Inside...

Las Muchachas: Lessons Learned from Two Unauthorized Adolescent Sisters ... 14
Annual Meeting Photos .............................................................. 40-46
Keeping Our Teens Safe on Social Networking Sites ...................... 47
Join other AACAP members, and family and youth advocates on May 10-11, 2012, to promote child and adolescent psychiatry and children’s mental health issues on Capitol Hill.

During this two-day event, you will join fellow members, residents, family members, and youth as you learn about the legislative process, develop relationships with legislators, and discuss the issues that most affect your patients and practice. The AACAP Department of Government Affairs will schedule your Congressional meetings, assist you on what to say and do during your meeting, and provide you with the policy materials to shape your message. Registration will open in early February.

For more information, visit http://www.aacap.org/cs/aacap_advocacy_day or contact Michael Linskey at mlinskey@aacap.org or 202.966.7300, ext. 126.
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Members and the News

Welcome New AACAP Members

Child Psychopharm List-Serve

A Tribute to Richard Patrick Malone, Jr., M.D.

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Poetry: Old Photographs

Research Forum • John S. March, M.D., M.P.H., and James McGough, M.D., M.S. 

Simon Wile Consultation Psychiatry Symposium • D. Catherine Fuchs, M.D. 

Founders Symposium: Phenotypes, Genetics, Imaging and Networks • Nevia Pavletic and Monique Ernst, M.D., Ph.D... 

New Developments in Mood Disorder Research from the AACAP+CACAP Joint Annual Meeting • Kiki Chang, M.D., 

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New Developments in Mood Disorder Research from the AACAP+CACAP Joint Annual Meeting • Kiki Chang, M.D., 

Keeping Our Teens Safe on Social Networking Sites • Dana Reid, D.O. 

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Diversity and Culture: Las Muchachas: Lessons Learned from Two Unauthorized Adolescent Sisters

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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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Ruth S. Gerson, M.D.

Whether you identify with the 99 percent, the 1 percent, or no percent at all, it is impossible to deny that persistent economic troubles are hitting our kids hard. Early intervention centers, after school programs, mental health services, teen health clinics, and food stamps are all on the budgetary chopping block. Almost one third of those who are unemployed today are parents with children (Lovell and Isaacs 2010). Many more children are living in poverty, and homelessness for children is increasing, in some states by as much as 50 percent (Lovell and Isaacs 2010). Child abuse appears to be increasing as well as a result of these economic conditions (Berger 2011). In my outpatient clinic at Bellevue Hospital, one of New York City’s public hospitals, every day brings patients whose parents are newly out of work. I talk to families struggling to afford their prescription copays and put food on the table, and parents frustrated that academic supports and special education programs are in such short supply. How do we help our patients navigate these mounting challenges?

As child and adolescent psychiatrists, we are constantly serving as advocates for our patients—fighting for their academic needs, making calls to connect them with social services and medical providers, and working to counter stigma by educating families and communities about mental illness. But we need to fight on a larger field. AACAP is a tireless advocate for our patients, working to protect access to quality care through local, state and federal education, outreach, and political action.

One outstanding representative of this advocacy work is AACAP’s new Jerry M. Wiener Resident Member to Council, Sourav Sengupta, M.D., M.P.H. A graduate of Duke University and Tufts School of Medicine, and now a child and adolescent psychiatry fellow at the Western Psychiatric Institute and Clinic at the University of Pittsburgh Medical Center, where he also completed his adult psychiatry training, Dr. Sengupta is already an accomplished advocate. Abigail Boden Schlesinger, M.D., director of Child and Adolescent Psychiatry and Triple Board Training at Western Psychiatric Institute and Clinic, describes him as “the best of the best.”

Dr. Sengupta has represented trainees and child psychiatrists at the Pennsylvania Psychiatric Leadership Council, at the American Psychiatric Association, and as Resident Representative to the Pittsburgh Regional Organization for Child and Adolescent Psychiatry Executive Council. In addition to his work in local and state outreach, Dr. Sengupta has been a leader in making advocacy accessible to trainees. As AACAP Advocacy Liaison, Dr. Sengupta taught advocacy workshops for trainees, coordinated resident and fellow participation in community outreach campaigns at AACAP’s Advocacy Day, and developed advocacy skills training material for residents and training programs. We are excited to see how Dr. Sengupta will develop these efforts as the Jerry M. Wiener Resident Representative to Council.

I would also like to recognize the incredible contributions of our outgoing Jerry M. Wiener Resident Member to Council, and co-chair of the Committee on Medical Students and Residents, Karimi Mailutha, M.D., M.P.H. Along with her esteemed co-chair, Michelle Horner, D.O., Dr. Mailutha has been a tireless and thoughtful leader. Together, Dr. Mailutha and Horner have developed and expanded innovative opportunities for medical students and residents at the Annual Meeting and beyond. We are perennially grateful to their work in fostering the next generation of child and adolescent psychiatrists. While we will be hard pressed to fill their shoes, I am thrilled to introduce my new co-chair on the Committee on Medical Students and Residents, Eric Williams, M.D. As an assistant adjunct professor in Child and Adolescent Psychiatry at the University of South Carolina School of Medicine, Eric has won several awards for his teaching and contributions to resident and medical student education.

Eric and I are excited to have the opportunity to further advance opportunities for trainees at next year’s Annual Meeting, in these pages, and in all the other ways that AACAP serves its resident and medical student members. You can find out about our latest projects on the Medical Students and Residents section of AACAP’s website: www.aacap.org/cs/students_and_residents. One of
our most exciting new projects that you can find there is AACAP’s Mentorship Network, developed in collaboration with Dorothy Stubbe, M.D., and the Training and Education Committee. Any trainee member looking for a mentor, be it someone in the same city who can meet for coffee or provide shadowing or research opportunities, or someone with specific clinical, research, or advocacy expertise, can sign up on our website. Interested mentors can sign up online too. The Mentorship Network will serve as a clearinghouse to match dedicated, expert mentors with trainees based on shared interests or location, so that the amazing mentorship supports that are available at the Annual Meeting can continue throughout the year. Through this mentorship, AACAP can foster the careers of our trainees, who are the next generation of child and adolescent psychiatrists, and encourage medical students and residents to consider child and adolescent psychiatry as a career. Our field remains drastically underserved; there are simply not enough of us to treat all of the children and families who need us. Advocacy, recruitment, and mentorship are crucial ways in which AACAP and its members work to ensure that in the future, no child goes without the care and attention they deserve, regardless of which percent they are in.

References

Dr. Gerson is a second year child and adolescent psychiatry resident at the NYU Child Study Center and Bellevue Hospital. She is also the John Schowalter Resident Member of Council. She may be reached at ruthgerson@gmail.com.
“It Hurts All Over!”

This is not a new patient. We’ve been following Beth since she was 5 years old. She had a jaw tumor that necessitated surgery, radiation, and chemotherapy. She’s now 19 years old. A few years ago, I inherited her from another doctor on the service. I’m not sure I remember why. I’ve been following her ever since. As a result of her previous treatment, she has lots of facial deformities and endocrine problems. She’s had numerous surgeries and sees an endocrinologist for short stature and delayed puberty. She’s just recently started growing.”

There was then an interesting and somewhat puzzling discussion as to whether Beth was short or small or petite followed by the remark that her intelligence was okay. This latter comment was gently challenged by the psychologist who said that she thought Beth had some “cognitive problems.”

“What would you say her IQ is?” I asked.

“Maybe in the 80’s,” answered the psychologist.

“But she goes to college,” a nurse added.

“Community college,” clarified the social worker. “And she’s only taking a few classes in child care. She can do that.”

Not being quite sure what all this discussion was about, I made a general remark to focus more clearly on psychosocial issues. “Whatever her height is or IQ or her amount of college, her past treatment and its consequences have wreaked havoc with her overall development.” This shifted the discussion.

“She’s overly protected by her mother. To make matters worse, she’s an only child. She’s been infantilized,” said the nurse.

“She’s really attached to her mother’s apron strings,” added the doctor.

“But she has taken some college courses and had a part-time job at McDonald’s. She used to ride her bike there,” said the social worker, as if to balance out the previous remarks.

“Does she have friends?” I asked.

“She has some. Not many.”

“Any significant friends?” I asked.

“No.”

“She just has begun to develop sexually,” remarked the doctor who then continued Beth’s history. “She was in remission until two months ago when she started to have headaches and tremor. The scans showed a cerebellar tumor. The family was upset. They thought everything was over 10 years ago and now there’s another cancer, probably due to the previous radiation treatments. Beth was upset too. Mom was in disbelief. She just ran out of the room after we told her. She was in disbelief. She just ran out of the room after we told her. The tumor was not resectable so surgery couldn’t be done. Due to the past levels of radiation, we couldn’t do radiation either. That left only chemotherapy. That upset the family, which wanted the treatment to go more quickly. Beth underwent her first chemotherapy. It went well, but she didn’t recuperate as quickly as we thought she should. She just laid there with occasional shrieks. She told us she was in pain and that she ‘hurts all over.’ She told me it hurt wherever I touched her. She didn’t say much else.” The doctor finished by saying that one week after the chemo finished she was feeling much better and got out of bed and acted more like Beth. I think a lot of her behaviors were due to the chemo making her feel badly.”

The social worker broke in to say that she had been talking to Beth and her mom. “Mom is really concerned that Beth will surrender. I’m concerned that they’ll all give up!”

I responded to this by asking the psychologist what she thought was going on. “Is this an adjustment disorder, a depression, a grief reaction, anger, or pain induced?”

“I think it’s some of all of those and would note that one week after the chemo finished she was feeling much better and got out of bed and acted more like Beth. I think a lot of her behaviors were due to the chemo making her feel badly.”

The social worker then asked if she could give the usual presentation on the family background. Everyone nodded for her to do so.

She then related the history of the family, that Beth’s biological father had not been involved for years, that her mom had happily remarried, that Beth liked her stepfather, that the stepfather’s family was supportive and lived close by, that the mother’s family was supportive, but lived in another state, that the family was more spiritual than religious, that mom loved New Orleans and its culture.
and that mom was very involved with Beth. She then talked about her work with Beth. “Our conversations have focused on the book, ‘Twilight.’ She told me to read the book. I told her that I had no time to read the book, so she told me to watch the movie. I’ve almost completed it.”

“It’s interesting,” I commented, “that she has chosen a movie dealing with adolescent love and lust with a boy who is immortal.”

Noting that there were two separate people doing therapy with Beth, I then asked the social worker and the psychologist what the goals of their contacts were. The psychologist answered that she wanted to help her family be more functional. “I want them to be able to express themselves and to deal with their feelings.”

The social worker responded less specifically that she thought spending time with Beth would be helpful. She added that Beth had been searching the internet about her illness. “What Beth will be reading on the net will present a rather bad prognosis,” remarked the doctor with concern in her voice.

“But it seems like the treatment has helped,” said the psychologist, as if to challenge the prognosis. “Yes,” explained the doctor, “but that’s probably mostly the effect of the steroids.” “Her prognosis is really poor,” said the doctor in a low tone. Several of the group asked for specifics and the doctor sadly gave them. I could feel the group’s sadness over the prognosis and their anxiety over Beth searching the net and what that might mean to Beth and her family.

“It’s ironic,” I commented, “that at the start of the conference, we were talking about our concern that Beth wasn’t acting like an adolescent and that we’re now concerned because she is. She’s now taking the initiative and actively searching for information about what’s wrong with her.”

The team then focused on whether Beth had the right to choose not to continue her treatment. Someone asked, “Can she turn it down?” Someone else then pointed out that she hadn’t even asked us any questions.

The doctor then was even more specific. “Should we tell her about advanced directives?” The anxiety rose further. The questions came in a flurry: “Does she know her rights . . . Does she have a choice . . . What do we need to tell her?” The flurry abated a bit when the social worker and the nurse, almost in unison, reminded the group that the family and Beth had received the pamphlets concerning advanced directives when they were admitted.

“Is Beth competent to make a decision?” the nurse asked again.

“She’s competent,” said the psychologist and most of the rest of the team nodded in agreement.
"So it’s not a legal issue?" I added. "We gave Beth and her parents the pamphlet. We did what we needed to, although it was before the diagnosis was definitively made and treatment begun. My advice is to bring it up again and be open for questions, then answer the questions, if there are any, in the most clear and succinct manner we can and then listen carefully for further questions. I think that it’s important to figure out who should have the task of bringing this up again? As I hear it, there are a lot of potential people involved. There’s the doctor who asked the psychologist to be involved, and then there’s the social worker who’s meeting with Beth and seems to be doing what the activities therapists usually do. And then there are the parents, and then there’s Beth listening to the internet. Are we clear about who’s doing what and ‘who’s on first?’"

The psychologist did not specifically answer my question. Instead, she answered the previously unanswered question of the group by remarking that she didn’t think there would be a problem with Beth and the advanced directive. The social worker, as if to finish the psychologist’s statement added, “The decision will be what the mother wants.”

“We need to remember the power of those apron strings,” I reminded the group.

Someone then told the doctor that she needed to start the process. “You need to ask the questions.”

The doctor acknowledged that she knew that, but clearly looked like she did not relish the responsibility.

“Maybe you could transfer the case back to the original doctor,” I jested. Most everyone laughed. For some reason, however, the doctor hadn’t heard what I said, only the laugh. She looked puzzled and asked me what I had said. I repeated my mock suggestion that she transfer the case. With a smile and a twinkle in her eye, the doctor said, “That sounds like a great idea!”

Dr. Drell is president of AACAP and head of the Division of Infant, Child, and Adolescent Psychiatry at the Louisiana State University Medical School in New Orleans, Louisiana. Dr. Drell may be reached at MDrell@lsuhsc.edu.

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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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.
Clinical Writing: Let’s Keep Those Keyboards Clicking!

Rachel Ritvo, M.D.

I gaze upon the last roses of the season: elegant, full blooms of white and pink in a graceful vase. They were hard won. The deer ate away the spring growth and then came drought. Summer travels threw off my schedule for black-spot spraying. As I clean out the black-spotted leaf litter from around the roses, I consider what will make next year a blooming success. Gardening is a constant effort to nurture in the midst of fluctuations and depredations of the environment.

Many at AACAP have tilled and toiled to nurture excellence in clinical writing for the benefit of our discipline and the enjoyment and education of our practitioners. AACAP News has maintained a Clinical Vignettes column. Michael Jellinek, M.D., and Schuyler Henderson, M.D., labored to sustain the Clinical Perspectives column in the Journal of the American Academy of Child and Adolescent Psychiatry (JAACAP).

For the past ten years, with the generous support of the Norbert and Charlotte Rieger Foundation, AACAP has offered a $4,500 award for a clinical psychodynamic paper published within the last three years, accepted for publication, or that remains unpublished. As with my rose garden, these efforts have produced many real beauties, but still pose puzzling challenges.

Martin Drell, M.D., has carried Clinical Vignettes single-handedly since early efforts to have members submit vignettes failed to bring in material. The Clinical Perspectives in JAACAP petered out, requiring unsustainable solicitation and editorial effort. The Rieger Psychodynamic Psychotherapy Paper Award has been fortunate in bringing in six to 12 submissions per year. In 2011, eight papers were submitted for consideration for the Rieger Award, and while these papers were often fascinating and well-composed, none of them managed to clear the bar and win the award.

During the Annual Meeting in Toronto, the Psychotherapy Committee met to explore the challenges of clinical writing with the team who judged the papers, as well as with Peter Tanguay, M.D., Stanley Leikén, M.D., and Barbara Leikén from the Rieger Foundation. Papers that have been published or accepted for publication stand the best chance of winning the award. But there are pitfalls for these papers. First, if the paper was not written specifically for a child and adolescent psychiatric (CAP) audience: for example, if it was directed primarily at a psychoanalytic audience, the language may be off-putting or unfamiliar to the psychiatric ear. Debates and controversies in the psychoanalytic world may not be directly relevant to CAPs. Also, these papers may not be directly engaged with contemporary psychiatric literature, nomenclature, and diagnostic categories. A different pitfall exists for papers that have been published as a research report. Even if the research treatment is inherently psychodynamic, a quantitatively-oriented presentation will usually lack sufficient discussion of the psychodynamic underpinnings or not include the compelling clinical vignettes or case presentations needed to meet the Rieger qualification that the paper bring the child or adolescent alive to the reader. Authors basing their work in research should look at the winning papers of Milrod, Gaensbauer, Terr, and Schechter (references are available at www.aacap.org), which were all written by authors actively involved in research. Authors submitting an unpublished paper should consider submitting their paper to a psychotherapy journal for peer review, which may provide valuable feedback that can improve the paper and make for a stronger Rieger submission.

