Inside...

Youth Culture: Not Just “Gay” or “Straight” – Youth Culture, Identity and Sexuality: An Interview with Peter Daniolos, M.D................................................. 288

Early Career Psychiatrist Committee: Two Years of Successful Regional Early Career Psychiatrist Networking Events – The ECP Connect Program Report .............. 296

The Creation of a Political Action Committee .................................................. 299
SAVE THE DATES
Call for Papers Submission Deadline: February 15, 2013
New Research Poster Submission Deadline: June 17, 2013
Book Hotel and View Preliminary Program: June 17, 2013

AACAP’s 60th ANNUAL MEETING
OCTOBER 22–27, 2013 • ORLANDO, FL
WALT DISNEY WORLD DOLPHIN HOTEL

Gabrielle A. Carlson, M.D.
Program Chair

Robert L. Hendren, D.O.
60th Anniversary Committee Chairs

Marilyn B. Benoit, M.D.

VISIT WWW.AACAP.ORG FOR THE LATEST ANNUAL MEETING INFORMATION!
# TABLE of CONTENTS

## COLUMNS

Jean Dunham, M.D., Section Editor • jeandunham@gmail.com

<table>
<thead>
<tr>
<th>Article Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>President’s Message: The Best Lollipop Ever • Martin J. Drell, M.D.</td>
<td>281</td>
</tr>
<tr>
<td>Editor’s Note • Wun Jung Kim, M.D., M.P.H.</td>
<td>283</td>
</tr>
<tr>
<td>Jerry M. Wiener Resident Member to Council: Training for the Changes Ahead •</td>
<td>284</td>
</tr>
<tr>
<td>Sourav Sengupta, M.D.</td>
<td></td>
</tr>
<tr>
<td>Ethics: What did you say? I am sure I must have misunderstood. • Arden Dingle,</td>
<td>286</td>
</tr>
<tr>
<td>M.D.</td>
<td></td>
</tr>
<tr>
<td>Youth Culture: Not Just “Gay” or “Straight” – Youth Culture, Identity and</td>
<td>288</td>
</tr>
<tr>
<td>Sexuality: An Interview with Peter Daniolos, M.D. • Karthik Sivashanker, M.D.</td>
<td></td>
</tr>
<tr>
<td>Forensics: Child Psychiatry: Tales from the Streets of Fist City • Stephen</td>
<td>290</td>
</tr>
<tr>
<td>Zerby, M.D.</td>
<td></td>
</tr>
<tr>
<td>Psychotherapy: Ann Alaoglu, M.D.: Winner of the 2012 AACAP Charlotte and</td>
<td>292</td>
</tr>
<tr>
<td>Norbert Rieger Psychodynamic Psychotherapy Paper Award • Nathaniel Donson, M.D.</td>
<td></td>
</tr>
</tbody>
</table>

## COMMITTEES

Ellen Heyneman, M.D., Section Editor • eheyneman@uscd.edu

<table>
<thead>
<tr>
<th>Committee Name</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>International Relations Committee: IACAPAP PARIS 2012 – Through the Eyes of</td>
<td>294</td>
</tr>
<tr>
<td>a Donald J. Cohen Fellow • Anusha Lachman, M.D.</td>
<td></td>
</tr>
<tr>
<td>Early Career Psychiatrist Committee: Two Years of Successful Regional Early</td>
<td>296</td>
</tr>
<tr>
<td>Career Psychiatrist Networking Events – The ECP Connect Program Report •</td>
<td></td>
</tr>
<tr>
<td>Jennifer Haak, M.D., Alex Strauss, M.D., Boris Lorberg, M.D., and Anne</td>
<td></td>
</tr>
<tr>
<td>Frederickson, M.D.</td>
<td></td>
</tr>
<tr>
<td>60th Anniversary Challenge: 60 Years. 60%. $60.</td>
<td>297</td>
</tr>
</tbody>
</table>

## NEWS

Stuart Goldman, M.D., Section Editor • stuart.goldman@childrens.harvard.edu

<table>
<thead>
<tr>
<th>Article Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advancing AACAP’s Advocacy Efforts: The Creation of a Political Action</td>
<td>299</td>
</tr>
<tr>
<td>Committee • Kristin Kroeger Ptakowski</td>
<td></td>
</tr>
<tr>
<td>News Updates • Stuart Goldman, M.D. and Garrett Sparks, M.D., M.S.</td>
<td>300</td>
</tr>
<tr>
<td>Monitoring of Psychotropic Medications for Children in Foster Care States</td>
<td>302</td>
</tr>
<tr>
<td>Grapple with Implementation • Kristin Kroeger Ptakowski</td>
<td></td>
</tr>
<tr>
<td>AACAP K12 Physician Scientist Program in Substance Abuse Funded by the National</td>
<td>304</td>
</tr>
<tr>
<td>Institute on Drug Abuse • Yoshi Davison</td>
<td></td>
</tr>
<tr>
<td>Catchers in the Rye Awards</td>
<td>306</td>
</tr>
</tbody>
</table>

## FEATURES

Debbie Carter, M.D., Section Editor • debbie.carter@ucdenver.edu

<table>
<thead>
<tr>
<th>Article Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Media Page • Garrett Sparks, M.D., M.S.</td>
<td>307</td>
</tr>
<tr>
<td>Poetry: Dancing Bear • Diane Schetky, M.D., The Diagnostic Process • Chuck</td>
<td>308</td>
</tr>
<tr>
<td>Joy, M.D.</td>
<td></td>
</tr>
</tbody>
</table>

## OPINIONS

Christopher Varley, M.D., Section Editor • chris.varley@seattlechildrens.org

<table>
<thead>
<tr>
<th>Article Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>On the Manure Pile: Fertilizing the Development of Social Skills • Jenna Saul,</td>
<td>310</td>
</tr>
<tr>
<td>M.D.</td>
<td></td>
</tr>
<tr>
<td>Letter to the Editor • Saul Wasserman, M.D.</td>
<td>311</td>
</tr>
<tr>
<td>A Retirement from Child and Adolescent Psychiatry • Douglas A. Kramer, M.D.,</td>
<td>312</td>
</tr>
<tr>
<td>M.S.</td>
<td></td>
</tr>
</tbody>
</table>

## FOR YOUR INFORMATION

<table>
<thead>
<tr>
<th>Article Name</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership Corner</td>
<td>314</td>
</tr>
<tr>
<td>AACAP News Want to Hear From You!</td>
<td>314</td>
</tr>
<tr>
<td>Welcome New AACAP Members</td>
<td>315</td>
</tr>
<tr>
<td>Upcoming Events</td>
<td>316</td>
</tr>
<tr>
<td>AACAP Policy Statement Procedures and Requirements</td>
<td>317</td>
</tr>
<tr>
<td>Thank You for Supporting AACAP</td>
<td>318</td>
</tr>
<tr>
<td>Classifieds</td>
<td>320</td>
</tr>
</tbody>
</table>

**COVER:** When you scuba dive in Indonesia’s Alor Islands, young boys canoe out in their dugouts, put on goggles, and swim down to greet you. Photo by Alvin Rosenfield, M.D.
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.
I have, on occasion, been accused of negative thinking when things are not up to my level of perfection. After years of therapy, I realize that some of these standards are “over the top” internalizations of my parents who seemed to expect nothing but the very best. Having started this process in motion, they inevitably became its victims when I realized that I could passive aggressively torture them by doing poorly in some area they valued. My scheme of punishing them with non-perfection worked non-perfectly, as I was frequently guilt-ridden knowing that I should be doing better.

