantly taking other clonidine-containing products, (e.g., Catapres® [clonidine hydrochloride], JENLOGA).
- Common adverse reactions (incidence at least 5% and twice the rate of placebo) include: somnolence, fatigue, upper respiratory tract infection, irritability, throat pain, insomnia, nightmares, emotional disorder, constipation, nasal congestion, increased body temperature, dry mouth, and ear pain.

Please see Brief Summary of full Prescribing Information on the adjacent pages.

**Non-stimulant for the treatment of ADHD**

Kapvay™ (clonidine hydrochloride) extended-release tablets 0.1 mg

**Extended-Release Formulation**

Kapvay™ is a trademark of Shionogi Inc.

Catapres® is a registered trademark of Boehringer Ingelheim.

*When you treat Attention Deficit/Hyperactivity Disorder (ADHD) with stimulants, for some patients, a question may be...*
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