In addition to the inherent challenge of writing a paper that brings a child to life and meets strict, scholarly quality standards, there is considerable clinical and ethical complexity to the task of obtaining patient and family consent before publication. In recent years, ethical standards have been strengthened to protect patient confidentiality, but this is not an insurmountable hurdle. Writers drawing on material from research studies may have obtained this permission in advance, and authors who are not conducting research may want to consider obtaining this consent earlier in the treatment, in order to have the consent prepared and to process issues around potential publication. As there is no publication requirement for the Rieger award, papers may be submitted that have not been cleared for publication by the patient. The 2002 Rieger winner, Vernon Rosario, M.D., never submitted his paper for publication because of his concern for his patient’s privacy.

The use of composite case material is becoming more common in our field partly to avoid the need for consent.

Presenting clinical material is not the only skill required for writing an excellent clinical paper. The case exists in a context. Why was this case chosen for presentation? What has already been written on the topic? How does this case reflect and address a controversy or debate in the literature? Will this paper change the reader’s mind? Will this paper add a new depth to the reader’s understanding?
Composites are illustrations and can be particularly helpful in papers or chapters written for teaching, but composite case material moves away from vividly reporting a single case in order to describe a new finding or a finding that overturns a previously accepted “truth” or “proven hypothesis.”

As AACAP strives to nurture clinical writing in our field, it may be helpful to consider the developmental trajectory of clinical writing. Does the ability to write compelling case summaries or vignettes begin with process notes? Do trainees have time for process notes? Some of the winning Rieger papers are clearly developed from classically-written process notes. Other papers have drawn on clinical material from video-recorded research sessions. And where else can the skills be developed? Writing for newsletters, the Clinical Vignettes in AACAP News, and local newsletters and bulletins, is an excellent entry into writing about clinical material.

Grand Rounds presentations are another venue, perhaps less frequently used than in the past, for developing clinical writing skills. CAPs who complete psychoanalytic training will have considerable experience with case writing by presenting training cases and writing required graduation papers. Other CAPs develop into full-fledged clinical writers by writing for teaching or reporting research. A significant minority of Rieger submissions have been written as chapters for edited books on a specific topic. How can we support writers at each step of the way and within their own developmental trajectories?

Presenting clinical material is not the only skill required for writing an excellent clinical paper. The case exists in a context. Why was this case chosen for presentation? What has already been written on the topic? How does this case reflect and address a controversy or debate in the literature? Will this paper change the reader’s mind? Will this paper add a new depth to the reader’s understanding? I think both JAACAP and the Rieger awards committee have found this contextual element to be the most elusive. From the Rieger awards committee experience, it appears that writers who have grappled with a topic and developed an understanding of that topic through persistent clinical work or research projects embedded in both the rich intellectual traditions of psychodynamics and current child and adolescent psychiatry have presented the best papers in the competition. The AACAP Psychotherapy Committee has wondered whether finding mentors for fledgling writers would support their development. Mentors could ask these contextual questions; they could read drafts, comment, and provide editing; and they could provide guidance and support as writers work through the type of projects that can produce sustained and profound reflection.

In winter the rose bed lays dormant but not so with writers. The next Rieger deadline is April 30, 2012. Let’s get those keyboards clicking!

Dr. Ritvo is on the faculty of the Baltimore-Washington Psychoanalytic Institute and Children’s National Medical Center, and has a private practice in Kensington, Maryland. Dr. Ritvo may be reached at rzm@comcast.net.

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 is available on www.aacap.org, and all submissions must be made online. Questions? Contact AACAP’s Meetings Department at 202.966.7300, ext. 2006 or meetings@aacap.org.
Thinking About Genes at the Annual Meeting

Once again, the Annual Meeting of the AACAP+CACAP in Toronto was a good opportunity to learn about progress being made in child and adolescent psychiatric genetics broadly, and child and adolescent psychiatric pharmacogenomics more narrowly. The meeting had a good representation of biological psychiatric research, including the Research Forum, which was dedicated to thinking through issues related to a wide range of biomarkers.

In recent years, some of the most interesting findings that are related to the clinical implications of gene variation can be found in the New Research poster sessions. This year was no exception. There were a number of new reports that varied from quite clear positive findings to the responsible and important reporting of negative results. I found it exciting that so many AACAP members attended these new research sessions.

Some quite interesting positive results were reported in a poster prepared by YongHee Hong, M.D., and a team from the SoonChunHyang Hospital in South Korea. This group was able to demonstrate significant gene-gene interactions that influenced methylphenidate response. They focused on three variants. These variants were a variable number tandem repeat (VNTR) in the dopamine D4 receptor gene (DRD4), the Orl polymorphism in the alpha 2 adrenergic receptor gene (ADRA2A), and the -3081A/T polymorphism in the noradrenaline transporter gene (SLC6A2). SLC6A2 is often referred to as NET1.

Another positive report was presented by Erika Nurmi, M.D., and a team from UCLA, who focused on risperidone response. While a number of candidate gene relationships were examined, they identified two positive findings. The first positive association was that C-allele homozygotes and heterozygotes of a promoter variant in the dopamine D5 receptor gene (DRD5) demonstrated a greater change in irritability score when compared to the T-allele homozygotes when treated with risperidone. The second positive finding was the association of a SNP in the serotonin 2A receptor gene (HTR2A) with improvement in social withdrawal. Subjects who were homozygous for the minor C-allele of this HTR2A SNP showed a 72% improvement in social withdrawal, as compared to the heterozygotes that had a 62% improvement, and the T-allele homozygotes that had a 49% improvement.

Furthermore, he suggested that the importance of using genetic data to enhance clinical practice would inevitably increase in the years ahead. I suspect that few readers will be surprised to learn that I was in strong agreement with his contrarian conclusion.

An example of a poster that reported important, albeit disappointing, negative findings was a meta-analysis of association studies of the potential role of the glutamate transporter gene (SLC1A1) in the development of obsessive compulsive disorder (OCD). This meta-analysis was the work of a consortium of investigators and was presented by Catherine Mayerfield, B.A. The conclusion of the meta-analysis was that there was not a strong link between SLC1A1 variants and OCD pathophysiology.

It has been fascinating to see the scientific content of the AACAP Annual Meeting evolve over the past 30 years. Until the coming of the new millennium, the “genetic” presentations at the Annual Meeting were primarily twin or family studies. There was much discussion about the importance of heritability with no discussion of possible mechanisms. The most recent decade has seen an increasing number of molecular genetic studies. It is now possible to identify functional variants and explore their possible implications. While we now have a couple of dozen new research reports at each meeting that address the potential implications of specific gene variants, I hope that we will soon be able to review several hundred posters per meeting given the feasibility of testing genomic hypotheses using virtually any of the treatment studies that are currently being conducted. This will be made possible as DNA will be inexpensively obtained on every subject in treatment studies and sequencing of known functional variations will become an automatic and quite routine part of data collection.

I particularly enjoyed the final plenary lecture of the meeting. The lecture had the intriguing title, “Is Child and Adolescent Psychiatry Ready for Personalized Medicine?” Peter Szatmari, M.D., did an excellent job of discussing our ever increasing understanding of the links between gene variants and the development of autism spectrum disorder. Dr. Szatmari began his lecture by discussing his dinner conversation of the previous evening. He confided to the audience that he had polled his colleagues at dinner to ascertain their answers to his question about the readiness of the field. He reported that his companions had unanimously declared that child and adolescent psychiatry
was not ready for personalized medicine. At that point in the lecture, he did not state his opinion. Instead, he presented quite compelling data that demonstrated the evolution of our understanding of a wide range of specific variants that are associated with autism spectrum disorder. At the end of this review, he stepped backward and stated that, in his opinion, the evidence contradicted the negative conclusions of his colleagues at dinner and that child and adolescent psychiatry was ready for personalized medicine. Furthermore, he suggested that the importance of using genetic data to enhance clinical practice would inevitably increase in the years ahead. I suspect that few readers will be surprised to learn that I was in strong agreement with his contrarian conclusion.

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 pharmacogenomics testing that the Mayo Clinic has licensed to AssureRx, which is a personalized medicine company that specializes in pharmacogenomics applications. Dr. Mrazek may be reached at Mrazek.david@mayo.edu.

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Las Muchachas: Lessons Learned from Two Unauthorized Adolescent Sisters

Amy Mayhew, M.D., M.P.H.

During my training, I became aware of an “invisible” adolescent population. Although living in Houston, a Texas city with a large, unauthorized (sometimes referred to as illegal or undocumented) population, we were only nominally aware of their problems with regard to access to care, intimidation, and prejudice. I came to appreciate the challenges faced by unauthorized immigrants through my weekly interactions with a particular family. By sharing some of these therapeutic experiences, I hope to facilitate reflection about these obstacles, a topic rarely discussed in didactics or supervision.

Introduction

Unauthorized immigrants make up about 29 percent (11.2 million people) of the foreign-born population in the United States; 60 percent (6.7 million people) are from Mexico. There are about 5.1 million children living in the United States with at least one unauthorized parent; 21 percent of that group (1.1 million) are unauthorized themselves (Pew Hispanic Foundation 2010). With one in five public school children in the United States of Latino origin and a sizeable proportion of those (15-20 percent) here as unauthorized residents, understanding this experience is a public health issue. However, professionals in the community may not distinguish country of origin, legal status, or even native-born versus foreign-born individuals (Pew Hispanic Foundation 2008). As mental health clinicians working with this population, it is essential to have a working knowledge of the unauthorized experience and how it impacts care.

Adolescents are constantly remaking themselves, and acculturation can increase their ability to navigate their environment. At the same time, this process may create a rift between them and their parents, as the younger generation becomes more comfortable in the adopted homeland and abandons certain customs of the family’s country of origin. The immigration status of the teenager and family members adds a new level of complexity to successfully completing this stage of maturation and development.

Paulina jumped to Sonya’s defense and a three-way argument ensued. The boy took an aggressive pose, the sisters did not back down, and the verbal attack escalated to a physical altercation. Paulina was knocked unconscious; Sonya’s mandible and finger were broken.

Lesson #1: Resources are limited in a county system

Our first obstacle after identifying a need for treatment was obtaining appropriate services. The only Spanish-speaking therapist in the county hospital had no availability. I had initially agreed to only see Sonya but soon realized there was no similar intervention available for Paulina. I decided to see both sisters, anticipating the synergy of the treatment would be helpful. Their mother had never driven the interstate highway and, after no longer finding a weekly driver, she learned to drive the 45-minute route to the clinic herself.

Lesson #2: We must advocate even in the face of intimidation

Señora Lopez was tenacious in her desire to protect her daughters. The day of the incident she tried to file a police report, only to be confronted by the other student’s mother, a police officer herself, who insisted her son was falsely accused. The assistant principal brought Señora Lopez into his office; he told her it was not “in her best interest” to pursue the issue. Their mother insisted on filing a police report; she also found a Victims of Crime advocate that pushed for the other student to be prosecuted. The
Lesson #3: The circumstances of immigration are associated with lack of security

The girls came to the United States from Guanajuato, Mexico, at the ages of seven and eight years old. Their father had worked in the United States for years, returning to Mexico only once a year; he was largely unknown to them. Hearing rumors that he was seeing another woman, Señora Lopez moved with her four small daughters to the United States, fearful of losing him and his financial support. The girls suspected their father was still involved with the other woman and might leave them for her, adding to the precariousness of their situation.

In Guanajuato, the family had an extensive social network; Paulina, in particular, had a close relationship with an uncle who passed away soon after their departure. As we discussed the difficulties of her current situation, she often mourned the loss of her uncle’s support. Although she no longer felt she belonged in Mexico, she sometimes wished they had never left there, and that the complications in their current life did not exist.

Lesson #4: Generational differences are accentuated by acculturation

An underlying therapeutic theme was the different expectations the girls and their mother had regarding household rules and behavior. Señora Lopez was the oldest of nine children, and from an early age helped her mother care for her siblings. When she was seventeen years old, she met her husband. Her mother forbade her from seeing him; forced to make a choice, she ran off with him. Although she recognized her parents’ inflexibility caused her rash decision, she found herself forbidding her girls from having boyfriends, going out unaccompanied, or visiting with friends. The girls felt the rules were excessive and unrealistic in the United States, and all secretly had boyfriends. When the mother discovered Sonya was seeing a boy of whom she disapproved, she told her to choose between him and her family. Although not convinced she wanted to continue with him, Sonya felt her mother’s rigidity didn’t give her a choice.

Señora Lopez felt frustrated with her inability to influence her daughters’ choices. She kept tight reins on all aspects of their lives to prevent what she saw as unnecessary contact or attention from the larger society. She did not initially recognize that this rigid control led to her daughters rebelling. We discussed how a more open dialogue and negotiating choices in certain arenas might cause the girls to listen to her point of view around safety. With time and practice, both parties expressed increased satisfaction with their day-to-day relationship.

Lesson #5: The future is uncertain

In the context of these stressors, the girls were trying to prepare for their future. Sonya was encouraged by her teachers to pursue a career in education, which had available entryways for unauthorized students. The guidance counselor dismissed this possibility, stating, “it won’t fit into your schedule—why don’t you do cosmetology?” Although Sonya had teacher recommendations, the counselor did not believe teaching was a viable possibility. Paulina was determined to go to college and become a doctor; however, she did not know how to apply to schools, obtain loans, or even what tests she needed to take.

Towards the end of the school year, the male student began to harass the girls again. He knocked one to the ground during a fire drill and dared her to react. His friends approached the other sister during a fire drill and dared her to react. His friends approached the other sister in class and asked if she knew they were after her. Their mother went to the assistant principal, who replied, “There is nothing I can do.” He recommended she transfer to another school, stating she had no evidence of bullying. One afternoon, while the mother waited to talk to him, his secretary whispered that he did not like people of Mexican decent and often made racist comments; he likely

continued on page 16
Las Muchachas continued from page 15

would not help her. The mother began to look into other school options.

Lesson #6: What is helpful is not always sufficient

As the year progressed, the girls changed from failing all of their classes to doing well, managed to reconnect with their friends and family, and had a decrease in their nightmares and hypervigilance. As I prepared to change training venues and terminate at the clinic, I tried to transition them to another clinician. Unfortunately, they did not continue due to financial constraints and reservations about working with a new provider. After eight months, I heard from the family. Paulina told me that Sonya had dropped out of school; they also had run out of medication and the nightmares had returned. She hoped to continue on to college and was actively speaking to her counselor. She also related that her mother had managed to obtain visa documents for the family through the Victims of Crime program.

Conclusions

Being aware of the competing demands of unauthorized patients is critical to their treatment, especially in the context of the trying journey of adolescence. The adolescent has to form an individual identity while remaining connected to family; the unauthorized adolescent must do so in the face of subtle and overt intimidation, uncertainty, and a complicated relationship with both this country and the family’s country of origin. As clinicians, our job is to provide a space to discuss these possible stressors and serve as an advocate when possible, keeping in mind that they, like most children, did not choose to come here and cannot choose to leave.

References


Dr. Mayhew is a second year child and adolescent psychiatry fellow at Cambridge Health Alliance in Cambridge, Massachusetts, and did her adult residency training at Baylor College of Medicine in Houston, Texas. Her specific interests are in childhood PTSD, immigration and cultural psychiatry, and the intersection between mental health and the juvenile justice system. Dr. Mayhew may be reached at amayhew@challiance.org.
News From the Regional Councils

Laurence Greenhill, M.D.

Visiting AACAP’s many local regional councils of child and adolescent psychiatry (ROCAPs) was one of my most enjoyable presidential duties. The energy, enthusiasm, optimism, and talent in our association are most evident at the local level. For that reason, it seemed that a regular column highlighting ongoing ROCAP activity would share the knowledge and experience among our membership. To accomplish this, I’ll be reporting on three regions in each AACAP issue.

New York

I would like to begin with my own ROCAP, the New York Council Child and Adolescent Psychiatry (NYCCAP). I interviewed NYCCAP’s Warren Ng, M.D., who reported that the 450 member NYCCAP has monthly executive committee meetings and four meetings for local AACAP members annually.

The NYCCAP provided great help through its local arrangements activities around the 2010 Annual Meeting in October, 2010, in New York City. Melvin Oatis, M.D., and Richard Pleak, M.D., were the Locall Arrangement Chairs and Rebecca Weis, M.D., and Gabrielle Shapiro, M.D., served as the chair of the Meeting Monitors and as the hair of Receptions, respectively.