The issue of how perfect to be in medicine has always presented a related challenge. In my last President’s Message (“Slow Down and Listen Up!”), I shared my worries that the field of medicine in general, and child and adolescent psychiatry specifically, was coming up short with regard to our attentiveness and listening to patients and their families.

In this column, I would like to report on my latest round of surgery and continue my musings about the vexing and complex issues I believe physicians face. These issues are not new.

When I was about to graduate, Julius Richmond, M.D., the head of my program at Boston Children’s/Judge Baker Guidance Center, with a missionary’s zeal, advised all the residents in my class to “leave the friendly confines” of Boston. He wanted us to spread the quality training we had received to other areas of the United States that had child and adolescent psychiatry shortages. He was pleased to hear that I had taken an academic position at Baylor in Houston, Texas. He would check up on me over the years, especially after I became a training director. My reception in Houston was not completely positive; as several child and adolescent psychiatrists kept telling me in various ways how stupid I was to be in academics when I could make twice as much money in private practice. Money, at that time, definitely trumped quality and training for many in entrepreneurial Houston. I should note that I preferred to follow Dr. Richmond’s advice to follow my bliss and that the money would follow.

Faced with such active resistance, my natural oppositional nature led me to double my efforts at teaching. Luckily, I was supported in my efforts to improve teaching by my bosses at Baylor. An added non-monetary compensation came from being appreciated by the residents for my efforts to improve their training.

I occasionally got a similar sense when I moved to New Orleans. There I was called an “elitist.” This irritated me enough that I sought consultation from Louisiana State University’s vice-chair at the time. The vice-chair laughed for a while, then stated that where he came from, being an “elitist” was considered a good thing.

I have always struggled with how to value what I feel is the right thing to do without devaluing what others do. I have, I think, been doing a slightly better job of this thanks to my years of personal therapy. I note also that these are very difficult times for trainers who seem to have more and more challenges deciding what standards should be set for their trainees to follow. To add to these challenges, it has been strongly suggested to me that part of the problem is a generational divide pitting “old farts” like me against the newer digital generation of trainers and trainees raised on Game Boys, computer games, and the Web. I have been told that the newer generation has trouble learning from lectures and those that give them. I am in anguish that this might be true and that what I think the residents need to be taught might be compromised by how I teach it. I also fear that I will drive the residents nuts when the 10 pounds of whatever I am supplying from the past does not fit in the present five pound bags they and the insurance companies provide to them. This fear has often focused on “med checks.” My gut check on med checks deals with whether the biopsychosocial approaches I am teaching are incompatible with the time allotted to the residents.

I have long since come to the conclusion that medicine, in general, has become so complex that we now, more than ever, absolutely need to seriously enhance our teaching of Professionalism and Ethics. These covert background skills, so called “soft skills,” seem to be absolutely needed.

As I become more interested in these issues, I, as President, think of appointing multiple task forces (MTF Disorder) to clarify and solve these problems. My favorite such task force is lovingly entitled the “How the hell can people be well trained and have access to so many excellent resources at AACAP and then come up with ‘that diagnosis’ and ‘that treatment’?” task force. As I write this, and my blood starts to boil, I have suddenly realized that I have delegated all these issues to the training, teaching, and educational components of the Back to Project Future Presidential Initiative. I will await what they have to say and move on to reporting my latest medical adventures.

I am just back from my corrective hip surgery at Massachusetts General Hospital (MGH), which was just

continued on page 282
The Best Lollipop Ever continued from page 281

proclaimed the #1 hospital in the United States by *U.S. News and World Report*. One cannot look anywhere on the campus without being faced by signs reminding one of this achievement.

I am happy to report that my experiences at MGH were excellent. They are #1 as far as I’m concerned.

My surgical adventure started months earlier with my introduction to Harry Rubash, M.D., the head of Orthopedics at MGH, by Mike Jellinek, M.D. Dr. Rubash was asked to look at my x-rays and to suggest who in the U.S. might be best at fixing me up. After looking at my x-rays in conjunction with Mark Vraras, M.D., the head of Trauma Orthopedics, Dr. Rubash suggested that I should come to see them. I was thrilled and felt from the start that I would be in “good hands.” As I prepared, I had numerous calls with Drs. Rubash and Vraras explaining what they planned. These calls were all facilitated by extraordinarily helpful administrative staff. No one ever seemed in a bad mood or hurried.

When I met Dr. Rubash for the first time, the day before my surgery, I saw a number of residents who were all very nice and personable. None appeared bedraggled or on their way to somewhere else. They all took time to talk and listen. They seemed thrilled to be there, even though, at the time of my surgery, all the residents were in the last days of their fellowships and transitioning to their first jobs. One was about to have his first child and his wife had already moved home to Columbus, Ohio. He was temporarily living with another orthopedic resident to save money. The residents all bemoaned the cost of living in Boston and the hardships this entailed, but this did not seem to interfere with their care. They all felt it was worth the cost and sacrifice to be in Dr. Rubash and Dr. Vraras’ program. They spoke highly and respectfully of both their bosses.

All this was wonderful for me as a patient. I clearly knew who was in charge and felt listened to. There seemed a palpable culture of excellence that was valued and advocated for. I paid attention to see if I could get some clues as to how this had occurred. It seemed to come from the top with Dr. Rubash (or was it Harvard, or MGH?). It was clear that it was Dr. Rubash’s program, that he was the boss, that he set the standards, and that he led by example. He seemed comfortable being a role model and did, in fact, “write a book” on acetabulums. The fact that he is 6’7” added to the aura. Like his residents, he was upbeat, pleasant, and forthcoming; was there for me; and was not bedraggled, nor rushed. These very positive attitudes and attributes seemed to flow downward.

An example of how this worked came when the resident gave me a lengthy, if not a bit scary informed consent as to my surgery. The list of potential risks on the form began with the word “death.” I joked that that seemed a bit harsh. The resident responded: “Dr. Rubash insists that we start with that, as it is a potential complication” and then went through a clear list of lesser risks.

I believe that a little gesture captured the spirit of the system. As I awoke from my surgery, I received the good news that the surgical team did not have to re-break and re-set my acetabulum. This was unexpected and meant that I would be able to bear weight; thus, making my recuperation easier and shorter in duration. As I drifted in and out wondering if I was dreaming or anesthetized, I moaned that my mouth was dry. A nurse gave me a lollipop to suck on. While I was expecting a sugar substitute, it was a real lollipop. After I was moved to my room, I noted that someone, I assume the recovery room nurse, had taped another lollipop to my ID bracelet. My visitors asked about why I had a lollipop taped to my ID bracelet. I didn’t know, so I asked the staff. “Oh, that’s Dr. Rubash. He has a thing with NPO status for his patients. He keeps them NPO longer than the other docs. He’s worried about aspiration.” Everyone was clear what Dr. Rubash’s standards were. They were not intimidated, hence the lollipop, but were respectful of what Dr. Rubash wanted.

I left MGH with a sense that all hospitals have their distinctive cultures. Some are better than others. I believe that these cultures start and are maintained by such persons as Drs. Rubash and Vraras. I believe these people grow up in such cultures or have had contact with persons who constantly strive to change the cultures they are in for the better. I believe that these cultures, once set up, are difficult to change. This is good when it comes to maintaining a good culture and bad when it comes to trying to change a “problematic culture.”

In this and my July/August 2012 President’s Message, I mentioned four hospitals I have been cared at since November 2011. Each had their unique cultures. There are excellent people working in each of these cultures. I challenge each of you to think about your own culture of caring and the culture where you work. How would you rate it? Can it be improved? Having determined your answer, please know that each of you has something to do with the quality of your own caregiving, and therefore, that of where you work. We are all role models. How are you as a role model? Each of us is a steward of healthcare and its ultimate success. Always remember this, especially when being buffeted by the challenges and complexities inherent in healthcare today. ■

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

Wun Jung Kim, M.D., M.P.H.

Dear Members:

It is time to report to you that it has been a privilege and honor to serve you as the editor of AACAP News as I complete my 5-year term with this issue. I took the appointment with some trepidation and was later surprised to discover that it was a 5-year term rather than a 3-year term. But 5 years/30 issues have moved faster than I imagined. In fact, it has been fun working with so many of you; and working together, changing the face and content of AACAP News. I have been able to accomplish the majority of the pledges I made at the beginning of my term: diverse authorship and topics; culturally sensitive topics such as youth culture, social networks, and international and racial issues; practitioner sensitive topics; economical, concise, and on-time production with electronic distribution; more emphasis on committee and Assembly/ROCAP issues than regular columns—to list just a few. There are also unaccomplished goals such as timely news coverage, partly due to a month-long publisher’s drafting period, which will hopefully improve.

This is my fourth newsletter editorship, beginning in my college years for a larger circulation of university communities and beyond with a strong political tilt. There are similar dynamics in all newsletter editing, with many headaches, but this was the most enjoyable one—perhaps due to its magazine format rather than a typical news/newsletter format, but largely due to collegiality, support, and help I have received from all of you. Being a hands-on editor, I saw myself as someone to provide direction, structure, and organization for AACAP News, which meant some consistency in the production, e.g., deadline, length, objectivity, fairness and transparency—creating an equal opportunity rather than over-relying on a few select members or repeated authorship. I firmly believe that AACAP News is a product of members for members, an important benefit of AACAP membership and education and communication to contribute to the mission of AACAP. It has been gratifying that I have played a small part and contributed to that end. However, I could not have done it without all your contributions by submitting articles, rendering supportive as well as critical feedback, and tolerating my limit setting (even meaner to close friends). Additionally, my editorial team, from the production editor (Patricia Jutz), former and present section editors to the managing editor (Rob Grant), have worked hard; they are a team of dedicated professional editors.

My predecessor, William Bernet, M.D., first organized the section editor system, and it helped to achieve error-free publication in almost every issue and made my duty less burdensome. The assistance of central office from Virginia Anthony and Heidi Fordi to departed and present staff has been invaluable by writing announcements and articles, providing information, and proofreading every issue. The last, but not the least to report, is that Uma Rao, M.D., will succeed me as the new editor starting with the 2013 January/February issue. She has worked with me closely as the Annual Meeting section editor during my entire tenure of editorship and is a very capable and experienced editor. I have no doubt that she will elevate AACAP News to a new, higher plane with the help of an excellent editorial team. I will enjoy reading it in my spare time rather than proofreading it line by line in the middle of night, sometimes on holidays in a different continent. My heartfelt thanks and happy holidays to all of you, readers/members and contributors!

Dr. Kim is professor emeritus at the University of Toledo and professor of psychiatry at the University of Pittsburgh. He may be reached at kimwj@upmc.edu.
No matter which political party controls the White House or the halls of Congress after this election season, we can all agree that we are in the midst of a period of flux in our health care system. If the Patient Protection and Affordable Care Act (PPACA) stands, child and adolescent psychiatry will need to take an active role in the myriad ways it will impact our mental health system. In the event of repeal or defunding, it is still likely that certain popular components are likely to survive in some manner.

Child and adolescent psychiatrists will be witnessing and taking part in significant changes in the provision of services to children and families dealing with mental illness. AACAP has been at the forefront of advocating for a more comprehensive, accessible mental health system and has been preparing child and adolescent psychiatrists for health care reform. As medical students, residents, and fellows, these important changes being implemented and decided upon now will influence and determine directions for our entire careers. It is vital that we work to educate ourselves about these changes, seek opportunities to train in emerging models of care, and actively position ourselves to influence changes to our mental health system to benefit children and families struggling with mental illness.

Educate yourself.

Essential Benefits? Health insurance exchanges? Accountable care organizations? What does it all mean? If you are generally tech-savvy EHR users and can influence the rational use and development of behavioral health EHRs. If your health system has a behavioral health EHR that needs improvement, contact your chief information officer or related official to voice your opinion or suggestions for increased functionality.

The Physician Payments Sunshine Act, which will require pharmaceutical manufacturers and certain other organizations to report payments or gifts valued at greater than $10 (including meals, entertainment, gifts, and honoraria) to physicians and teaching hospitals, will finally go into effect in January 2013. The U.S. Department of Health and Human Services will then publish this data in a publicly searchable database. Trainees need to monitor this rapidly changing system to determine how it may impact training and education opportunities, conflict of interest policies, and the culture surrounding detailing and continuing medical education (CME).

Trainees do what they are trained to do.

Trainees develop lifelong learning and practice habits during residency and fellowship. We feel most comfortable doing what we have been trained to do. When considering job opportunities as early career psychiatrists, trainees naturally consider careers to which they have been exposed. However, the new health care landscape is bringing with it an array of different practice setting beyond traditional “inpatient versus outpatient.”
There are a bevy of programs increasing access to child and adolescent psychiatry services through consultation with primary care providers. Others are seeking to co-locate or integrate behavioral health services into primary care settings. Child and adolescent psychiatrists are providing services via telemedicine. There is steady growth of patients utilizing behavioral health services in public sector settings. Given these significant potential changes in the mental health system, are we as trainees receiving adequate training opportunities to develop the knowledge and skills required to flourish in these exciting and challenging practice settings?