Next came the NYCCAP supported Inaugural Advocacy Night in March 2011 that included representatives from Children and Adults with Attention Deficit Disorder (CHADD), National Alliance for the Mentally Ill (NAMI), and the American Academy of Pediatrics to introduce our members in training to the opportunities for advocacy in child and adolescent psychiatry. Jose Vito, M.D., president of the NYCCAP, Maalobeka Gangopadhyay, M.D., a first year child fellow; and Dr. Oshadi, a second year fellow, planned the event. The Council held an End of Year Party, in June 23, 2011 at Pete’s Tavern to thank the membership for a successful year and to acknowledge our vibrant community of child and adolescent psychiatrists.

The NYCCAP held its annual Members in Training Welcoming Night on August 9, 2011, at the Session 73 East Side restaurant, under the direction of Cathryn Galanter, M.D., Dr. Gangopadhyay, and Dennis Gee, M.D. Moving to this more social and informal venue proved successful in drawing in over 80 new trainees. As then AACAP President, I was able to greet the new members in training and discuss AACAP membership benefits and advocacy opportunities. There even was a membership raffle for a first year child and adolescent fellow.

Sponsored by an AACAP Early Career Psychiatrist (ECP) CONNECT Grant, the New York Council presented a symposium on the Essentials of Private Practice on October 4, 2011, at Pete’s Tavern. Under the leadership of Vera Feuer, M.D., the chair of NYCCAP’s Early Career Psychiatrists (ECP) Committee, the panel leading the discussion consisted of a private child and adolescent psychiatrist solo practitioner, an accountant, and a malpractice lawyer to share tips on starting a private practice. The Connect Grant also provided funds to set up a local the NYCCAP web-based resource page for ECPs and members in training.

Eastern Pennsylvania and Southern New Jersey

I interview Rama Roa Gogineni, M.D., the program chair of the Regional Council of Child and Adolescent Psychiatry of Eastern Pennsylvania and Southern New Jersey (RCCAPPSNJ), a 234-member association spanning two states. This ROCAP holds monthly meetings for its members, 8 executive committee meetings, and three CME programs a year.

These include an annual Child and Adolescent Psychotherapy and Psychopharmacology (CAPP) conference each September that featured lectures by Timothy Dugan, M.D., Gabrielle Carlson, M.D., and Harold Carlson, M.D. The CAPP’s title for the full-day meeting was “Pediatric Bipolar Disorder, Mood Lability, Complications of Medication Treatments, Risk Management, and Complementary Medicine.” The meeting registered 130 attendees, 30 of whom were trainees. In addition, each June, the RCCAPPSNJ holds an annual Staples Memorial Lecture and Dinner. This year’s meeting featured then President-elect Martin Drell, M.D., now AACAP president) who lectured on “Rebuilding, Recession, Reductions, and Rascals: A balance of continuity, change and chaos.”

RCCAPPSNJ has many ongoing activities, such as the development of a membership directory, mock boards, having the largest representation from a ROCAP at AACAP’s National Advocacy Day, starting a Collaboration of Care Committee with pediatricians, an Annual Career Day, Travel Sponsorship of Fellows interested in attending the AACAP Annual Meeting, a web page for the region, and an ECP Committee that was awarded a $2000 AACAP

continued on page 18
News From the Regional Councils continued from page 17

CONNECT grant for promoting activities for ECP members. Anne Fredrickson, M.D., the ECP chair, was instrumental in getting ECPs to come an hour early to the Staples Lecture to meet with Dr. Drell.

North Carolina

Finally, I chatted with Kaye McGinty, M.D., past-president and treasurer of the North Carolina Council of Child and Adolescent Psychiatrists (NCCCAP). (Current president is Erin Malloy, M.D.) This NCCCAP schedules four executive committee meetings a year, and a three-day NCCCAP Annual Meeting in conjunction with the North Carolina Psychiatric Association that gives CME credit to attendees. The 2011 NCCCAP meeting was held in Asheville, North Carolina, and featured William Beardsley, M.D., who spoke on “Depression in Mothers” and “Working with Latina Families, Cultural Considerations” that discussed local projects as well as international child psychiatry projects working with families in Chile. Two NCCCAP members presented after Dr. Beardslee: Luke Smith, M.D., and Roberto Blanco, M.D. The annual Marc Amaya Award was given at this conference to a medical student from one of the four medical schools in North Carolina. This award has been given every year since 2005, and each awardee has pursued psychiatry. The NCCCAP holds a regional Advocacy Day every year in conjunction with North Carolina Pediatric Society (NCPS) and child psychiatry residents and attendings. The NCCCAP has been collaborating with other mental health and pediatric associations to advance community mental health, with a project to make certain that state-supported intensive in-home care is of the highest quality. Efforts are underway to promote private collaborative models of care delivery, including co-locating child psychiatrists in pediatrician’s offices and the use of Telepsychiatry in North Carolina.

These are some of the exciting projects undertaken by our members at the local level, showing that our profession is a natural soil for advocacy and community commitment.

Dr. Greenhill, AACAP past-president, is Ruane Professor of Clinical Psychiatry at Columbia University, and a research psychiatrist II at the New York State Psychiatric Institute. He maintains a half-time private practice. He may be reached at larrylgreenhill@gmail.com.

**Annual Meeting Program Committee Travel Scholarships Available**

If you are considering submitting a proposal for the 59th AACAP Annual Meeting, October 23-28, 2012, in San Francisco, you or your co-presenters may be eligible for a Travel Scholarship from the AACAP Program Committee, supported by AACAP’s Campaign for America’s Kids.

A limited number of scholarships are available to presenters and poster primary authors in the following categories:

- **Junior scholars:** defined as AACAP members who are within seven years of completing their child and adolescent psychiatry clinical training. Scholarship winners in this category will receive a $500 travel scholarship to be used towards attending the Annual Meeting as well as a complimentary registration for the meeting.

- **Senior researchers:** defined as non-child psychiatrists doing seminal scientific research in areas related to the mission of AACAP. Scholarship winners in this category will receive a $1,000 travel scholarship to be used towards attending the Annual Meeting as well as a complimentary registration for the meeting.

Scholarship requests will be evaluated based on the submission for the Annual Meeting. If you or one of your presenters is interested in applying for either of these scholarships, please indicate your interest in the online Call for Papers submission website. If you have questions about eligibility, please contact Jill Zeigenfus, Deputy Director of Meetings at jzeigenfus@aacap.org.
The Council’s action shifts focus from merely implementing MOC to opening up discussions about the underlying rationale for the new MOC requirements; whether they have proven benefit and are worth the added costs and burdens.

MOC requirements apply to diplomates who received time-limited specialty certification, which became effective on October 1, 1994. MOC requirements include:

1) an unrestricted medical license;
2) CME and self-assessment activities (which will also be expanded in 2013);
3) passing recertification exams once every 10 years; and
4) starting in 2013, completion of Performance in Practice (PIP) Units.

Each PIP unit consists “of both a Clinical Module (chart review) and a Feedback Module (Patient/Peer second-party external review). Clinical modules require that diplomates collect data from at least five patient cases in a specific category... obtained from the diplomate’s personal practice over the previous 3-year period. Each diplomate must then compare data from the five patient cases with published best practices, or practice guidelines or peer-based standards of care..., and develop a plan to improve effectiveness or efficiency of his/her clinical activities. Within 24 months, each diplomate is required to solicit feedback from at least another five peers and five patients to see if improvements in performance have occurred.” (ABPN website)

“Feedback Modules (Patient/Peer Second Party External Review)...require each diplomate to solicit personal performance feedback from at least five peers and five patients concerning the diplomate’s clinical activity over the previous three years. Each diplomate must then identify opportunities for improvement in the effectiveness and/or efficiency in their performance as related to the core competencies and take steps to implement suggested improvements. Within 24 months, each diplomate is required to solicit feedback from at least another five peers and five patients to see if improvements in performance have occurred.” (ABPN website)

Over a 10 year period, diplomates will be required to complete 3 PIP units. As the PIP requirements start taking effect in 2013, several issues are of heightened interest. The new MOC requirements, in particular PIP, could cause significant
changes for the practices of psychiatrists. Yet psychiatrists who are most affected by these changes have not had a significant voice in evaluating the underlying rationale for and scope of the changes in MOC.

The specific points in the 2011 APA Referendum that the AACAP Council endorsed are the following:

1) The patient feedback requirements for the purpose of reporting to the Board is unacceptable, as it creates ethical conflicts, and has the potential to damage treatment.

2) The requirements other than a cognitive knowledge examination once in 10 years, regular participation in continuing medical education, and maintenance of licensure pose undue and unnecessary burden[s] on psychiatrists.”

The APA Referendum had previously been supported by approximately 80 percent of APA members who voted in the election. However, because less than 40 percent of the membership voted, the referendum did not carry the power necessary to pass.

The AACAP Council also passed a motion that the AACAP President would support discussions between AACAP leadership, the ABPN, and include representation from the AACAP Assembly.

These motions were presented to the AACAP Assembly by the Working Group on MOC Review. The following is a summary of some of the discussions of the Working Group. Unlike the motions the Council passed, this summary does not represent official AACAP policy.

The stated purpose of MOC, as noted in the ABPN website (neurology) is the following:

“With so much attention on medical errors and liability issues, as well as spiraling health care costs, the public is demanding that their physicians demonstrate expertise and competence. The ABMS [American Board of Medical Specialties] established the MOC program as a professional response to the need for public accountability and transparency.”

The purpose of MOC raises several questions: To what extent has quality of care deteriorated? What are the best, most cost-effective ways of ensuring physician expertise and competence that are valid, reliable, and have proven benefit? To what extent is the demand for public accountability and transparency due to frustrations with spiraling health care costs rather than to deficits in the expertise and competence of physicians? The larger issues related to spiraling healthcare costs are generally outside of the scope of Medical Licensing and Certifying Boards.

Ways of ensuring physician competence and quality of care include passing periodic cognitive knowledge exams and completing CME activities, including self-assessment activities. Without clear evidence that these ways of ensuring quality are ineffective, physicians will now also be required to implement certain PIP procedures for MOC. These procedures have not been adequately tested to ascertain whether they have proven benefit, that they are not onerous or time-consuming, and do not increase health care costs.

The PIP requirements include obtaining patient and peer feedback for MOC. The requirement for patient feedback for MOC creates ethical conflicts, is detrimental to the psychiatric relationship, and should be eliminated from MOC requirements. Peer feedback for MOC is of questionable benefit, may be detrimental in this context, and should be eliminated from MOC.

MOC requirements also change the fundamental landscape of licensing and certifying boards from ensuring that physicians provide care that meets acceptable standards to adding the goal of improving medical care. Requiring that physicians pass periodic cognitive exams ensures that physicians keep current with advances in medical care, and in this way MOC already improves medical care. However, broader interpretations of improving medical care under PIP requirements introduce confusion about the adequacy of providing care that meets acceptable standards. It creates medical liability issues with problems of unintended consequences.

We need to be aware of these major changes in our field, to evaluate their rationale, and to determine which of these changes advance our field and which do not. Sharing information about MOC and providing feedback to our professional organizations can help us have a voice in matters crucial to our profession.

Dr. Holzgrefe was a member of the Assembly Working Group on MOC. She is an assistant clinical professor in Psychiatry at The George Washington University School of Medicine in Washington, D.C., and has a private practice in Chevy Chase, MD. Dr. Holzgrefe may be reached at jholzgrefe@msn.com.
Tess, age 14 years, was hospitalized on a psychiatric unit after an intentional acetaminophen overdose. She had no formal psychiatric history and had never received psychiatric treatment. Tess appeared hopeless and defeated as she confessed that she had been feeling sad and lonely since her family moved to their current location about two years ago. She stated that she had had trouble making friends in her new school and her grades had also dropped from Bs and Cs to Ds and Es. She had gone from being popular in her previous school to being a “loner” in her current school. Tess had only one close friend, of whom her parents disapproved. In fact, Tess had a legal charge pending for attempting to steal alcohol from a grocery store with this friend. She also embarrassedly admitted to a previous legal charge the year before for child pornography after posting a picture of a naked teenage boy, a “sext” message originally intended for someone else, as her MySpace picture for a period of less than 24 hours. When the boy discovered this, he was so mortified that he told his school guidance counselor he wanted to kill himself. The boy’s parents pressed charges, resulting in the child pornography charge. From this point on, Tess became progressively more depressed. Tess had feared that the judge would be “harsher on her” for the alcohol theft charge due to her prior legal history, which prompted her suicide attempt.

Today’s generation of adolescents uses social media, including the Internet and cell phones, to aid in the social and emotional developmental task of incorporating sexuality into a sense of self and relationships. An estimated 93 percent of youth use the Internet regularly, and 20 percent of teens have sexted (sent inappropriate sexual messages/pictures via cell phone) (Delmonico and Griffin 2008; NCPTUP 2008). Sexting appears among the top ten health concerns for children for the first time (#10) in the National Poll on Children’s Health (2011), rated by 20 percent of adults as a big problem. Internet safety was the 6th ranked concern by 23 percent of adults. Although this immediate access to information and to social connections can be beneficial in providing immediate social support and knowledge about sexual and general health issues, the rapid rate at which information can be disseminated can also be dangerous (O’Keeffe 2011). Teens can garner instant attention by taking a provocative picture and sending it as a text message by phone (O’Keeffe 2011; Katzman 2010). Revealing photos can be uploaded onto a computer and sent by e-mail through the internet, where they remain permanently in “cyberspace.” Teenagers can use web cameras on interactive web sites and engage in sexual behaviors “live.” It is clear that the combination of impulsivity, limited judgment, sexual development/curiosity, and immediate access can lead to dangerous consequences.

This technology has both created complications for the millennial teen and added to the responsibilities of pediatric health care providers, who must keep up with these new developments in social media, as well as current trends in adolescent sexual behavior, in order to ask appropriate questions during psychiatric evaluation. A careful psychiatric interview, including a thorough sexual history, is necessary to formulate the differential diagnosis when these adolescents present. Diagnoses include, but are not limited to: mood disorders (Ybarra 2005), anxiety disorders (Reid 2007), psychotic disorders, pervasive developmental disorders, substance use...
Although teens may present with sexually inappropriate use of social media as their chief complaints, sometimes these behaviors may only be discovered incidentally, such as with Tess. It is therefore important to ask questions about their use of the Internet and cell phones when asking teens about hobbies, high risk behaviors, and interpersonal relationships. Teenagers often do not volunteer this information, so if the clinician does not specifically ask, critical information could be missed. Knowledge about this behavior can be helpful in formulating a thorough differential diagnosis and beginning appropriate treatment, which may include psychoeducation, medications, hospitalization, individual therapy, family therapy, group therapy, and/or school services.

Let’s revisit this case. Although Tess had indeed been suffering from depression, the posting of a naked picture on her MySpace profile seemed to be more a function of poor judgment than a consequence of her psychiatric illness. During her hospitalization, Tess clearly and consistently stated that her mood had had no impact on her actions; at the time, she had simply thought it would be “funny” to post the picture. She admitted that she had no idea of the consequences and “didn’t think it was a big deal.”

Although teens may present with sexually inappropriate use of social media as their chief complaints, sometimes these behaviors may only be discovered incidentally, such as with Tess. It is therefore important to ask questions about their use of the Internet and cell phones when asking teens about hobbies, high risk behaviors, and interpersonal relationships. Teenagers often do not volunteer this information, so if the clinician does not specifically ask, critical information could be missed. Knowledge about this behavior can be helpful in formulating a thorough differential diagnosis and beginning appropriate treatment, which may include psychoeducation, medications, hospitalization, individual therapy, family therapy, group therapy, and/or school services.

There are several references that provide further information on this topic:


Dr. Flaherty is chair of the AACAP Committee on Adolescent Psychiatry. She is editor in chief of Adolescent Psychiatry, the journal of the American Society for Adolescent Psychiatry. She may be reached at lflaher770@aol.com.

Dr. Martel is an attending psychiatrist at Children’s Memorial Hospital in Chicago, Illinois, and associate professor of Psychiatry, Clinical Scholar Track, at Northwestern University’s Feinberg School of Medicine. She is a member of the Committee on Adolescent Psychiatry, and chair of the College Student Mental Health Committee. Dr. Martel may be reached at almmd@aol.com.