If not, perhaps we can use this period of change as an opportunity to seek out and develop new training opportunities that can better prepare us for the emerging environment. Are any of these practice settings available as rotations, clinics, or electives at your training program? If you know of faculty working in any of these innovative practice settings – check to see if they would consider having trainees involved. Nothing replaces apprenticeship in learning if you may enjoy a particular type of work. If these opportunities are not yet available, approach your training administration to express your interest. You may be able to help create the framework for a new training experience!

Trainees can influence the changes ahead.

Funding pressures and increasing focus on quality measures in all aspects of health care appear to threaten the long-term viability of fee-for-service payment structures as a foundation of our health system. Serving “in the trenches” of providing mental health care to America’s children and families, trainees are well-suited to help re-conceptualize systems of care that focus on providing value and the highest quality care within growing resource constraints. As AACAP and other allied professional health organizations work with legislators and administrators, do not hesitate to voice your input into the process. What do you feel are the important changes that need to happen in training and education, access, and service delivery? What are the core values that need to remain? What are the new frontiers in research and services that we need to develop as a field?

One way to contribute to this process is by engaging Back to Project Future (BPF, www.aacap.org/cs/back_to_project_future). Martin Drell, M.D.’s Presidential Initiative. BPF is focused on developing priorities for child and adolescent psychiatry for the coming decade. Ideas and questions can be emailed to bpfquest@aacap.org. The Committee on Medical Students and Residents (MSR) is also collecting feedback for BPF, so do not hesitate to be in touch with MSR leadership.

On a separate note, I would like to take a moment to thank Ruth Gerson, M.D., AACAP’s outgoing John E. Schowalter, M.D. Resident Member of Council, for her assiduous work in helping to lead the Committee on Medical Students and Residents, her tremendous energy in helping to build up the AACAP Mentorship Network, and her myriad efforts to improve the AACAP experience for trainees across the country. We wish her the best as she stays on in New York to take on the role of associate director of the Children’s Comprehensive Psychiatric Emergency Program at Bellevue Hospital Center. We are also excited to welcome our new Schowalter Resident Member of Council, Marika Wrzosek, M.D. She hales from the Massachusetts General Hospital/McLean Hospital CAP fellowship program, and from the University of Illinois – Chicago general adult psychiatry residency prior to that. She brings with her tremendous leadership and education experience, which we are sure she will utilize to benefit trainees throughout AACAP.

Dr. Sengupta is a graduate of Duke University and Tufts School of Medicine, and is a child and adolescent psychiatry fellow at the Western Psychiatric Institute and Clinic at the University of Pittsburgh Medical Center. Dr. Sengupta is the AACAP’s Jerry M. Wiener Resident Member to Council. He may be reached at sourav.sengupta@alumni.duke.edu.
What did you say? I am sure I must have misunderstood.

To channel Miss Manners, who frequently offers excellent psychiatric advice, one should be thoughtful about sharing one’s thoughts aloud, particularly when it is not clear who might be in the audience. This point was made very clear recently when I received a forwarded e-mail from a colleague asking if I knew the child and adolescent psychiatrist (CAP) who had sent the original message. The CAP was complaining to one of the speakers involved in a recent panel discussion on health care economics in which several participants supported the benefits of universal health care for children, adolescents, and families. The CAP shared information about his political affiliations and angrily commented at length about the burden of having to financially support undeserving individuals with his tax dollars because they are “lazy, shiftless, and choose not to be productive.”

Obviously, he was not expecting to have his message shared with others, demonstrating one of the problems with using e-mail to communicate.

Should I have read the message? No, I should not have. However, the e-mail was addressed to me, from a colleague, with a subject line asking me if I knew this particular CAP—which happens to be a common question from this colleague, although the context is usually asking for my opinion of his or her clinical skills. And, by the time I realized that this message was different, I basically had finished reading it (it was pretty short). And, I definitely had the reaction of "Who is this person? And, how can he say this?" It also was clear that this e-mail had been sent to a number of other individuals by the time it had reached me.

Several aspects of the message were notable. In addition to the tone, I was stunned that this practitioner appeared to have such negative attributions about a patient population that includes a significant number of children and adolescents. While I have no idea to whom this CAP was referring, the overwhelming number of individuals who receive economic support and medical insurance from the government are children and adolescents. And, regardless of what one thinks about the adults, denying care to children and adolescents because of the behavior of their parents or other involved adults is not a value consistent with the standards of child and adolescent psychiatry, or indeed of medicine. And, as we all know, learning to effectively work with all types of adults to support and work towards the best interests of the involved children is a major challenge in child and adolescent psychiatric practice. As the AACAP Code of Ethics makes clear, the priority is to ensure the best interests of the child and I would argue that we, as practitioners and members of society have an obligation to ensure that youth have access to care and financial support, even if their adults do not fulfill their obligations. This physician certainly has a right to his opinions and to share them. However, medical practitioners have a professional obligation to prioritize their patients and to not behave in a manner that belittles or degrades them. While this message was shared beyond its intended audience, this CAP sent it to an individual he did not know, which tends to have a higher than usual risk that it will be shared with others.

Physicians must communicate their personal and professional beliefs in a manner that conveys respect for the people they care for and work with. All of us have countertransference feelings, often very negative ones, about parents...
and other adults who are not caring for their children and adolescents. It is a natural reaction and one that psychiatry has a long history of trying to understand and manage. It also is a common conviction that adults should care for themselves and those they are responsible for. Particularly with the advent of and constant use of electronic media to communicate, it is essential that physicians learn to monitor and manage how they share their ideas, thoughts, and emotions. Children and adolescents, and their families, should not find out through a careless e-mail that their physician appears to not consider them worthy of being helped.

Clearly, I do not know who the undeserving individuals are. However, the tone and the descriptive context were suggestive of a population that tends to include a large number of youth. Even if one chooses not to care for certain populations, as a physician and as a CAP, one has a responsibility to share one’s ideas and beliefs in a manner that is consistent with the values and convictions of the field. Electronic media has fundamentally changed the world of communication in some basic ways, particularly in the arena of keeping information confined. All of us should think twice (or more) before sending out any form of electronic communication, keeping in mind that once it leaves us there is no control over who has access. And, to paraphrase many wise people throughout history, if you don’t have anything nice to say, maybe you shouldn’t say anything at all.

Dr. Dingle is the chair of the AACAP Ethics Committee and the Child and Adolescent Psychiatry program director at Emory University in Atlanta, Georgia. She coordinates the Ethics Column in AACAP News. She may be reached at adingle@emory.edu.

15 million children and teenagers in America have a psychiatric disorder. Left untreated, emotional and mental disorders shatter lives, families, and dreams.

AACAP’s Campaign for America’s Kids supports innovative initiatives in advocacy, education, and research aimed at improving access to treatment for all children.

In 2012, CFAK supports projects such as the Summer Medical Student Fellowships and Advocacy Day Outreach.

Not Just “Gay” or “Straight” – Youth Culture, Identity and Sexuality: An Interview with Peter Daniolos, M.D.

What do you see as the role of child and adolescent psychiatrists in addressing issues around sexuality for lesbian, gay, bisexual, and transgender (LGBT) youth?

I think it’s important to first ask what we mean by the term “LGBT.” The categories and labels that we try to apply to youth are often not accepted by the youth themselves, who identify themselves in unique ways. Youth often do not like labeling and the “LGBT” population is hugely diverse. For example, when asked how they identify themselves, nine percent of youth respondents responded with terms such as “hetero-flexible.” That said, 71 percent chose standard labels so these are still relevant (Russell et al. 2009). We need to ask youth how they identify themselves before putting them in predefined categories.

In addition to our tendency to label, we also tend to focus on the angst of these youth while ignoring their resilience. In a *Time* magazine (10/05) cover story, Savin Williams argues, “They [LGBT youth] are more diverse than they are similar, and more resilient than suicidal.” He notes that youth are increasingly not defining themselves by their sexuality alone.

Galatzer Levy argues that “it is important that society as a whole come to terms with this new generation of well-adjusted, competent young men and women, who differ from their peers in terms of sexual orientation but little else” (Cohler and Galatzer-Levy 2000). In fact, one study suggested that gay and bisexual students are more likely to use a broader range of coping resources than heterosexual peers (Lock and Steiner 1999). Another study indicated LGBT youth may also develop greater interpersonal problem-solving skills than heterosexual peers; resilience seems often to develop out of adversity. It is essential that we highlight and explore strengths and not only vulnerabilities in this population.

Child and adolescent psychiatrists need to focus on understanding the child in front of us and not make assumptions about issues of sexuality. How often we still ask questions such as, “Do you have a boyfriend/girlfriend,” assuming that the child is heterosexual! What a great way to shut down open discussion of sexuality! Equally important is not to assume that the child is LGbT based on his/her presentation. An adolescent may demonstrate some of the behaviors, attitudes, and beliefs of an LGBT youth, yet not identify with that label or be ready to discuss it freely. We need to step back and not presume anything in either direction.

Do you see any trends (positive or negative) in the portrayal of LGBT youth in the popular media?

Popular media’s acceptance and portrayal of the LGBT community has dramatically shifted. In the fall of 2012, NBC will be releasing a show called the “The New Normal” about a gay couple interviewing a surrogate for pregnancy. What a change from when I was a boy growing up in North Dakota! The number of programs in the media portraying gay figures has increased substantially: *South Park*, *The Sims*, *Modern Family*, *Glee*, *Gray’s Anatomy*, *Happy Endings*, *Nurse Jackie*, *Six Feet Under*, *Ellen*, and *Will and Grace*, are just some of the programs featuring gay figures in television and film.

One notable exception is sports and sports-related media. Many gay men and women in team sports feel too threatened to come out while still actively playing. Gareth “Alfie” Thomas [retired rugby player in Wales, United Kingdom] is the only openly gay man in a team sport who came out while playing. Interestingly, he was shocked to hear this fact, assuming that sports in the United States were more “progressive.” Ultimately, culture goes both ways. Yes, it has progressed toward acceptance of the LGBT community, but there are still areas where it is very difficult to be openly LGBT. Thomas wondered aloud in an interview in 2010 why the NCAA has not formally stated, “We welcome all players regardless of sexuality.” What an impact that would have!

What impact will Obama’s endorsement of gay marriage have for LGBT youth?

An unbelievably positive one. This is a historic, watershed moment, and will have a huge impact on children regardless of political affiliation. Obama’s stated position “evolved” and he credited his change of mind to “knowing other gay people” such as befriending gay men and women who were the parents of his daughters’ classmates, or individuals serving in the military. Obama’s experience highlights how knowing healthy, productive individuals who are also gay can erase stereotypes.

Many people believe that equality for LGBT individuals is the last frontier of human civil rights. In the United States, only seven states legally endorse gay marriage, including (I am happy to say) my new home state of Iowa. Only 14 states have legal protections for bullying based on sexual orientation and gender identity. We have a long way to go for equality for gay individuals; an endorsement of support from the president is a significant step in the right direction.

That said, immediate peer connections more directly impact youth’s mental
health. Kids are often given the message that they are evil and worthless for being gay by their peers, and that sense of worthlessness can wreak havoc on identity integration in LGBT youth, which in turn can lead to psychopathology. A study by Rosario and colleagues (Rosario et al. 2011) found that in an ethnically diverse sample of 156 LGB youth in New York City, greater identity integration was related to fewer depressive and anxious symptoms, fewer conduct problems and higher self-esteem both cross-sectionally and longitudinally. Thus, the message that it is normal and acceptable to be gay must not only come from the top down, but also horizontally from peers.

Do you have any suggestions for conducting interviews of sexual history for children?

As clinicians, the most important intervention is to make some statement during the interview to normalize sexuality. Open statements such as “We see all different kinds of kids here” will create a supportive space for a discussion of sexuality. If the child communicates about bullying or teasing around sexuality, empathic validation is needed. I often will say things such as “It makes me so mad to hear that. Know why that makes me mad? Because nobody has any idea who you are. You may not even know who you are; it is not fair to make assumptions. It makes me even more mad because there is nothing wrong with being gay.” This last statement, affirming that being gay is a normal outcome for sexual development, is the most important.

Can you expand on the issues of stigmatization and identity integration for gay youth?

Gay youth often try to pass as heterosexual. As Martin (1982) notes, “This facade results in socialization becoming a process of deception at all levels.” Another frequent message given to gay youth is to “tone it down a bit.” In other words, don’t be too gay. Yoshino (2007) builds on the work of Goffman and others, examining stigma management techniques used by minorities, including gay professionals who need to “cover” or tone down their homosexuality. It is acceptable to be a “homosexual professional,” but not acceptable to be a “professional homosexual.”

In terms of stigmatization, the least accepted youth tend to be gender atypical. Feminine boys, regardless of their sexuality, are most often targeted for bullying and are less tolerated by their peers (Diamond and Savin-Williams 2003) than openly gay but gender-typical youth (Horn 2007). Social acceptance is highly correlated with risk for suicide. The Oregon Healthy Teens Survey 2006-08 (Hatzenbuehler 2011) anonymously surveyed nearly 32,000 11th grade Oregon students. It found that social environment constrains risk for suicide over and above individual risk-factors. LGB youth in general were more than 5 times as likely to have attempted suicide in the previous 12 months as their heterosexual peers (21.5% v. 4.2%). Those living in unsupportive environments were 20% more likely to attempt suicide than LGB youth in supportive environments.