Dr. Hua is a child and adolescent psychiatrist at the University of Michigan and a member of the AACAP Committee on Adolescent Psychiatry. Dr. Hua may be reached at llhua@umich.edu.
Receiving financial support from the Educational Outreach Program provided by the Life Members Fund allowed me to attend my first AACAP Annual Meeting. I really enjoyed attending the lectures, symposia and poster sessions, and found the formalized mentorship program to be very helpful. However, the Life Members Dinner was a highlight of the week. I was not sure what to expect at this gathering, but was eager to meet those that had made my attendance at the meeting possible. During the cocktail hour, I spent time getting to know some of my fellow residents better, and over dinner I conversed with individual Life Members in a way that would not have otherwise occurred at the meeting. It was immediately clear that this group shared a very special sense of community. They even made sure that some of those that could not physically join them at the dinner were connected via cell phone during the speeches. As they shared stories and reminisced, their collective energy was palpable. This offered a glimpse into what for many appeared to have been a sustaining community, on both professional and personal terms. Their investment in the trajectory of AACAP has been significant. They recalled the trials, tribulations and joys of building hospitals, clinics and departments, fostering training programs, and engaging in their local AACAP regional organizations.

It was a privilege to be in the company of these esteemed clinicians, academicians, and leaders. As young trainees, it is easy to be caught up in the daily race to keep up with our patients, responsibilities and call schedules. It is easy to forget that we are actually shaping our own professional narrative, and that each stage of the career trajectory is important. It was clear that these leaders shared a sense of vision and initiative, which they still exhibit by the existence of the Life Members Fund and their investment in trainees. I left feeling a sense of gratitude for having been included in this group, but also an even greater sense of responsibility to engage and invest in AACAP and its mission.

Dr. Quigley is a triple board resident at the University of Kentucky College of Medicine Program in Lexington, Kentucky.

Mentorship Grants for Medical Students: A Recipient’s Experience

This year, I was honored to be one of seven medical student recipients of the AACAP Life Members Mentorship Grant to attend the AACAP+CACAP Joint Annual Meeting in Toronto. In addition to participating in daily mentorship activities, we were invited to attend the 4th Annual Life Members Reception and Dinner on October 20, 2011. I know that I speak for the other six medical student recipients when I offer thanks to the AACAP Development Committee, and specifically the Life Members Subcommittee, for creating the program this year.

Through the course of the evening, I learned that each Life Member has at least thirty years of AACAP involvement, and that the group’s membership currently spans an age range from 65 to 101 years old. The camaraderie between the Life Members was amazing to observe, as these men and women who have known each other for decades greeted each other and caught up on both personal and professional levels. The unveiling of the Secret Seven was a perfect example of how these relationships have been nurtured. In 1968, a group of seven child and adolescent psychiatrists from Houston formed a Journal club.

Although there have been some changes in membership over the years, the group developed from professional colleagues into lifelong friends and it continues to thrive 43 years later. What a treat it was for me to hear their story, and to see in action the balance of work and personal life that is required to have a long and fulfilling career!

Also at the dinner, the symbol of an owl was formally announced as a new logo to represent the Life Members. Laurence L. Greenhill, M.D., then AACAP president, discussed that throughout the centuries and within different cultures, owls have symbolized many concepts: intelligence, wisdom, mystery, secret knowledge, transition, protection, and the keeper of spirits. As someone whose

continued on page 24
career in psychiatry has yet to begin, I
was struck by how apropos this sym-
bol is for the Life Members group. The
obvious association was the wealth of
experience, accomplishment, and wis-
dom in the room that night. On further
reflection, I realized that the lesser-
known symbolic meanings also reflect
the spirit of the Life Members. They have
transitioned the field from its begin-
nings to its current state through their
clinical work, research, and academic
endeavors. As protectors, they provide
mentorship to medical students and
residents aspiring to become child and
adolescent psychiatrists to ensure that
the field will continue to thrive.

Ms. Welte is a fourth year medical
student at the University of
Missouri-Columbia.

This is Your Opportunity to
Comment on the Journal

The Ad Hoc Committee on Editorship and Publications is review-
ing the work of the Journal of the American Academy of Child &
Adolescent Psychiatry and the Journal editor. The Committee has
convened and asks AACAP members to answer a few questions
regarding their thoughts about the Journal.

What aspects of the Journal do you like best?
What suggestions would you make for changes
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Mentorship Grants for Medical Students: A Recipient’s Experience continued from page 23
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ADHD Medications and the Cardiovascular System

Issues regarding the safety of the two stimulant medications (methylphenidate and dextroamphetamine) for ADHD have garnered both public and professional attention. The well-documented potential for misuse/abuse of both agents has led to a Federal Drug Administration (FDA) black box warning. Additionally, concerns about cardiac events, with dextroamphetamine, has also resulted in a second cardiac component of the FDA black box warning for dextroamphetamine. It should be noted that the cardiac warning is with a “misuse” specifier. While not “black boxed,” these concerns have extended, at least for some, to the methylphenidate preparations as well. Clinicians have been left with one of the most effective agents in our medication armamentarium being tarnished both by abuse potential (clearly deserved) and cardiovascular safety (questionably deserved but commonly believed by the public). While the abuse potential remains, Cooper et al., in the *New England Journal of Medicine*, have finally addressed the cardiovascular risk of stimulants, finding that there is none. Their study of pooled data looked for any serious cardiovascular event (sudden death, myocardial infarction and stroke) in 1,200,000, two to twenty-four year olds across four health plans. This included over 3,763,000 patient medication years of treatment and over 2.5 million patient years of follow up. They found risk rates for a serious cardiovascular event, across all populations of 3.1/100,000 person years and no statistically significant differences in rates between the patients receiving stimulants and those who did not. Simply put there is no evidence that therapeutic doses of either of the two stimulants has a statistically significant impact on the cardiovascular system. Given the effectiveness of the stimulants in the treatment of ADHD, patients should not be denied care based upon cardiovascular concerns.


www.nejm.org/doi/full/10.1056/NEJMoal1102122#t=article

Inattention or Hyperactivity

There is more than ample evidence that ADHD has a negative impact on educational achievement as well as having a wide range of other adverse outcomes, e.g., depression, anxiety, substance abuse. However, it is also very clear that children with ADHD represent a heterogeneous group, even with respect to the core symptoms of inattention and hyperactivity. In the educational outcome studies to date there has been a pooling of all ADHD types including a pooling of the hyperactivity and inattention symptoms, without attempts at examining the possible independent contributions of each of these core cluster symptom sets. In Pingault’s study in November’s *American Journal of Psychiatry*, for the first time, each of these core dimensions are addressed independently. In their study of 2,000 representative, non-clinical Canadian children, they divided the participants into four dimensional groupings along the hyperactivity (low to high) and inattention (low to high) axis. They then examined their educational outcomes, as determined by having achieved a high school diploma, over the course of the next 16 years. They found that, when disaggregated, hyperactivity, even in the highest group (which is clearly a clinical one), did not independently predict adverse outcomes. However inattention did, with the highest inattention group having an odds ratio of 7.66 of failure to achieve a diploma when compared to those with the least inattention (best attention). Additionally, they found that changing trajectories mattered. Those children that demonstrated an increasingly inattentive trajectory, also fared more poorly in the educational domain (odds ratio of 2.67) and those with a positive trajectory improved (odds ratio of 3.87) when compared to their original groups. For clinicians and parents this offers several important points, albeit limited to educational achievement.

First, inattention puts children at risk and disproportional efforts to identify and intervene with these children (those most affected by inattention) are most critical. Second, efforts at improving attention matter; when successful, as evidenced by an improving trajectory, they have a positive impact on outcome. So while further studies are needed, this study suggests that identification of those most at risk and interventions that target inattention (medications and behavioral) matter.


Medications, Development, and Adverse Events

While general awareness of the developmental variations in medication response and in adverse events is common, details on the specific nature of age X medication adverse events is far less so. In Safer’s review; *Age-Grouped Differences in Adverse Drug Events from Psychotropic Medication*, he addresses this gap through his extensive literature review. His findings, organized by class are as follows:
Methylphenidate and Amphetamines: Decreased growth velocity in both height and weight, with a differentially increased effect in younger children and as duration of usage lengthens. Children have more abdominal pain than adults, but fewer headaches. While adults often report some euphoria, children report decreases in mood, tearfulness and feeling subdued. Again this effect is greater in the youngest (pre-school, early school age populations) with pre-schoolers also reporting increases in anxiety.

Atomoxetine: Decreased growth velocities in both height and weight have been reported as has increased somnolence and vomiting, again differentially affecting the youngest age groups. Sexual dysfunction has been reported in approximately 25% of adolescent males, but this is far below the mean of almost 60% in adult males.

Venlafaxine: Has the same age dependent suicidality concerns as the SSRIs, but an even greater decrease in growth velocity, particularly in the school age group. It (along with paroxetine-both off label) is associated with the highest rate increases in reported suicidality. In other reports this was believed to be attributable to their relatively short half lives.

Mirtazapine: Has the same age dependent suicidality concerns as the other antidepressants, but is also associated with weight gain (7% increase in one 8 week trial), which is comparable to the weight gain reported in adults.

Anti-psychotics:
First Generation: Haloperidol was found to have an appreciably greater rate of dystonic reactions in teens with a concomitant increase in the protective effects of anticholinergics. The other adverse effects (sedation, other extrapyramidal effects) are believed to be comparable to those in adults.

Second Generation: All but ziprasidone have clearly been shown to have even greater weight gain (proportionally) than in adults. This is most noteworthy with olanzapine of the commonly used agents: weight gains of over 7% in 2/3 of those receiving it. Weight gain (by percentage) is worst in the youngest age groups. With the exception of tardive dyskinesias (lower), almost all other adverse effects, particularly sedation, are higher with each of the agents in children, when compared to adults.

There were also some medication specific findings with more marked abnormalities of lipids (olanzapine), prolactin and liver enzymes (olanzapine and risperidone), increases in heart rate and blood pressure (quetiapine), and QTC prolongation (ziprasidone).

Mood Stabilizers:
Lithium: modest increases in nausea and vomiting in youths when compared to adults.

Valproic acid: Increases in liver toxicity and pancreatitis, particularly in those under 10. Increases in the rates of polycystic ovaries in teen girls when compared to adult women.

The author goes on to comment about the multiple possible mechanisms for the differential effects noted above, including underlying brain differences, differences in metabolism and endocrine status, and increased physical activity levels. For clinicians the message is clear, given that (generally speaking except with stimulants) the positive evidence is more modest and the side effects more pronounced, greater care in initiating medications in pediatric population must be the rule. Early age of initiation and longer term administration appear to be among the most important determinants of adverse events.


Apologize to the Children: Healing Child Abuse Trauma through Attachment Reconciliation

By Gaston E. Blom, M.D.

Larch Press, 2009
152 pages ~ $16.95 (softcover)

Children who suffer abuse often become part of welfare and human service systems that may inadvertently exacerbate the original abuse trauma. Such children frequently become further “victimized” by multiple placements away from home and community. Through a series of moving child narratives, this book challenges the usual management and treatment approaches to child-abuse trauma. It also presents elements of restorative justice such as acknowledgment, truth-telling, contrition, apology, repentance, forgiveness, amnesty and reconciliation in the attachment reconciliation process. The book draws on parallels to the Truth and Reconciliation Commission in South Africa, which helped that nation heal from apartheid violence.

Gaston Blom, M.D., has nearly 60 years of experience working as a child and adolescent psychiatrist and psychoanalyst. He has worked with abused foster and adopted children from all over the world. He can be reached at gastonblom@comcast.net.

Kids on Meds

By Kevin T. Kalikow, M.D.

W.W. Norton & Company, 2011
448 pages ~ $27.95 (hardcover)

This book introduces the general reader to the world of psychopharmacology. Written for parents and healthcare professionals, in an easy-to-read style, it addresses the confusing topics of how medicines are named, how the brain works, and what happens to medicine as it travels through the body. It is particularly helpful to parents navigating through the complicated and often confusing information about psychiatric medication. Through explanations on various disorders, this book also offers the diagnostic clarification parents need to make a sound decision regarding treatment. The final chapter examines the controversial topic of whether psychiatric medicines are over- or under-prescribed to children and adolescents.

Kevin T. Kalikow, M.D., is a child and adolescent psychiatrist in private practice and a clinical assistant professor of psychiatry and behavioral sciences at New York Medical College. He has also written Your Child in the Balance: Solving the Psychiatric Medicine Dilemma.

AACAP members who would like to have their work featured on the Media Page may send a copy and/or a synopsis to the new Resident Editor, Garrett Sparks, M.D., at Western Psychiatric Institute and Clinic, 3811 O’Hara Street, Pittsburgh, PA, 15213 or email sparksgm@upmc.edu.
POETRY

Old Photographs
Kieran D. O’Malley, M.D.

Look at this life
As it unfolds
Before your eyes.

Black and white miniature shapes
Expand through the lens of time reflected.

Could it have all happened
So long ago
In another time,
In another world.

The frozen images
in a folded brown album
Become live again;
Dancing eyes and smiles
And laughter fill so many pages.

All re-captured in a separate
Life time
Back when it all began.
Funny to see it now.

Even a family interrupted
Happened;
and exists in
a space beyond the
Celluloid print.
One never really knows
Where life will take us.
Old photographs
Bring grounding to that Journey.

Seems to me
It’s time for
New photographic images
Which
will become
Old photographs
Of our digital era.

Dublin, January 6th 2011

Kieran D. O’Malley, M.D., is a Belfast born child and adolescent psychiatrist who trained and practised for over two decades in the United States and Canada. He returned to Ireland in spring 2006 and currently divides his time between community psychiatry practise at Charlemont Clinic and Consultation/Liaison at Our Lady’s Children’s Hospital Crumlin in Dublin. He has a long standing special interest in Fetal Alcohol Spectrum Disorder.

Individuals interested in submitting poetry should e-mail Poetry Coordinator Charles Joy, M.D., at crjoy1@gmail.com.
SAVE THE DATES!

- Call for Papers Submission Deadline: February 15, 2012
- Book Hotel and View Preliminary Program: June 15, 2012

59TH ANNUAL MEETING

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

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Visit www.aacap.org for the latest Annual Meeting Information.
The Research Forum in Toronto, *Advancing Biomarker Sciences in Pediatric Psychiatry*, convened on the opening day of the AACAP+CACAP Joint Annual Meeting. Led by Co-Chairs John S. March, M.D., M.P.H., and James McGough, M.D., M.S., the program introduced participants to the emerging field of biomarker science as specifically applied to issues of diagnosis, prognosis, and treatment response in pediatric emotional and behavioral disorders. Presentations provided an overview of the current regulatory environment for the development of diagnostic and companion biomarkers and biosignatures, reviewed current and potential applications of biomarker sciences in psychiatry, and provided a forum for participants to describe perceived impediments for the integration of biomarkers into clinical use.

Dr. March presented an introduction that reviewed basic definitions and outlined the potential of biomarker sciences in the future service of personalized medicine. Ni A. Khin, M.D., medical team leader with the Center for Drug Evaluation and Research, U.S. Food and Drug Administration, discussed regulatory requirements for biomarker development. Molly Oliveri, Ph.D., director of the Division of Developmental Translational Research at the National Institute of Mental Health (NIMH), outlined current National Institutes of Health (NIH) funding priorities, activities and recent findings in biomarker sciences for mental health, with a particular emphasis on the NIMH Strategic Plan and the Research Domain Criteria (RDoC) Project. Magali Haas, M.D., Ph.D., provided an industry perspective. William Potter, M.D., Ph.D., described the process of biomarker identification and validation as applied to Alzheimer’s Disease. Kathleen Pager, M.D., M.P.H., discussed the role of diagnostic biomarkers in predicting treatment response in early-onset depression. Madhukar Trivedi, M.D., outlined the current multi-site study funded by the NIMH Biomarker Initiative to discover biosignatures predictive of antidepressant treatment response.

During the open discussion, it was evident that meaningful advances in personalizing psychiatric medicine would require substantial research funding and the ability to pool clinical data across very large patient samples. In the afternoon session, participants divided into working groups to discuss additional impediments to the development and application of biomarker sciences to neurodevelopmental disorders, with particular emphases on genomics and proteomics, neuroimaging, and electroencephalography. Issues raised included the inability to integrate diagnostic and treatment outcome data among psychiatric practitioners, the lack of standardized clinical assessment and treatment outcome measures across the field; and limitations of our current diagnostic system as it relates to the underlying biology. A summary of the Research Forum presentations and discussion is under preparation for submission to the *Journal of the American Academy of Child and Adolescent Psychiatry*.