Gay straight alliances (GSAs) may be one way of facilitating identity consolidation for gay youth. In 1993, Massachusetts Governor Weld created The Governor’s Commission of Gay and Lesbian Youth after hearing testimony from a GSA, Project 10 East at Cambridge Rindge and Latin H.S where I later consulted as a Child and Adolescent Psychiatry Fellow at The Cambridge Hospital/Harvard. The Cambridge program was modeled after Project 10 started by Virginia Uribe in California. Weld mandated a GSA and safe faculty contact in every Massachusetts public high school. GSAs now exist in over 4,000 schools across the country and provide role-models and mentors, a safe space, and opportunities for leadership and activism.

Regardless of whether we think of them as a distinct category, LGBT youth share much in common with all adolescents, albeit with distinctions all their own. And they have a tendency to suffer greatly if deprived of social and familial support. As child and adolescent psychiatrists, we need to be a clear voice of support when working with LGBT or questioning youth, and not add our voices to those that condemn them by, for example, presuming heterosexuality. Such a seemingly benign question will remain in that adolescent’s mind long after they leave our office, only further clouding their attempts to see themselves more clearly.

References


Dr. Sivashanker is a PGY-3 resident at the New York Presbyterian Weill-Cornell Adult Psychiatry Program in New York. He serves on the AACAP Ethics Committee. He may be reached at sivashanker@gmail.com.
One of the first things any child and adolescent psychiatry trainee becomes familiar with is the rule of consent for treatment that is dictated by state law. At the time, the pugnacious city in which I trained was renowned for its storied boxing tradition, the culture of which appeared to seep into every aspect of life of my beloved city. The mundane act of stepping onto an elevator could very easily lead to a conflict over whether or not you said “thank you” when the door was held open or “good morning.” In those days the place was called “Fist City.”

Fist City child and adolescent psychiatry clearly has its unique challenges. “Doc, you really gotta get this kid’s ADHD under better control – you see I think some of our neighbors are in the mob and we don’t want anything happening to us, you know?” I could not recall any lectures on this type of situation, but it seemed that a dose increase was in order. “The stakes here are higher than I was led to believe – I don’t want anyone getting killed,” I thought to myself.

It was not long before it became clear that child and adolescent psychiatry training was far more involved with the courts than that of adult psychiatry. Divorce and child custody issues and their effect on children’s mental health became readily apparent and the review of custody and guardianship orders became routine. One of the strangest guardianship issues that we commonly saw was in the emergency room. It was shockingly common for adults to bring in a child for a mental health evaluation. At the door we would ask this adult how she was related to the child. “I’m his aunt” was the usual reply. “What does that mean?” we would ask. “I’m his aunt.” Well what does that mean? “Who are you? Who is this kid?” we would blurt out. Well the common explanation was one I had never imagined. Woman after woman in this situation would tell a similar story: starting at a young age the kid would start spending a lot of time at the woman’s house and often due to factors such as biological parental substance addiction/absence the kid would basically end up living there without a guardianship order of any kind. Even though the kid’s mother lived on the same block, there was really no legal guardian. An aunt was a non-related woman with a big enough heart to bring an unrelated kid into her home and raise him/her as her own child. Sometimes in child and adolescent psychiatry we see both ends of the spectrum – the very bad as well as the very good – an interesting window into the human psyche…

“So there was this clown from my medical school class who, when he heard I was joining our child and adolescent psychiatry fellowship remarked, “Ah – vegetable gardening.” This was a slur against our profession – implying that child and adolescent psychiatry was a “soft” field of study, unlike his thuggish world of neurology. That particular individual never heard the end of the story however – how my child and adolescent psychiatry experience led me to an interest in law, crime, and forensic psychiatry.”

Now for some very bad. Again, child cases often have a greater degree of involvement with courts. Sometimes parents wanted you to testify favorably regarding their particular case. In forensic training we learn about “double agency” – serving two masters, the patient and the court – and how/why it should be avoided. In child and adolescent psychiatry, we at times face something along the line of “triple agency” – balancing the patient’s interest, the parents’ interest, and that of the court/society. Now, in Fist City, breaking the news to a leather-clad parent three times your size sometimes heightens anxiety. This could go along the line of, “I’m sorry Mr. Huge Angry Man, but I can’t testify to that in court regarding your case. Sometimes these guys would not take “no” for an answer, and they said they were coming to “see” me. Like most child and adolescent psychiatrists, I would avoid the clinic during those hours and hang out in what in those old days were called “music stores.” Curiosity would lead me to creep up the back stairwell to the clinic to see whether those guys would actually show up – and sure enough they would actually be there waiting for me. Now I do not know whether they wanted to intimidate me, beat me up, kill me, or all of the above. Well they would do worse: threaten a lawsuit.

So, I told my colleague I had to meet with some lawyer who was House Counsel. Hearing his name, she told me “whatever this guy tells you just agree – he’s an alpha male.” I asked what that was. She said, “you know how gorillas always have an alpha male as their leader and they tear to pieces any gorilla that opposes them? That’s an alpha male.” Not really wanting to be torn to pieces, I would vow to follow her advice. So I would go into one of those buildings that psychiatrists rarely ever enter – nice lobby, waterfall, sign-in desk, and tile floor. It was a little bit like Las Vegas or Atlantic City. You would go to an office suite and invariably a secretary would ask you if you would like any coffee, sir?” I would always reply,
“No, no thank you; I’m about to meet an alpha male. I’m nervous enough. I don’t really need any coffee right now, thank you.” Then you would be brought back to some office that was dark – like you could barely see this guy sitting behind his huge desk and you would hand over documents relating to your threat. This was a lawyer. He would review them and tell you not to worry; there was no case here, just a guy trying to intimidate a child and adolescent psychiatrist. I agreed with that intimidation part. He would say to pass along any communication regarding the case to him. Being a psychiatrist I quickly thought of various scenarios of being contacted about this case and asked him should I still pass along that communication to him. Leaning over the desk into the light such that his facial features could finally be seen, he would hiss, “You refer them to me”. At that moment I would remember that this was an alpha male I was dealing with and I did not want him jumping over that desk and tearing me to pieces, so I would agree.

Reflecting on these clinical experiences I began to think to myself that to practice child and adolescent psychiatry one needs a law degree, a bodyguard, martial arts training – maybe all of that. Then the light bulb in my head flickered – forensic psychiatry! Remaining a psychiatrist, I would receive additional training in the law, handling these difficult situations, dealing with dangerous people, and get myself toughened up a bit in settings like jails, prisons, state hospitals, etc. So this is the story of how my child and adolescent psychiatry experience led me to return to an additional fellowship in forensic psychiatry that I have found an extremely rewarding experience.