Dr. March is a professor of Psychiatry and Behavioral Sciences and director of the Division of Neurosciences Medicine at the Duke Clinical Research Institute where he oversees Phase I-IV clinical trials in psychiatry, neurology, and pain. He may be reached at john.march@duke.edu.

Dr. McGough is professor of Clinical Psychiatry at the UCLA Semel Institute for Neuroscience and Human Behavior, where he is director of the Child and Adolescent Psychopharmacology Program and chair of the UCLA Medical Institutional Review Board. He may be reached at jmcgough@mednet.ucla.edu.
Studies have shown prevalence rates of delirium, up to 60 percent in the non-ventilated group and up to 80 percent in the ventilated group (Gunther 2008). Epidemiologic studies of delirium in adult intensive care medical and surgical units have identified variable prevalence rates of delirium, up to 60 percent in the non-ventilated group and up to 80 percent in the ventilated group (Gunther 2008). Studies have shown that ventilated adults with delirium have three times greater risk of death after controlling for other factors. In the pediatric literature, we do not have prospective studies regarding incidence or prevalence.

The adult literature on delirium in the acute care setting in which there is a significant number of patients with brain dysfunction may be admitted. Barriers to recognition of brain dysfunction include lack of research in the field of pediatric delirium as well as lack of understanding of the pathophysiology of pediatric delirium. Understanding the epidemiology of this syndrome in children requires accurate identification of these children. The adult literature on delirium in the intensive care setting has demonstrated the potential for significant morbidity and mortality when not recognized and clinically managed (Ely 2004).

The pediatric intensive care unit is an acute care setting in which there is a significant number of patients with brain dysfunction may be admitted. Barriers to recognition of brain dysfunction include lack of research in the field of pediatric delirium as well as lack of understanding of the pathophysiology of pediatric delirium. Understanding the epidemiology of this syndrome in children requires accurate identification of these children. The adult literature on delirium in the intensive care setting has demonstrated the potential for significant morbidity and mortality when not recognized and clinically managed (Ely 2004).

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The team at Vanderbilt reviewed the barriers to recognition of pediatric delirium in our pediatric intensive care unit (PICU). A key factor was the absence of a screening tool for bedside nurses to incorporate into their routine care of children. Also identified was a lack of understanding of the pathophysiology of delirium in children and tolerance of the hypoactive state of delirium due to the lack of disruption of the routine care. Sedation and pain management protocols can increase risk for delirium in the absence of understanding of the role of neurotransmitter dysregulation in the pathophysiology of delirium. We noted that the intensive care teams focused primarily on other organ systems with a more cursory review of the brain function.

A tool to screen for delirium in a pediatric population is needed to help identify the incidence and prevalence of pediatric delirium in the intensive care unit as well as to increase our understanding of the morbidity and mortality of pediatric delirium. Improved identification of pediatric delirium should lead to a review of routine monitoring protocols in the intensive care unit and contribute to reassessment of sedation and pain management protocols. The Vanderbilt team developed and validated a tool for bedside nurses to screen for delirium in children 5 years and older. The pCAM-ICU is available at the website www.mc.vanderbilt.edu/icudelirium/assessment_pediatric.html (Smith 2011).

Pediatric Bipolar Disorder is an important topic in the world of consultation liaison psychiatry. National trends indicate that the diagnosis in youth has been steadily increasing. This is accompanied by a steady increase of office-based visits with children on antipsychotic medications (Moreno 2007). Since the introduction of the concept of pediatric bipolar disorder, the field has attempted to develop consensus on the diagnosis but with inadequate nosology affecting clinical assessment of these children. Robert Althoff, M.D., Ph.D., gave an outstanding review of the neuroscientific features and life course of severe mood dysregulation (SMD) in children. The Child Behavior Checklist profile for SMD includes elevations in Anxious/Depressed, Attention Problems, and Aggressive Behavior. His group has demonstrated that this profile is highly associated with suicidality by both self-report and parent-report. These children grow up to have difficulty with self-regulation as adults (Althoff 2010). A review of genetics and epigenetics indicates that SMD is heritable with early life influence of the environment. Environmental factors appear to decrease with increasing age. The profile may be associated with epigenetic methylation differences between discordant MZ twin pairs.

Dr. Althoff reviewed the components of assessment of these children with a focus on detailed attention to patterns of mood and associated symptoms. It is critical to consider the pattern of aggression with review of precipitants and factors that help alleviate the aggression. The group has developed the Vermont Family Based Approach, providing a multidisciplinary treatment that includes a Family Wellness Coach and a Focused Family Coach. The wellness coach focuses upon a comprehensive approach to health including nutrition, exercise and daily patterns of behavior such as music training, a reading program, and peer support. There is a component that works with parents on effective parenting strategies. The treatment strategy incorporates the importance of both pharmacologic and non-pharmacologic interventions and encourages consideration of longitudinal patterns of behavior in the context of environmental influences.

Telepsychiatry is another unique approach to consultation liaison work.
with children and families. **Antonio Pignatiello, M.D.**, from the University of Toronto provided a clear and effective description of the SickKids Telelink Mental Health Program in Canada, describing the mission to implement knowledge, collaborate with primary care clinicians and other experts in the satellite areas, education of other clinicians and trainees at the University of Toronto, and evaluation and research on the effectiveness of telepsychiatry. He outlined the necessary components for implementation of telepsychiatry which include available technology, service deliverables, funding, infrastructure, and champions of the program. Their program provides direct consultation to children and adolescents and their families, direct consultation to programs, professional to professional consultations, and an educational link to Grand Rounds at the University of Toronto.

What is the value of telepsychiatry? This format enables local access to rural communities while factoring in the economics of service to a critical mass of the population. Primary care is enhanced with professional support to isolated communities, encouraging continuity of care. Work with the local health care providers can reduce the stigma of consultation with a psychiatrist while effectively distributing scarce resources. This approach can decrease security issues when working with a population in the legal system.

The Televiews Study was designed to assess the perspective of children and adolescents regarding this telepsychiatry. Key components identified included the importance of a pre-session to prepare the youngsters and the importance of personalizing the experience and having initial social “chit-chat” to warm up the youngster. Dr. Pignatiello described how this program has been successfully incorporated into teaching and research at his institution. The presentation effectively demonstrated a consultation model that overcomes the challenges of low population density. The program can be viewed at [www.aboutkidshealth.ca/News/TeleLink-helping-kids-at-a-distance.aspx?articleID=13963&categoryID=news-type](http://www.aboutkidshealth.ca/News/TeleLink-helping-kids-at-a-distance.aspx?articleID=13963&categoryID=news-type).

The symposium honored **Paula Rauch, M.D.**, with the Simon Wile Consultation Liaison Award for 2011. She presented on *Parenting at a Challenging Time: The Marjorie K. Korff PACT Program*. This was a wonderful presentation of a unique approach to consultation liaison psychiatry in which the consultation is focused upon a parent in need. These are parents who are experiencing stress of their own cancer. The presence of cancer in a parent presents a unique stress to the children, and many parents do not know how to communicate effectively with their children about their cancer. Children and parents need honesty and hope in the presence of severe illness, but this is often in the context of significant uncertainty. Childhood coping is linked to parental coping, leading to the vision by Dr. Rauch to offer a consultation model to parents with cancer.

Parents may underestimate the psychological stress of their children and be more focused upon their own psychological distress and physical side effects of the cancer and the treatment. Understanding child development provides a structure for communication with children. The child psychiatrist has the skills to integrate child development into parenting support. The website [www.mghpact.org](http://www.mghpact.org) provides information for parents and professionals including resources for education and handouts for parents. The PACT program is not intended to replace psychiatric assessment of a parent but rather to provide guidance and information for parents as they navigate an extremely difficult time in life. Dr. Rauch effectively demonstrated the critical importance of working with mothers with breast cancer to guide them through the complexity of parenting while struggling with serious medical illness. The award for Dr. Rauch is a wonderful acknowledgement of her outstanding work.

Consultation liaison psychiatry is a fascinating subspecialty in child psychiatry. The need for increased collaboration with primary care providers to ensure access for children and their families is increasingly apparent. This will require innovative efforts by both child psychiatry and primary care to develop financially viable methods for the provision of mental health care integrated with physical health care.

**References**


**Dr. Fuchs is the division chief of Child and Adolescent Psychiatry and training director at Vanderbilt University Medical Center. She is a consultation liaison child psychiatrist who works closely with pediatric intensive care unit to develop standards of care for children with acute brain pathology. She may be reached at catherine.fuchs@Vanderbilt.Edu.**
Founders Symposium: Phenotypes, Genetics, Imaging and Networks

Nevia Pavletic and Monique Ernst, M.D., Ph.D.

Chair by Neal D. Ryan, M.D., and Bennett L. Leventhal, M.D., this year’s Founders Symposium brought together experts in genetic epidemiology (Kathleen R. Merikangas, Ph.D.), imaging genetics (Jason P. Lerch, Ph.D.) and neuroimaging (Kelly N. Botteron, M.D.). This symposium addressed the ways in which advancements in genetic and neuroimaging research can contribute to progress in the etiological understanding of psychiatric disorders. Most critical was the elaboration on the lessons learned from the decoding of the human genome and the advent of neuroimaging techniques, both in terms of optimal research strategy and promises for bringing out new neurophysiological understanding with therapeutic implications.

In her presentation, Recent Progress in Gene Identification for Selected Neurologic Disorders: Relevance to Psychiatry, Dr. Merikangas highlighted some of the roadblocks that scientists have encountered as they search for direct linkages between specific genes and psychiatric illness. Most of her talk focused on neurological diseases as examples of the potential yield of genetics to unravel risk factors of complex diseases, which characterize most psychiatric illnesses. Genetic research in neuropsychiatric diseases is hampered by phenotypic validity, high prevalence of comorbidity, and multifactorial etiology (explaining the large phenotypic heterogeneity). Perhaps the most pervasive impediments rest on the lack of phenotypic validity and the inherent complexity of human genes (Merikangas 2002), which underlie the difficulty in delineating links between genotype and phenotype. This situation is compounded by the environmental influences on phenotypic expression.

This lack of clarity, particularly in the realm of psychiatric illness, has led some scientists in the last decade to hone in on gene-by-environment interactions (GxEs), the process by which an individual’s environment and genotype simultaneously affect one another (Duncan and Keller 2011). Nearly all of these studies use a candidate gene-by-environment (cGxE) method. The overall picture is still unclear, despite more than one-hundred papers having been published on cGxEs in the field of psychiatry. Part of this lack of clarity is due to a strong publication bias toward positive results. Furthermore, genome-wide association studies (GWAS) have been mostly unsuccessful at replicating the results from these cGxE studies. Overall, psychiatric research using cGxEs to date has been largely inconclusive.

Clinical phenotypes, e.g., DSM-IV definitions of psychiatric disorders, tend to be vague with overlapping symptoms. This lack of clarity can be catastrophic, leading to the search for a specific gene in individuals who do not even share a common illness. To circumvent this issue, researchers have shifted their attention to the connection between genes and intermediate biological signatures of psychiatric diagnoses, such as brain response patterns to given stimuli. Such “intermediate phenotypes” are quantifiable, and have proven to be easier in establishing genetic linkages, because they are closer to the gene action. Much work needs to be done to fully exploit the genetic information for understanding psychopathology and designing targeted treatments.

Dr. Lerch, in his talk, Imaging, Genetics, Psychiatry and the Mouse, focused on the use of high-field magnetic resonance imaging in the mouse to study the effects of individual genes on brain and behavior. Dr. Lerch focused on Autism Spectrum Disorders and examined various classifications to help identify homogeneous clinical phenotypes. Particularly, most mouse models consist of mice with gene knockouts/manipulations, and genes that are suspected to contribute to the autism phenotype. In parallel, mouse imaging has been developed with the refinement of the MRI technology, which permits to image volumes down to 100 microns. Thus, the effects of genetic manipulation can be examined with exquisite sensitivity on brain structures. Most exciting is the demonstration in the mouse models that short-term changes in brain anatomy can be identified following learning. Dr. Lerch highlighted two studies in human adults, illustrating brain plasticity. One study (Draganski et al. 2004) examined structural changes in the brains of subjects who learned how to juggle over a three-month period. The juggler group and the comparison group showed no grey matter differences at baseline, but, after the 3-month training, the jugglers showed greater grey matter volumes in posterior cortices. Similarly, structural MRIs of London taxi drivers were found to have significantly larger posterior hippocampi relative to comparison subjects (Maguire et al. 2000). These data evidence learning-induced cortical plasticity at a structural level.

Dr. Botteron addressed Recent Advances in Neurodevelopmental Imaging in Children and Adolescents: Structural Connectivity and Healthy Neurodevelopment. Among the novel discoveries in pediatric imaging, Dr. Botteron presented unprecedented data on neuroimaging of the fetal brain. These images were incredibly clear, which evidenced the current possibility of correcting for large movements, which is the strongest limitation in pediatric imaging. The prevalent imaging techniques currently in use for studying pediatric populations are being revised to more accurately quantify the dynamic nature of the developing child brain. Although the child (> 6 years old) and adult brain do not differ much in terms of size, MRI studies have shown that the volumes of different regions change with age, but not along similar temporal trajectories (Giedd et al. 1999). This raises the issue of current imaging templates used for MRI analysis (such as the MNI305 Talairach-like coordinate system), which can potentially compromise the accuracy of analyses of pediatric data. Accordingly, researchers are now
developing average age-appropriate atlas templates in order to enhance the quality of pediatric MRI analysis (Fonov et al, 2011). As alluded in Dr. Lerch’s talk, brain structure is also affected by experience. Interactions between ontogenic changes and influences of experience may need to be taken into consideration in the study of pediatric imaging. Hormonal effects, particularly during puberty, are another source of variance that will need to be systematically examined.

In conclusion, the Founders Symposium described how the recent scientific innovations in genetics and neuroimaging can expand the understanding of psychiatric disorders, particularly across development. However, despite the huge strides made in these two research domains, the complexity of the human brain and behavior continues to stump neuroscience research and to be a formidable challenge.

References

Nevia Pavletic holds a B.A. in Sociology from the University of Maryland. Currently, she is assisting in research on pediatric anxiety and depression at the National Institutes of Health, and suicide prevention at the Uniformed Services University of the Health Sciences.

Dr. Ernst is head of Neurodevelopment of Reward Systems, Emotional Development and Affective Neuroscience Branch, Mood and Anxiety Disorders Program, at the National Institute of Mental Health. She may be reached at ernstm@mail.nih.gov.

Interested in Submitting an Idea for a Clinical Consultation Breakfast, Media Theatre, or Special Interest Study Group at the Annual Meeting?

Clinical Consultation Breakfasts, Media Theatre, and Special Interest Study Groups are just three types of programs at the Annual Meeting, but provide attendees with unique experiences that are not typically seen in standard Symposia.

Clinical Consultation Breakfasts are a forum for experts to share clinical wisdom and discuss difficult cases with attendees, including discussions of diagnosis, treatment, or other clinical issues. These are ticketed events and are limited to 15 participants. Contact the Clinical Consultation Breakfast Coordinator, Mark Chenven, M.D., at mchenven@vistahill.org for more information.

Media Theatre programs feature full length motion pictures, commercially released documentaries, videotapes produced by members, music, and other forms of media relevant to child and adolescent psychiatry. Questions regarding Media Theatre programs should be directed to the Media Theatre Coordinator, Mark DeAntonio, M.D., at mdeantonio@mednet.ucla.edu.

Special Interest Study Groups (SIGs), ticketed events for a maximum of 25 participants, are designed to allow individuals with similar interests to share their clinical or research experience, develop collaborations or networks, or discuss mutual interests. It is a particularly useful forum for emerging or ongoing collaborative groups. If you’re interested in submitting an idea for a SIG and have questions, contact Judith Crowell, M.D., the Special Interest Study Group Coordinator at Judith.Crowell@sbumed.org.

A Call for Papers abstract must be submitted by February 15, 2012, in order to present any of these programs at the Annual Meeting. Visit www.aacap.org to submit your application.
New Developments in Mood Disorder Research from the AACAP+CACAP Joint Annual Meeting

Kiki Chang, M.D., and Meghan Howe, L.C.S.W.

The AACAP+CACAP Annual Meeting provided ample opportunity to explore new findings regarding the etiology, diagnosis, and treatment of children and adolescents with mood disorders that ranged from early signs of depression to fully developed bipolar disorder (BD).

First, there were several presentations regarding treatment of youth with BD. Robert A. Kowatch, M.D., Ph.D., presented data from a 6-week double-blind, randomized trial of 46 preschoolers (3-7 years old) with BD treated with risperidone, valproate, or placebo. Response rates were 88%, 50%, and 15%, finding that risperidone was significantly better than placebo for treating manic symptoms, but valproate was not. Adverse effects were as expected, with risperidone having the most weight gain, and body mass index (BMI) and insulin levels increasing in both active arms.

Melissa P. Delbello, M.D., M.S., found that adjunctive topiramate (target dose 150 mg BID) significantly reduced cannabis use in adolescents with BD and cannabis dependence. Subjects in the topiramate arm used 0.5 joints every 2 weeks, rather than 2 joints per week for the placebo arm, and also had less weight gain. No cognitive adverse effects were reported. Next, Kiki Chang, M.D., reported results from an open-label study of adjunctive lamotrigine in 247 children and adolescents with bipolar I disorder, in hypomanic, manic, mixed, or depressive mood states. Response was considered as 6 consecutive weeks of mild or less severity of bipolar symptoms. Overall response rate was 60%, regardless of mood state. Importantly, there were no reports of Stevens Johnson syndrome or Toxic Epidermal Necrolysis (TEN) and only 4 participants were discontinued due to a rash. Finally, results from the Treatment of Early Age Mania (TEAM) study were presented. Karen Dineen Wagner, M.D., Ph.D., reported that in 290 children with early-onset BD, age 6–15 years, risperidone treatment clearly beat treatment with valproate or lithium monotherapy. Neurobiological effects of medications used to treat youth with BD were presented in another symposium, with Mani N. Pavuluri, M.D., Ph.D., and Alessandra M. Passarotti, Ph.D., presenting data on lithium and risperidone, Dr. DelBello reporting fMRI data on ziprasidone, and Dr. Chang presenting MRS and fMRI data regarding quetiapine.

Another area of large interest was youth at risk for BD development. Most of these youth studied had at least one biological parent with BD. Ester Mesman, M.S., reported that such “bipolar offspring” from a Dutch sample had high rates of elevated mRNA expression of inflammatory genes, such as PTX3 and IL6, indicating that these children, particularly those already with mood difficulties, may experience chronic inflammatory states that may be related to mood disorder development. Mark P. Ellenbogen, Ph.D., found that bipolar offspring already with mood disorders had a higher rate of serum cortisol increase upon awakening than healthy offspring, or healthy controls. Furthermore, higher levels of interpersonal chronic stress predicted greater cortisol increases in the morning. Is this elevated cortisol response a trait finding? Or is it a “scar” from having a mood disorder already? Further longitudinal studies are needed to clarify these issues. Indeed, phenomenological data from just such longitudinal studies were presented by David Axelson, M.D., from Pittsburgh, Jon Shaw, M.D., from Miami, Manon Hillegers, M.D., Ph.D. from the Netherlands, and Anne Duffy, M.D., M.S.C., from Halifax, Nova Scotia, Canada. The international representation in this field of study was quite impressive, indicating that this important topic is being tackled on a global level. Finally, intriguing neuroimaging data were presented in a related symposium on biomarkers in youth at high-risk for BD. The story here had consistent findings in ventrolateral prefrontal cortex (VLPFC), or approximately BA 47. Tomas Hajek, M.D., Ph.D., found increased right inferior frontal gyrus (IFG) volume (BA 47) in both affected and unaffected first-degree relatives of adults with BD. Pilyoung Kim, Ph.D. from the National Institute of Mental Health (NIMH) reported on increased activation in VLPFC (BA 45) in 13 healthy bipolar offspring compared to youth already with BD and healthy controls, when performing a cognitive flexibility task. Finally, Cecile LaDouceur, Ph.D., reported on fMRI findings from healthy bipolar offspring performing a working memory task. Functional connectivity (FC) analysis found less FC in a VLPFC seeded network (amygdala, fusiform gyrus, medial frontal cortex) in at risk youth. Preliminary longitudinal data from these children suggested that youth who eventually developed mood disorders showed decreases in VLPFC activation. Thus, this area of the brain may be uniquely involved in the risk and development of BD in children and adolescents.

In another study of 24 bipolar offspring, Janet Woźniak, M.D., found that higher Child Behavior Checklist (CBCL) scores correlated with higher anterior cingulate cortex (ACC) glutamate levels. Although biological risk factors are still not clear, researchers have already begun intervening to attempt to prevent the development of BD in these youth. David Miklowitz, Ph.D., reported on open and controlled data from a study of Family Focused Therapy (FFT) in youth at high-risk for BD. Twelve-weeks of manualized FFT significantly improved symptoms of depression, mania and suicidality in these youth. In another presentation, Amy Garrett, Ph.D. presented fMRI findings from this study that demonstrated that subjects in both FFT and a control condition had increased DLPFC and decreased amygdalar activation in response to a facial emotion task over the course of the study. Higher baseline amygdalar activation correlated with greater improvement in depressive symptoms. Using fMRI to study the neural correlates of change and to predict...
response to psychotherapy is an exciting possibility in the field of pediatric mood disorder research.

Other speakers discussed different aspects of children with bipolar spectrum disorders. Benjamin Goldstein, M.D., Ph.D., reported data from the COBY study, finding new onset substance use disorders (SUD) in 32% of the sample. Predictors for SUD at baseline included panic disorder, a family history of SUD, comorbid ODD/CD, lower family cohesion, and less antidepressant use, while predictors later on included increased mood symptoms and decreased levels of treatment. From a different sample, Timothy Wilens, M.D., reported that increased deficits in emotional regulation were correlated with increased SUD in youth with BD.

Finally from the world of depression: a fascinating symposium discussing the potential for repetitive transcranial magnetic stimulation (rTMS) use in youth was chaired by Christopher Wall, M.D. This is a technology that has been applied in the pediatric population for a variety of illnesses – including autism, ADHD, Tourette’s, schizophrenia and mood disorders, but thus far, the sample sizes studied have been exceedingly low. However, the early evidence is that it has been safely used, well tolerated and is showing some positive treatment effects. Dr. Wall shared data from a recent open-label trial of 8 adolescents with treatment-refractory depression who received 30 rTMS treatments to the left DLPFC over 6-8 weeks. Depression severity ratings decreased significantly over the course of the treatment, as early as 10 treatments. Another potentially exciting treatment for youth with depression is exercise: the benefits seem clear but have not yet been well studied in depressed youth. Richard Dopp, M.D., found that 13 adolescents who underwent a 12-week exercise program had significant improvements in mood, sleep quality, and BMI.

The cutting edge research presented at the Annual Meeting bodes well not just for better understanding of the biological underpinnings of mood disorder development, but also for better treatments for these disorders once they develop.

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Lawrence A. Stone, M.D. Plenary: Is Child and Adolescent Psychiatry Ready For Personalized Medicine?

The Second Annual Lawrence A. Stone, M.D. Plenary, held this past October at the AACAP+CACAP Joint Annual Meeting in Toronto, featured a keynote address titled, “Is Child and Adolescent Psychiatry Ready for Personalized Medicine?” by Peter Szatmari, M.D. In his lecture, Dr. Szatmari discussed the increased understanding of the links between genetic data and the development of autism spectrum disorder, concluding that child and adolescent psychiatry is in fact, ready for personalized medicine.

Dr. Stone served as AACAP President from 1995-97 and is an active member of the AACAP community. The Lawrence A. Stone, M.D. Plenary is endowed in perpetuity in loving tribute from Marnette Stone.
Around Culture and Diversity

Zheya Jenny Yu, M.D., Ph.D.

As I sat in the airport waiting for my flight back from the Annual Meeting to my routine life of taking care of my patients and my family, I was proud to say the joint meeting of the AACAP/CACAP was the most fruitful conference I ever attended.

On a personal level, this was my third trip to Toronto. The first time was in 2000 when my husband drove me, my dad who was visiting, and my older daughter through Niagara Falls for a conference of the American Lung Association (I was doing research in Asthma at the Children’s Hospital of Philadelphia). Going through the border, the immigration officer gave my dad a hard time, which set a negative tone for the visit. On the second trip, I was still in my child psychiatry fellowship training, and came along with a colleague for the same joint meeting of AACAP/CACAP in 2004. I have to say I was kind of lost during that meeting – I did not know whom to meet or what lectures to go to. The brochures were tossed, but luckily a free Pink Freud shirt is still in my closet to treasure.

This time, I had a place where I belonged, a forum to stand on, and a more confident voice to speak with. I was focused and ready to go. I had no sights to see or people to meet besides one long lost college roommate (she became a dental hygienist in Toronto). My schedule was so packed that I forgot to go to the exhibition booth to collect my free pen.

I followed the Diversity and Culture “logo” everywhere. Starting with the Culture and Diversity program meeting soon after I landed in Toronto on Tuesday morning and ending with the Clinical Consultation Breakfast meeting on Saturday morning, I listened to, talked about, and met with people who are interested in “culture and diversity.” The central point was the debut of the Practice Parameter for Culture Competence – what a well done job! Soon there will be a tangible standard to hold child and adolescent psychiatrists to, one not easily ignored.

One of the discussions at hand during the meeting was that of having potential caucuses. I decided to visit both the Latino and African-American caucus meetings, now in their second year, to experience them first hand. I have to say, I felt a sense of belonging at both places, perhaps because I shared an innate sense of having a distinctive status, so tangible in the convened groups.

There were 40 or more people attending the Latino Caucus. Participants sat in a large irregular circle getting larger and larger by the minute. There were people from all countries and backgrounds, Latino themselves or simply interested in Latin cultures, eating tortilla chips and salsa. People introduced themselves in mixtures of English and Spanish. It brought to mind my daughter’s comments about my way of speaking, “why do you say certain words in English when you talk to your Chinese friends?” They discussed mentorship, missions, list-serves, as well as forming subcommittees. There was a strong energy and healthy sense of enthusiasm for future directions.

All the way across on the other end of the second floor, I quietly entered the room where the Black Caucus was meeting. The air felt more serious and formal as people old and young sat in rows with the co-chairs on the podium. This meeting was more organized; methodically moving through the different topics on the agenda. This was also a diverse audience, and I felt comfortable and welcome. The themes were similar, “how do we find a mentor, how do we have our voice be heard clearly, and how do we recruit more black medical students into the field?

Ayesha Mian, M.D.

Given the multicultural flavor of Toronto, it seemed fitting that the meeting offered a number of presentations focused on the needs of different minority groups. It speaks to not only the growing diversity of our population, but also the growing research and scholarship in the field. A clinical case conference that discussed identity, familial and gender concerns of an ethnic and sexual minority youth attracted a large audience and elicited a thoughtful dialogue. Workshops and consultation breakfasts focused on training in cultural competency and understanding medication non-adherence in the cultural context. A large crowd gathered to watch Babies, a fascinating documentary on the first 18 months of life of four infants living in four distinct parts of the world; each with their own unique cultural contexts, expectations, and practices.

Keeping the current geo-socio-political situation in mind, members of the Diversity and Culture Committee offered a media theater presentation and a workshop focused on Muslim youth in the United States. The movie Moolym offered a spring board to discuss parenting practices in Islam and highlighted the struggles Muslim youth might experience as they grapple with negotiating their identities in the current world. Other presentations underlining the needs and issues of minority youth were interspersed throughout the program.

The Diversity and Culture Roundtable discussed issues pertaining to international medical graduates (IMGs).
Attended by many senior members of the AACAP, a three-hour-long vigorous discussion took place at the roundtable. Participants brought forth the notion that whereas the IMGs may have unique needs regarding acculturative stress, discrimination, language matters, etc.; due to their dualistic cultural identity and an array of professionally relevant, comparative experiences, they are in a unique position to contribute to the advancement of psychiatric concepts in an era of global focus. They may provide an important liaison between the United States and the rest of the world, functioning as cultural ambassadors between American psychiatry and international psychiatry. It was deemed noteworthy that AACAP take an initiative to officially address needs to maintain the professional esteem and identity of IMGs. This may include, but is not limited to, provision of quality education, advocacy, training of their teachers and mentors, and a platform in organized child psychiatry.

The question of developing an IMG caucus was brought forth in various settings at the meeting, and opinions were solicited by various members of the AACAP. Future issues of AACAP News will showcase some of the arguments that were made for and against such an idea.

Overall, the meeting presentations reflected the diversity seen among the attendees. Maintenance of this tradition of continuing to submit strong scholarship work will further strengthen the field of diversity and minorities.

Dr. Yu is a clinical assistant professor of Psychiatry at University of Pennsylvania, working in a community mental health center where she serves children and family including many children of Asian immigrants. Dr. Yu has been on the Culture and Diversity Committee since 2010. She can be reached at zheya.yu@uphs.upenn.edu.

Dr. Mian 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.

Medical Student Fellowship Opportunities

Deadline: February 15, 2012

AACAP is pleased to offer two fellowship programs for medical students interested in child and adolescent psychiatry. The awards listed below have an application deadline of February 15, 2012. Please check the AACAP website for a complete listing of award opportunities.

Jeanne Spurlock Minority Medical Student Research Fellowships in Substance Abuse and Addiction

Supported by the National Institute on Drug Abuse

The Jeanne Spurlock Minority Medical Student Research Fellowship in Substance Abuse and Addiction provides up to $4,000 for 12 weeks of research training in substance abuse and addiction under a child and adolescent psychiatrist mentor. This program also provides additional travel funds to attend the 59th AACAP Annual Meeting in San Francisco, California, October 23-28, 2012.

Summer Medical Student Fellowships in Child and Adolescent Psychiatry

Supported by AACAP’s Campaign for America’s Kids

The Summer Medical Student Fellowship provides up to $3,500 for 12 weeks of clinical or research training under a child and adolescent psychiatrist mentor. This program also provides additional travel funds to attend the 59th AACAP Annual Meeting in San Francisco, California, October 23-28, 2012.

The distribution of all awards is contingent upon the receipt of adequate funding. AACAP reserves the right to waive liabilities.

For a complete listing of award opportunities or for more information, please contact the Department of Research, Training, and Education at training@aacap.org or visit the AACAP website at www.aacap.org/cs/awards.
Life Members Wisdom Clinical Perspectives: Reflections – Wisdom and Hindsight

Paramjit T. Joshi, M.D.

In Remembrance of things past and moving on:
Wisdom comes in many forms. For this year’s Life Members Wisdom Clinical Perspectives, four seminal works that were done and published almost three decades ago were highlighted. The presentations were based on the original manuscripts and, in their own right, were seminal works done by senior members of AACAP. The focus was 1) the idea underlying the work; 2) how the work was conducted and its impact on the field at the time of the original publication; 3) the impact of the original work on the field of child and adolescent psychiatry; and 4) lessons learned. The symposium was chaired and moderated by John Schowalter, M.D.

Thomas F. Anders, M.D., presented his seminal work on Sleep Disorders in Children. This was a paper published in Pediatrics in 1972. His work was done in the laboratory at Montefiore Hospital in New York and was based on the observations made by video-taping children during sleep, along with the polysomnographic readings of their sleep cycles. As Dr. Anders quoted Freud, “Dreams preserve sleep,” he highlighted the fact that new-born infants spend much time in REM sleep. Sleep disorders were classified in the ICD-2 and then subsequently in the DSM. He later went on to study sleep patterns in children with autism and discussed the notion of the importance of sleep hygiene. His research and observations suggested that if the child took a nap for one hour at four p.m., she would have less trouble at night. Dr. Anders spoke about the value of

his mentors, Albert Solnit, M.D., and Howard Roffwarg, M.D., and how their guidance, encouragement and offering opportunities helped him launch his research career that has spanned over three decades from the East coast to the West coast at major medical institutions.

Theodore Shapiro, M.D., titled his talk “The past is in the present: Retro is the new modern.” He presented his earliest work at the Bellevue Hospital in New York; “The house of Bender” as he referred to it. He spoke about the “logic of science is to limit bias” and, with this in mind, his earlier work was focused on the development of methods for child and adolescent psychopharmacology trials. Along with his mentor, Barbara Fish, M.D., he conducted a six-week empirical study examining 7-to-17-year-olds with psychosis (mild, moderate, severe) who were treated with either chlorpromazine, diphenhydramine, or placebo. Each subject completed an IQ test and electroencephalogram (EEG) while being observed clinically for changes in symptomatology. He also made a keen observation that at higher doses of medications, the patients developed what was then called “Therapeutic Toxicity.” He presented his work at his first AACAP Annual Meeting in Hershey, Pennsylvania, in 1963 when there were just 350 members of the Academy – how far we have come since! Dr. Shapiro also spoke about Dr. Fish, whom he published his paper with, his mentor who fostered his interests and inquisitive mind, and was invaluable in giving him the freedom to pursue his research interests. Subsequently he became interested in the teaching and practicing of psychodynamic psychotherapy and evidence-based outcomes.