Dr. Zerby is the coordinator for the Forensics Column in AACAP News. If you are interested in submitting an article for consideration, please contact him at zerbysa@upmc.edu.
Ann Alaoglu, M.D.: Winner of the 2012 AACAP Charlotte and Norbert Rieger Psychodynamic Psychotherapy Paper Award

The Norbert and Charlotte Rieger Psychodynamic Psychotherapy Paper Award was established in 2001. By that time the long tradition of dynamic psychotherapy essential to good clinical practice was becoming less and less a part of child and adolescent psychiatry residency training. The award was established by AACAP with the Rieger Foundation to emphasize the importance of preserving psychotherapeutic skills and to encourage the writing of clinical case material about the effectiveness of the doctor-patient relationship in the healing of disturbed young children. The Rieger Award offers a stipend of $4,500 to the author of a paper submitted before the May 1st deadline each year. Papers are judged by members of AACAP’s Psychotherapy Committee according to a series of criteria including a review of pertinent psychiatric literature, the flow of engaging psychodynamic clinical material, an appreciation of developmental principles, and the paper’s use as a teaching tool.

This year’s winner of the Rieger Psychodynamic Psychotherapy Award, Ann Alaoglu, M.D., worked with her co-authors at the Lodge School Program in the Washington, D.C. area. The Lodge School Program was founded in 2001 after the closing of Chestnut Lodge Hospital. Her co-authors included members of the Chestnut Lodge Study Group: E. James Anthony, M.D.; Andrew Carroll, Ph.D.; Vincent Del Balzo, LCSW-C; Richard C. Fritsch, Ph.D.; Paul M. Gedo, Ph.D.; Richard Imirowicz, M.D.; Karol Kullberg LCSW-C; Lauren Mazow, Ph.D.; and Rebecca Rieger, Ph.D. In the case reported, Karol Kullberg provided family therapy and Lauren Mazow, individual therapy, while Dr. Alaoglu served as medicating psychiatrist.

Expressing her delight at winning the award, Dr. Alaoglu told me that it was during a study group meeting at the home of E. James and Virginia Anthony that she learned about AACAP’s Rieger paper prize. Most of all, she was pleased that the award will “get our work out there,” within the current therapeutic climate, “in which the principles supporting this kind of psychodynamic work are so little appreciated, and in which there is such a need to demonstrate the complex and prolonged efforts needed for successful work with high risk children and adolescents.” The Lodge School applies a psychodynamically-oriented, multi-modal day program model of care in which the development of relationships among students, teachers, and clinical staff provides many of the milieu and containment functions formerly available within long-term hospital settings. The successful story of her patient, Alexa Z., is not unusual with children who stay in the Lodge School for several years and engage in attachment-based treatment.

The winning paper is a remarkable narrative, titled “Untangling Psyche and Soma: A Traumatized Adolescent with Lyme Disease,” about the treatment of a school-avoidant adolescent girl with a severe complex persistent disorder. Alexa Z. entered the Lodge School with a significant trauma history, chronic somatic problems associated with Lyme disease, family conflict, self-injurious behaviors, depression, anorexia, psychotic symptoms, and a mood disorder. Outpatient psychotherapy, psychopharmacological treatment, and short-term hospitalizations had yielded no therapeutic change.

Literature concerning in-patient treatment models is reviewed, showing how the older practice of long-term treatment gradually gave way to short-term hospitalizations, primarily addressing imminent dangerousness. At the Lodge School, adolescents are maintained within family and community, complicating matters of containment as well as their developmental needs for family separation. Admission decisions are based on estimates of the adolescent’s strengths, potential to form attachments, and some degree of internal control. Treatment is aimed at removing interferences to the adolescent’s healthy drive to complete development.

Discussing Alexa’s “relational containment,” Dr. Alaoglu comments, “The school environment affords a child any number of people to whom [she] can try to connect: teachers, peers, individual therapists, family therapists, group therapists, support counselors, principal, clinical director, administrative staff. This array of potential relationships offers the child flexibility in finding connections.
that meet [her] idiosyncratic needs, diminish anxiety, motivate attendance and success, and help [her] engage in the work of the program.” Skillful work by the family therapist became another critical aspect of the containment phase of treatment. Psychiatric containment also became integral in stabilizing and containing Alexa, although because of her age, trauma history, histrionic somatic symptoms, and ongoing treatment for Lyme disease, targeting symptoms for medication intervention became inordinately complex.

The next two sections of the paper discuss “Working Through.” Family therapy was focused on reorganizing a highly enmeshed family which encumbered Alexa’s development. Individual psychotherapy entailed a reorganization of Alexa’s intrapsychic dynamics in which her attempted enactments of blurry family boundaries were countered with clarification, ego support, and empathy. In the Lodge School Program, the usual boundaries of psychotherapeutic confidentiality were opened and shared within the team to avoid further maladaptive enactments. Alexa’s therapist “used her countertransference experiences to guide her interventions [and these] became the mainstay of the therapeutic work.” Alexa’s hostility was no longer unspeakable; she achieved a sense of having a mind, with its own workings, utilized her aggression to power newfound autonomy, and began to understand that an ability to tolerate conflict enabled her “to explore how her psychological crises related to her somatic ones; how her body might distract her from her mind [and] how her physical illness drew her mother back in as caregiver [serving] to elicit the nurturing she craved but simultaneously protested.”

Termination occurred at Alexa’s high school graduation. A summary discussion noted: “Treatment within the biopsychosocial model operates to remove obstacles to development by analyzing conflict and providing temporary support for compromised ego functions, so that the normal developmental thrust that has been derailed can return to a more ordinary developmental trajectory.”

Dr. Alaoglu’s career proceeded from an undergraduate “highest honors” degree at the University of California and subsequent Masters Degree in Physics, through her medical education at the Stanford University School of Medicine and graduation from the Washington Psychoanalytic Institute, where she remains a faculty member. Originally, Dr. Alaoglu was headed for a career in physics, then in pediatrics as a research hematologist-oncologist at The National Institutes of Health Cancer Institute. (An early paper was titled “Efficacy of Bone Scans in the Detection of Recurrent Ewing’s Sarcoma.”) While in Washington, she completed her psychiatric education with an adult and child fellowship at Georgetown University Hospital, and is currently Board Certified in pediatrics, psychiatry, and child and adolescent psychiatry. Dr. Alaoglu told me that her training in pediatrics has enabled her to feel more comfortable with medical issues than many psychiatrists who have not had a medical residency training experience.

At Chestnut Lodge, Dr. Alaoglu became medical director of the Rose Hill Residential Treatment Center, then director of Child, Adolescent, and Family Services; and later, administrator of the inpatient, residential, and outpatient units. She was responsible for the psychiatric evaluation and treatment planning for adolescents and children where the focus was on recurrently hospitalized, treatment-resistant patients. She also participated in the development of a Residential Treatment Center and Partial Hospitalization Program, providing long-term intensive psychotherapy and medication management, as well as psychotherapy supervision for trainees in psychology. Currently, in the full-time private practice of child, adolescent, and adult psychiatry and psychanalysis, she consults at the Frost Center, a special education setting for emotionally disturbed elementary through high school students that includes the Lodge School Program.