Cynthia R. Pfeffer, M.D.'s presentation was about her original paper published in the Journal of the American Academy of Child and Adolescent Psychiatry (JAACAP) in 1984: “Suicidal Behavior in Normal Children Compared to Hospitalized Children.” It was the first report about suicidal ideation in normal children (11.9%). At the time, it was unthinkable that normal children would harbor such thoughts. She then started to delve into the issue of risk factors for suicide. This then lead Dr. Pfeffer to develop an instrument, the “Child Suicide Potential Scale,” to measure suicidal ideations in an organized and methodical manner. This was the first of many studies she published subsequently on the topic of depression and suicide. In 1986, she received federal and state funding to study the prevention of suicide and the same year published her book “The suicidal child”. Dr. Pfeffer's trajectory led to other questions that needed to be answered such as – what is the relationship between family history of depression and suicide as risk factors and the role of serotonin. Her seminal work in this area garnered the first Norbert Reiger Award from AACAP in 1998. Dr. Pfeffer also spoke about the influence of David Schaffer, M.D.’s earlier work in the area of suicide and how that influenced her own research.

Carol & Dick Gross, M.D. at the Life Member Dinner
The final speaker, Lenore Terr, M.D., chose to focus on her earlier study on post-traumatic stress disorder (PTSD) as related to the 1976 Chowchilla incident in California where 26 kids were kidnapped on a school bus and held for 16 hours. She was able to follow these children at one year and again four to five years later. Based on her observations of these kids, she wrote about the symptoms of PTSD as she saw them then: cognitive reshaping, futurelessness, re-enactment, post-traumatic play. In our current understanding of PTSD, the early descriptions of the phenomenology of the symptoms remain unchanged. She recounted her conversation with Anna Freud about studying this population and the response she got from Anna Freud was “This does not interest me – this is not psychoanalysis.” Dr. Terr also had the good fortune to work under Selma Freiberg and summed up about the qualities of a researcher: a) moving from curiosity to consuming interest; b) taking chances; c) looking forward; and d) letting further curiosity take the lead. Her interests following the above guidelines led to a lifetime of studying the effects of disasters and trauma. In addition to Professor Freiberg, she was influenced by Andy Watson, M.D., and his work on child abuse, Renee Spitz, M.D., who wrote about the “Praying Mantis Position” often seen in neglected and abused kids. Now, Dr. Terr has come to shape how we think about the psychological consequences of trauma and disasters.

The common theme that threaded through this program was the value of smart, dedicated mentors who were willing to take a chance with you; being at the right time at the right place; and having the motivation and where-with-all to walk through that door when the opportunity knocked. We have a lot to learn from those who came before us – it is passing the words of the wise from one generation to the next. This symposium was personally a highlight for me and perhaps the only reason to get older – so as to one day be able to join this very illustrious group of “Lifers” who have so much to offer. In short, this program offered both retrospective and prospective examination of four seminal papers from the authors of the original papers – a rare treat!

Dr. Joshi is president-elect of the AACAP and endowed professor and chair of Psychiatry and Behavioral Sciences at Children’s National Medical Center in Washington, D.C. Dr. Joshi may be reached at pjoshi@childrensnational.org.
Karl Menninger, M.D. Plenary and Joseph Noshpitz Memorial History Lecture

Diane K. Shrier, M.D.
AACAP Contributing Editor

Karl Menninger Plenary
“Yesterday, Today, and Tomorrow.”

by Martin J. Drell, M.D.

As incoming President, Martin “Marty” Drell, M.D., gave a talk on his Presidential Initiative called “Yesterday, Today, and Tomorrow.” Yesterday focused on Marty’s life course to date on how he became a child psychiatrist and how his career choices paralleled changes within child and adolescent psychiatry.

Regarding Today, Marty talked about the six main clusters of issues of concern to child and adolescent psychiatrists. These include:

1) Economic difficulties with reduced reimbursement from the public sector and private insurance companies, and diminished availability of funding for research and training.

2) Better linkages between child and adolescent psychiatry and primary care disciplines in anticipation of implementation of the Affordable Care Act with a need for reimbursable mental health screening by primary care practitioners, as well as funds and infrastructure to provide services for those who screen positive.

3) Work-force issues are a continuing challenge as we remain a “shortage” specialty. AACAP’s Work Force Committee has initiated a new “Campaign for American Children.”

4) Identity and scope of practice issues pertain to who and what we are and what roles we will have. Too many child psychiatrists are being reimbursed only for evaluations and medication management rather than the full scope of practice, with fear of being replaced by other mental health disciplines.

5) Big Pharma and its impact on where we get our knowledge of medications. The media and our own field have raised issues of misuse, overuse and underuse of medications to treat children and adolescents.

6) Access issues pertain to how many children and adolescents with serious psychiatric disorders are not being provided the services they need, how difficult it is for them to access effective care, and also whether child and adolescent psychiatrists are treating primarily less disturbed patients and families.

Over the past 30 years, there has been increased knowledge and skills among child and adolescent psychiatrists to better enable us to help children and families. However, concerns and challenges about access, funding, work force and scope of practice remain.

The final topic of Marty’s talk, Tomorrow, focused on our challenges for the future. As AACAP reaches its 60th year in 2013, a revisiting of the publication “Project Future” is planned. In addition to the six current concerns, it will be important to better integrate into clinical practice the rapid scientific and technologic advances with effective use of electronic resources and health records. Health care reform and implementation of the Affordable Care Act in 2014 raises new challenges for child and adolescent psychiatrists in planning how to better integrate our services with primary care without being replaced by other disciplines. At the end of Marty’s term as President in 2013, all these current and future issues will have been studied and planned for as we celebrate the 60th anniversary of AACAP.

The Karl Menninger Plenary, M.D. is supported by Ronald Filippi, M.D.

Joseph Noshpitz Memorial History Lecture: “Should Moral Development Compete with Concerns About Social-Emotional and Cognitive Development in Our Efforts to Prevent Mental Health Problems?”

by Susan J. Bradley, M.D.

David Cline, M.D., introduced the topic by quoting from Dr. Noshpitz’s writings in 1989: “we have a much graver issue
to children [than parental abuse, sexual exploitation, neglect, family violence, and serious developmental problems] – a major breakdown in the moral structure of middle class youth, the erosion of conscience for more money and power....”

The speaker, Susan J. Bradley, M.D., professor emeritus at the University of Toronto and former division director at The Hospital for Sick Children in Toronto, framed the question she was asked to address: “Should we, as child psychiatrists, be more concerned about moral development than socio-emotional development?” She researched this question through reading three of Robert Coles, M.D.’s books on the moral and spiritual life of children.

A number of issues arise for us as child and adolescent psychiatrists if we decide to focus on moral development. We live in a multi-cultural society and thus whose version of morality are we espousing? Socio-economic disparities may affect morality. Who should teach morality? In the past, it has been done by parents and by clergy teaching the difference between right and wrong and getting along with other people. It is not clear that moral understanding is related to psychopathology. Children who have been very badly treated in their lives and have so much anger about it may feel justified in their behavior, despite knowing right from wrong. Children within the autism spectrum have trouble understanding moral issues and understanding others. She concluded that child psychiatrists do not have special skills and knowledge in this area.

Dr. Bradley indicated that it is more important for child and adolescent psychiatrists to continue to help children gain competence in the social-emotional arena, including affect regulation, which will make it more likely that they will get along better with others. She suggests we focus on the following:

1) Label feelings clearly, know the contextual basis in which these feelings arise, problem-solve in different situations.

2) Help parents to support their children when they are feeling very stressed and upset by talking to them and helping them find ways of managing their feelings, including during imaginative play with peers.

3) Encourage peer and school successes.

Other factors interfere with children’s socio-emotional development:

1) Genetic vulnerabilities with differential susceptibility to environment and also physiological factors such as vagal control and allostatic load.

2) Allostatic load refers to the effect of prolonged/chronic stress on the regulation of the stress response (in either direction – up or down). For example, children of depressed mothers showed hyper-arousal with a slow return to baseline which correlated with harsh, intrusive parenting.

3) Children with difficult temperaments did less well in poor quality parenting environments, including high rates of behavior problems, but also profited the most in positive environments with the lowest rates of behavior problems.

The Joseph Nosphitz Memorial History Lecture is supported by the Grove Foundation.

Dr. Shrier is clinical professor of psychiatry and of pediatrics, George Washington University Medical Center, Washington, D.C. and contributing editor to AACAP News. Dr. Shrier may be reached at dianeshrier@rcn.com.
Winners of the Pilot Research Award, supported by Lilly USA, LLC

David Van Norstrand and Sophianne Subbiah, recipients of the Life Members Mentorship Grants for Medical Students at the Life Members Dinner

John Schowalter, M.D. and David Herzog, M.D. with recipients of the Life Members Mentorship Grants for Medical Students and Educational Outreach Program for Child and Adolescent Psychiatry Residents, supported by the Life Members Fund at the Life Members Dinner

Young Shin Kim, M.D., Ph.D. with AACAP staffer Melinda Lim

Enjoying one of the many social events during the Annual Meeting

SMILE! Friends, members and mentors all sharing a laugh during the meeting
ANNUAL MEETING

JANUARY/FEBRUARY 2012

Gordan Hodas, M.D., Bob Klaehn, M.D. & Kieran O’Malley, M.D.

Good times - Great friends!

Laurence Greenhill, M.D. with David Tran, Julia Tan, and Ernika Quinby, recipients of the Jeanne Spurlock Minority Medical Student Research Fellowship in Substance Abuse and Addiction, supported by NIDA, at the Young Leaders Awards Luncheon

BRIGHT smiles - brighter futures!

Jess Shatkin, M.D., M.P.H. and Michelle Horner, D.O. at the Presidents Reception

Attendees from Korea (with its flag)
ANNUAL MEETING

Cathryn Galanter, M.D. and Alice Mao, M.D.

Laughs and smiles abound during the Welcome Reception!

Yoshie Davison, M.S.W., Director of Research, Training and Education, Michael Houston, M.D., Immediate Past Speaker of the Assembly, and Grace Im

Having a GREAT time at the International Reception!

Edward Ritvo, M.D. with Jessica Chuang, recipient of the Summer Medical Student Fellowship in Child and Adolescent Psychiatry, supported by AACAP’s CFAK at New Research Poster Session 6
Keeping Our Teens Safe on Social Networking Sites

Understanding the Appeal of SNS to Teens

For most teens, maintaining a social life is very important. Teens seek a place where they can be themselves and interact with others who share similar interests. The Internet has made this easier, offering the ability to socialize and connect anytime, anywhere. Since communication on these sites is not face-to-face and there is some degree of anonymity, this increases the appeal to teens who may be shy in public. Teenage girls have higher use of SNS overall compared to boys. However, one big difference regarding use is that older boys tend to use these sites to make new friends and flirt compared to girls of their age who use these sites to connect with existing friends (Lenhert et al. 2007).

Adolescence is a time of identity development and SNS allow teens to explore their identity by personalizing their profile page. Teens can freely experiment and explore their identity while getting feedback from friends.

Understanding the Risks Associated with SNS

Clinicians need to understand the risks associated with SNS so they can educate, inform, and advise their teen patients, as well as the teens’ families. There are a number of risks associated with SNS including safety and privacy, unwanted attention, cyberbullying, decrease in face-to-face interaction, and time away from schoolwork and other hobbies.

Safety/Privacy

Safety is one of the biggest concerns associated with the use of SNS since these sites are accessible to anyone. While there are privacy settings that limit access of a user’s profile page to their friends, privacy settings are not always used by teens since they may not be aware of them or may not know how to navigate them. Also, the setting options on sites like Facebook have been known to change frequently. Many users may accept changes to these settings or accept a recommendation without reading the fine print and their pages may unknowingly become public. It may be a good idea for teens to increase their awareness around safety and privacy and enlist the help of a parent or adult to check their privacy settings frequently to ensure that they are effective and up to date.

When they do not restrict access to their pages, teens may not realize that the personal information they post on their profile page can accurately identify and locate them, making them easy targets for predators and hackers. This is the case with very personal information like hometown, birth date, school name, address, and phone numbers.

Many of these sites are anonymous and there is no verification process for users who wish to join. Predators may take advantage of this by creating profiles and pretending to be someone they are not to lure teens. Teens can accept friend invitations unknowingly as a desire to increase their friend network or thinking they are friends of friends and therefore safe. Facebook is one of the few sites that require users to use their first and last name when joining, but this does not eliminate this risk.

Unlike face-to-face communication, online communication is never without a trace. Pictures, blog entries, and messages can be downloaded and shared for many years and may be used against teens. Media reports have shown that college admission offices and employers access the Facebook pages of potential candidates when making decisions regarding admissions or employment. There have also been reported incidents where students have been suspended or criminally charged on the basis of information posted on their Facebook profile page. Teens may also be judged negatively by the behaviors of their friends; the profile pages of a teen’s friends may be accessed through a teens’ page. Many teens may come to regret their activities or posts on these sites years later.

continued on page 48
Unwanted Attention and Cyberbullying

Oftentimes, teens are unaware of the risks and consequences of posting information about risk-taking behaviors like sex, substance abuse, and violence on their pages regardless of whether or not the information is valid. Posting nude or sexually provocative pictures on one’s site can result in unwanted contact from predators and may lead to cyberbullying.

Although the accuracy of displayed risk-taking behaviors is unclear, previous studies have shown that these references may often be associated with thinking about or engaging in the profiled behavior (Moreno 2010). Displaying this information on these sites may normalize these behaviors and encourage other teens to engage in similar activities.

Cyberbullying is a serious concern on SNS and this occurs when one posts embarrassing photos, rumors, threats, and negative comments on the Internet with the intention of humiliating and emotionally hurting someone else. Recent media reports have depicted the impact of cyberbullying on the lives of many teens, some of these incidents unfortunately resulting in deaths by suicide.

Time Taken Away from Other Activities and Decrease in Face-to-Face Interaction

There is the concern of overreliance on SNS for social interaction. It is easy for teens to just get on these sites anytime and interact with friends without leaving their house. Many teens no longer pick up the phone to call and talk to their friends since it is just as easy to post a message on their friend’s profile page or use instant messaging to communicate. Teens may spend a lot of time on these sites and this can take away time from their schoolwork and even from engaging in other hobbies or outdoor activities.

How Can Clinicians Discuss the Use of SNS with their Teen Patients?

It is important that clinicians feel comfortable in discussing the use of these sites with their teen patients. One way clinicians can do so is to invite their teen patients to show them their profile pages and to share what they do on these sites. This is a good opportunity for clinicians to talk with their patients about any concerns they may have while viewing the pages. Clinicians who are not members of these sites may consider creating a basic account or visiting these sites to become more familiar with them. Clinicians can also ask their teen patients to tell them about their use on these sites. Here are a few questions clinicians can ask to gain a better idea what teens are doing on these sites:

- Do you use SNS? If you do, how many sites do you belong to? Which sites are your favorites? Why?
- Do you have a personal profile page and if so what personal information do you have on your page?
- How many friends are in your network?
- What do you use these sites for and how often do you visit or engage in these sites?
- What kind of information do you share when you post a comment on your page or a message on a friend’s page?
- What does the use of these sites mean to you?
- Do you have pictures and/or videos of you, your friends and family on these sites?
- Is your profile page private? How do you know that? If so, do you check your privacy setting options frequently?
- Do you have any risk taking behavior associations on your page?
- Has anyone ever posted anything negative or embarrassing about you on these sites? Have you ever posted
anything negative or embarrassing about anyone else on these sites?

■ Have you done anything you have regretted on these sites?

■ Has your use of these sites impacted your other activities (i.e. time spent with family, schoolwork, face to face time with friends)?

How Can Clinicians Address Concerns of SNS with Parents?

Many parents have concerns about their teen’s activities and friendships formed on these sites, especially since parents may have less contact or awareness of these friends. For example, teens may not bring their online friends home for their parents to meet and many teens do not discuss their online activities or friends with their parents.

Although many parents are concerned about their teen’s activities on these sites, prohibiting use is not the answer and may cause their teens to rebel.

Instead, parents should have open communication with their teens regarding their activity on these sites. Some researchers recommend that parents create their own page on the same site and add their teen as a friend so they can view their teen’s profile. Parents can also invite their teens to show them their page. Parents should talk to their teens about what is and is not appropriate to do on these sites. Parents may also limit the amount of time their teens spend on these sites.

Conclusion

SNS are very popular among teens, and along with the benefits come serious risks. It is crucial that clinicians familiarize themselves with these sites, as well as understand the appeal of these sites to teens and the risks associated with them. In doing so, clinicians can better educate their teen patients and their families about issues regarding SNS. Teens must consider the public nature of these sites and should use caution when adding friends to their personal network and when disclosing personal information. No information shared on these sites is ever completely private.

References


Dr. Reid is a first year child and adolescent psychiatry fellow at Emory University School of Medicine in Atlanta, Georgia. She can be reached at dana.reid@emory.edu. She is also a member of the Media Committee.

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

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

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Sheraton New York Hotel and Towers
New York, NY

**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., M.S.

Expected Attendance: 400+

**February 10-11, 2012**
Omni San Diego Hotel
San Diego, CA

**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.

Expected Attendance: 100-400

**March 21-24, 2012**
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Pittsburgh, PA

**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.

Expected Attendance: 150-200

For more information, please visit, [www.aacap.org/cs/exhibit_and_sponsorship_opportunities/upcoming_meeting_exhibit_opportunities](http://www.aacap.org/cs/exhibit_and_sponsorship_opportunities/upcoming_meeting_exhibit_opportunities) or contact: Lauren Kokernak 202.966.7300, ext. 104 or [exhibits@aacap.org](mailto:exhibits@aacap.org).
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In Memoriam

AACAP would like to extend our condolences to the family and friends of the following members:

James H. Duffy, M.D., Roanoke, Texas
Richard P. Malone, M.D., Philadelphia, Pennsylvania
Maria Pease, M.D., San Francisco, California
Ulrich C. Schoette, M.D., Seattle, Washington
Robert F. Schreiber, M.D., Berkley, California

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

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Harriet Stern, M.D., Denver, Colorado
Sally A. Sveda, M.D., Newton Center, Massachusetts
Ann Marie Taylor, M.D., Omaha, Nebraska

Paul Glass, M.D.

Dr. Glass, of Austin, Texas, and formerly, Bethesda, Maryland, was recognized at AACAP’s 50th anniversary as one of three members “making a difference to the Academy.”

Most remember him as the official Academy photographer for over twenty decades, recording our triumphs and personally mailing pictures to thousands of members. It is because of his efforts that we have rich archives of visual history. His dedication and singular commitment to preserving and creating records of our specialty, is noted with appreciation.
A Tribute to Richard Patrick Malone, Jr., M.D.

Richard Patrick Malone, Jr., M.D.,
Professor of Psychiatry and Co-Director
of the Drexel Autism Consortium at the
Drexel University College of Medicine,
Philadelphia, Pennsylvania, died unexpect-
edly on October 3, 2011. He was born in
Mt. Pleasant, Pennsylvania, on June 25,
1952. He graduated Phi Beta Kappa with a
B.A. in Psychology and Philosophy from the
University of Pittsburgh in 1974; received
an M.A. in Psychology from St. John’s
University, New York, NY, in 1975; and
his M.D. from Hahnemann University, Philadelphia, PA, in 1983. Dr.
Malone completed his residency in Psychiatry in 1986 and fellowship
in Child Psychiatry in 1988, both at Medical College of Pennsylvania
(MCP)/Eastern Pennsylvania Psychiatric Institute (EPPI). From 1988
through 1990 he was a research fellow in Child Psychopharmacology
at the New York University School of Medicine/Bellevue Hospital,
funded by the Institutional Research Training Grant in Child
Psychopharmacology from the National Institute of Mental Health
(NIMH), NRSA 5 T32 MH-18915, under the directorship of Magda
Campbell, M.D.

In 1990, Dr. Malone joined the faculty of the MCP/ Hahnemann
University School of Medicine, and made significant contributions to
its clinical, educational and research programs. His expertise in autism,
aggressive and explosive conduct disorder and psychopharmacological
treatments of these disorders was recognized nationally and interna-
tionally. He was responsible for the start of the Drexel Autism Center
and was active in committees and groups established for children with
autism. He was funded to conduct clinical trials in psychopharmacology
by the National Institute of Mental Health (NIMH) (1992-2011) and
by the Food and Drug Administration (FDA) 2002-2008. This research
resulted in 33 articles published in peer-reviewed journals, several
book chapters and numerous abstracts and presentations at national
and international meetings. The purpose of his research was not only
the critical assessment of the efficacy of psychoactive agents but also
of their safety in children. Dr. Malone was a long-term member of
several national advisory committees with the FDA and the NIMH that
reviewed the safety of psychoactive agents and research grant applica-
tions. He was most supportive in aiding the careers of junior members
of his research team, residents and students who were co-authors of
his publications. Dr. Malone received the Clinical Research Scientist
Award in 2004 and was named Outstanding Teacher of the Year in
2005 by the Residents, both at Drexel University College of Medicine.

Dr. Malone touched many lives and will be remembered not only as a
highly respected researcher nationally and internationally and expert
in autism spectrum disorders but also as a superb and kind clinician
who cared deeply about his patients and their families; a devoted
teacher and student; a great colleague and friend and above all, one
of the finest of human beings. His tragic and untimely death leaves a
great vacuum in our field. He is survived by his son, wife, mother and
three sisters.

Magda Campbell, M.D.
Professor Emeritus of Psychiatry
New York University
School of Medicine

Vivian Kafantaris, M.D.
Associate Professor of Psychiatry
Hofstra North Shore-LIJ
School of Medicine

CHILD PSYCHOPHARM LIST-SERVE

Members of AACAP are invited to join
the CHILD PSYCHOPHARM LIST-SERVE
(CPLS). It is a free on-line group, comprised
mostly of child and adolescent psychiatrists
from the United States and abroad but
also including some pediatric neurologists,
pediatricians, psychologists, neuropsy-
chologists and Advanced Psychiatric Nurse
Practitioners.

The CPLS is managed and moderated by
Howard Rudominer, M.D., a Life Member
of AACAP, and is run independently from
AACAP. It has grown rapidly to over 750
members mostly from the United States, but
also worldwide, who actively share experi-
ences, questions and information in lively
on-line discussions. Sometimes difficult
diagnostic, therapeutic or even research ori-
tented questions or issues posted on-line will
be responded to within an hour or less!

Although we have child and adolescent
psychiatrists with wide differences in expe-
rience as members, including prominent
researchers in the field, we are, particularly,
encouraging Child Psychiatry Fellows and
Early Career Psychiatrists to join. We feel
that the listserve will greatly enhance and
expand the knowledge already gained
from Fellowship training and attendance at
National and Regional Meetings.

Anyone interested in joining this exciting
and informative listserve should email Dr.
Rudominer at hrudmd@gmail.com.
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JANUARY/FEBRUARY 2012 53
Members and the NEWS

FOR YOUR INFORMATION

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

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

- **Henry Gault, M.D.**, spoke with a writer for the *Associated Press* about parents monitoring their children’s online activity. The article, “Parental Dilemma: Whether to Spy on Their Kids,” appeared September 3, 2011. He also discussed imaginary friends with a columnist for the *Chicago Sun-Times*. The article, “The Real Deal about Pretend Pals,” was posted October 16, 2011. Then, he and **John Walkup, M.D.**, were interviewed for a documentary on PBS about Tourette’s, *Different is the New Normal: Living a Life with Tourette’s*, which aired on November 6, 2011.


- **Patrick Kelly, M.D.**, connected with a reporter from the *Chicago Tribune* to discuss children with anxiety about going to school. The article, “Kids’ Complaints about Returning to School Sometimes Reflect Serious Problems,” appeared on September 12, 2011.


- **Nancy Rappaport, M.D.**, connected with a Chicago Tribune reporter to discuss youth suicide. The article, “Schools’ Reaction to Suicides May Do More Harm than Good,” was posted on October 20, 2011.


- **Joseph Lee, M.D.**, discussed the new drug bromo-dragonfly with Dr. Oz on *The Dr. Oz Show*. The segment, “America’s New Deadly Drug: Dragonfly,” aired on November 8, 2011.

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Every effort was made to list names correctly. If you find an error, please accept our apologies and contact Hannah Smith at 202-966-7300, ext. 130 or hsmith@aacap.org.
FOR YOUR INFORMATION

2. Administrative / Management Responsibilities
   - Children in the continuum of care.
   - Coordination of psychiatric care of responsibility for provision, oversight, and coordination of psychiatric care of children in the continuum of care.

   Responsibilities:
   1. Clinical Responsibilities
      - Provide psychiatric assessment, evaluation, psychopharmacological follow-up, and monitoring of children's treatment.
      - Back-up to psychiatric consultants and clinical staff as needed.
      - On-call responsibilities as part of a rotation of psychiatric staff for after-hour emergencies.
      - Provide consultation and training to clinical staff.
      - Participate in interdisciplinary teams.
      - Provide documentation as required by agency practices and licensing requirements.

   2. Administrative / Management Responsibilities
      - Coordination and monitoring of psychiatric consultants.
      - Continuous improvement and monitoring of implementation of psychiatric policies and procedures.
      - Participate in the ongoing development of standards for clinical practice at the Village.

   3. Professional Leadership Responsibilities
      - Provides consultation to the President / CEO and COO on medical and psychiatric needs in systems of care.
      - Liaison to the medical community.
      - Liaison to the psychiatric community.
      - Liaison to the academic community.
      - Develop collaborations with the Planning, Performance & Accountability department.

   Qualifications:
   - Connecticut state professional license.
   - Board certification in Psychiatry and Child and Adolescent Psychiatry.
   - Cultural competency to serve African American, Latino/Puerto Rican, and West Indian families.
   - Experience in evaluation and treatment of children in the child welfare system.
   - Proficient with word processing and spreadsheet applications. Possess solid general computer skills, including ability to work in a Windows XP environment. Familiarity with specific applications used by the Village a plus.
   - Physically able to perform the essential functions of the position in a standard office environment, with or without reasonable accommodations, and the ability to interact with children and adolescents in a therapeutic environment/situation without risk of injury.

   Submit applications to:
   Jennifer Lubee
   The Village for Families & Children, Inc.
   331 Wethersfield Avenue
   Hartford, CT 06114
   Phone: 860-297-0560
   Fax: 860-296-1071
   E-mail: Jlubee@villageforchildren.org
   www.villageforchildren.org

PSYCHIATRIST, CHILD AND ADOLESCENT AMBULATORY PROGRAMS
Bridgeport Hospital
Bridgeport, Connecticut

As a Child and Adolescent Psychiatrist in our REACH Child Psychiatric Services program, you will develop and monitor psychiatric programs for children and adolescents, to include setting clinical policies, procedures and guidelines, planning programs and formulating program goals. In this key role, you will provide direct clinical supervision to the PA/APRN of the Child Program and perform clinical duties in the Adolescent IOP Program, to include initial psychiatric evaluations, rounding and prescribing medications as needed. Will also participate in quality assurance programs, as well as help prepare for and participate in regulatory surveys.

Position Requirements: Must be Board Certified/Board Eligible with clinical, administrative and quality assurance experience, as well as experience in community psychiatry, triage and the development of therapeutic milieu.

Company Overview: At Bridgeport Hospital, a professional journey awaits.

A member of the Yale New Haven Health System, we are a 425-bed community teaching hospital affiliated with the Yale University School of Medicine. As one of the largest hospitals in Fairfield County, Connecticut, we offer state-of-the-art services and out-of-this-world resources and rewards. For a satisfying medical career there is just one destination: Bridgeport Hospital.

To learn more or apply online, please visit:
Phone: 203-384-3166
E-mail: Cheryl.Weisenberg@bpthosp.org
www.bridgeporthospitalcareers.org
EOE

ILLINOIS

CHILD/ ADOLESCENT PSYCHIATRIST
PRA: Perakis, Resis, Woods & Associates
Crystal Lake, Illinois

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.

PRA Philosophy and Treatment Focus: PRA’s philosophy is to provide treatment that is problem centered and solution focused. We also seek to help individuals work through the underlying motivations that contribute to and sustain their current problems. PRA strives to build the individual’s own skills in order to increase personal insight and control. Our goal is to provide the client with a greater understanding of self and the ability to make changes in their own lives.

Qualifications: Must be licensed in the state of Illinois and be board eligible but would prefer board certified. Must present ability to communicate effectively with children and families.

Submit applications to:
Paula M. Comm
1701 E. Woodfield Road, Suite 1000
Schaumburg, IL 60173
Phone: 847-240-2211 x224
Fax: 847-240-2218
E-mail: pmc@prapsych.com
www.prapsych.com
MARYLAND

CHILD AND ADOLESCENT PSYCHIATRIST
Sheppard Pratt Physicians, P.A.
Director, Autism Clinic
Outpatient Neuropsychiatry

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: Ms. Barbara Magid
Director for Professional Services
Phone: 410-938-3460
E-mail: bmagid@sheppardpratt.org

TEXAS

BOARD CERTIFIED CHILD PSYCHIATRIST
University of Texas Southwestern Medical Center

The University of Texas Southwestern Medical Center at Dallas Division of Child and Adolescent Psychiatry, in the Department of Psychiatry, is seeking a board certified Child and Adolescent Psychiatrist at the Assistant/Associate Rank to serve as Medical Director for the Day Treatment Program at Children’s Medical Center. The Day Treatment Unit serves the needs of children and adolescents from 2 to 18 years of age, and provides assessment, treatment planning, medication management, and discharge planning for a maximum census of approximately 12 patients. The primary responsibility of the successful candidate will be to lead a multidisciplinary team consisting of a Nurse, Teacher, Clinical Social Worker, and Therapists. Duties would also include teaching child psychiatry fellows, general psychiatry residents, medical students, and other allied health students. This position is responsible for maintaining productivity measures and operational revenue benchmarks. Participation in clinical research is encouraged.

Nearby: UT Southwestern Medical Center ranks among the top academic medical centers in the world. Our distinguished faculty includes active Nobel Prize winners. Nearly 4,200 medical, graduate and allied health students, residents and postdoctoral fellows are trained each year. Our physicians provide care to patients at UT Southwestern University Hospitals and Clinics as well as three other affiliated hospitals. The Dallas area boasts a low cost of living with diverse neighborhoods and great schools. The area has world class quality of life options, with more than 175 museums and art galleries, premier performance halls, numerous parks, lakes, golf courses and seven professional sport franchises.

Qualifications: Candidates must have or be able to obtain a Texas medical license and be board certified or board eligible in Child and Adolescent Psychiatry.

Interested applicants should forward curriculum vitae and letter of interest to: Graham J. Emslie, M.D., Chief Division of Child and Adolescent Psychiatry

Send CV to:
Search Committee
c/o Tammy M. Newcomb
VCU, Box 980710,
Richmond VA 23298

VCU is an Equal Opportunity/Affirmative Action employer. Women, minorities, and persons with disabilities are encouraged to apply.

VIRGINIA

CHILD PSYCHIATRIST
Virginia Commonwealth University: Medical College of Virginia Hospitals, Division of Child and Adolescent Psychiatry in the Department of Psychiatry, is recruiting a Virginia license-eligible BE/BC child psychiatrist faculty. Will work as Inpatient/Outpatient attending and will be responsible for administration and clinical care as well as teaching and supervision of medical students, residents and child fellows. In addition, consultation work with community agencies will be available. Must have an interest in teaching and academic work, as well as the ability to work on interdisciplinary teams. Demonstrated experience working in and fostering a diverse faculty, staff, and student environment or commitment to do so as a faculty member at VCU.

Department has seven full-time child psychiatrists, child fellowship, approximately 75 full-time faculty, a child research institute and well-funded research in genetics, child and women’s mental health, addictions and psychopharmacology. VCU is a large urban university with robust health science campus and 750-bed university hospital. Richmond, State Capital, has moderate climate and rich mix of history with modern facilities, excellent suburban housing, public/private schools. Internet provides comparative cost of living.

Department of Psychiatry UT Southwestern Medical Center 5323 Harry Hines Blvd.
Dallas, Texas 75390-8589
ATTN: Jackie Gransberry
The University of Texas Southwestern Medical Center is an Equal Opportunity/Affirmative Action Employer.
Lifelong Learning Institute

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For more information, visit www.aacap.org or contact meetings@aacap.org or 202.966.7300, ext. 2006.

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