The AACAP Charlotte and Norbert Rieber Psychodynamic Psychotherapy Paper Award recognizes the best published or unpublished paper, written by an AACAP member, that uses a psychodynamic framework and presents clinical material demonstrating the inner life of an infant, child or adolescent in order to illustrate the paper’s idea or hypothesis. For more information on this award, please visit: http://www.aacap.org/cs/awards/riegerpsychotherapy.

Dr. Donson is in the private practice of psychiatry and psychoanalysis in Englewood, New Jersey; is a liaison member for the Association for Child Psychoanalysis of AACAP’s Psychotherapy Committee; and on the faculties of the Columbia (New York) Psychoanalytic Center for Training and Research and the Institute for Infant and Preschool Mental Health in East Orange, New Jersey. He may be reached at MNDonson@aol.com.
“There can be no keener revelation of a society’s soul than the way in which it treats its children.”
– Nelson Mandela

like many others, when I first received the e-mail informing me of my selection for the Donald J. Cohen (DJC) Fellowship, I needed to read it twice to make sure I was not imagining it! In retrospect, maybe this is precisely the reason that fellows are selected - to be afforded the opportunity to reinforce one’s sense of achievement, to teach the fellow to question the chosen path, to make one wary while simultaneously building confidence. A tall order indeed!

It is a privilege to participate in a program that from a distance appears to target “like-minded” clinicians in a common field, yet at a closer look reveals a far greater blend of young people at varying stages in their careers. The International Association of Child and Adolescent Psychiatrists and Allied Professions (IACAPAP) in Paris 2012, enticed as a conference that would showcase “brain, Mind and Development” as a pervasive theme. The anticipation of attending a conference of this magnitude was quite palpable. Everyone scurries in and out of meeting rooms and lectures, all keen to attend as many talks as possible, while other more seasoned attendees calmly choose a few select presentations. Lesson number one for an over-eager young conference attendee: for maximum benefit, choose talks wisely and relax. One cannot possibly attend everything! The “institutes” scheduled prior to the conference proceedings whet my appetite with the latest updates and controversial discussions, setting the scene for rest of the week. It was another lesson in time management as one attempted to attend lectures on new genetic and research developments while still trying not to miss out on more clinically based symposia. The richest offering to the young attendee perhaps was in the form of the poster presentations on a variety of topics, showcasing advanced research and imaging findings to interesting cases reports and clinically translatable research.

At first, the thrill of being part of a conference of this magnitude was quite palpable. Everyone scurries in and out of meeting rooms and lectures, all keen to attend as many talks as possible, while other more seasoned attendees calmly choose a few select presentations. Lesson number one for an over-eager young conference attendee: for maximum benefit, choose talks wisely and relax. One cannot possibly attend everything! The “institutes” scheduled prior to the conference proceedings whet my appetite with the latest updates and controversial discussions, setting the scene for rest of the week. It was another lesson in time management as one attempted to attend lectures on new genetic and research developments while still trying not to miss out on more clinically based symposia. The richest offering to the young attendee perhaps was in the form of the poster presentations on a variety of topics, showcasing advanced research and imaging findings to interesting cases reports and clinically translatable research.

It takes a certain amount of trust (that carefully hides the discomfort), having to introduce and share personal journeys with a group of strangers from such diverse backgrounds. As we nervously initiated conversations, and practiced our best introduction lines with each other, I could not help but smile at the irony...this group of DJC Fellows, developing experts in the most difficult of fields – the world of children – are finding it the most intimidating to form new friendships! As the days progressed, the camaraderie was evident; we were not that different after all! We attended each other’s presentations with great interest, and listened to ideas in group sessions with bated curiosity. As the trust developed, so too did the learning. The invaluable input from individual mentors and the enigmatic fellowship coordinators made this program a melting pot of academic and personal growth.

The DJC program offered an opportunity to share our successes and ambitions, as well as our mistakes, failures, and challenges. Suddenly, it did not seem that
foolish anymore to verbalize thoughts or opinions in a setting of people representing mentors, international experts, and researchers. It is often said that leadership and learning are indispensable to each other. This program demonstrated exactly that. As a recently qualified child and adolescent psychiatrist from the tip of Africa, I join the ranks in a tiny and under-resourced fraternity. I am regularly faced with clinical dilemmas, academic stumbling blocks, and resource nightmares, while trying to manage mental health problems in children with incomprensible adversities. So my initial skepticism at sharing in this forum was fuelled by real thoughts: Why would other professionals from more advantaged and developed settings be interested in my experiences? Who would identify with my challenges of treating HIV positive children not accessing mental health services when the kinds of challenges facing others included writing successful grant applications or not getting published in the highest impact journals? What could we possibly learn from each other given the enormous gap between our experiences?

This perhaps was where the DJC Fellowship served as a platform to demonstrate what often is missed when people attend big international conferences – that while our challenges may differ, our ambitions are the same! We all want to be better at what we do; we all desire to make a difference in the lives of the children we treat. We all aspire to be the kind of leaders and experts that we scramble to listen to at these conferences. But perhaps the most important lesson learned as a DJC Fellow, was that there is indeed “unity in diversity,” and that given the opportunity we have the ability to learn, lead, and grow.

As we left Paris, feeling enriched by the experience, we also felt a sense of pride that our contribution to the field of child and adolescent mental health, however small, will make an impact. Like Andres Martin, M.D., reminded us, while we need to think globally we need to continue to act locally. Many of my colleagues would now have returned to enviable academic institutions and child research centers, while others would return to their countries as the lone professional offering hope to millions of children. We are indebted to the Donald J. Cohen Fellowship Program and the IACAPAP leadership for the opportunity. From here forward, seeing the change from within and within our community will be the result of all true learning.

Dr. Lachman is currently working as a child and adolescent psychiatrist, consultant in the Inpatient Adolescent Unit and part of the pediatric consultation liaison service at Tygerberg Hospital, University of Stellenbosch, Cape Town, South Africa. Special interests are HIV and Neuropsychiatry in adolescents, Dual Diagnosis (substances and first episode psychosis).
As our readers may know, in 2011 the ECP Connect program awarded its first $2,000 grants to 15 enthusiastic ROCAP (Regional Organization of Child and Adolescent Psychiatry) recipients; Financial Sponsor: Children For America’s Kids. The objective of these grants was to encourage educational and networking events, foster mentorship, and improve ECP connections with their regional organizations outside of the annual meeting. As 2012 is drawing to its close, we can safely say – “Goal accomplished!” From California to the East Coast, ECPs were hard at work over the last 2 years – planning and hosting successful programs that ranged from a NYC dinner meeting to three days of events in Nebraska. ECP Connect was able to support and fund programs for over 300 participants. The programs included a wide variety of different experiences and successfully forged connections among trainees, ECPs, and more senior child and adolescent psychiatrists. The enthusiasm and support of the program was obvious as the ECP Committee received reports back from the organizers and gathered survey feedback from participants. Read on for a sample description of the events in one of the ROCAPs (NJ/ Pennsylvania ROCAP) and to get ideas for your own ECP event in the future!

Alex Strauss, M.D., and Anne Frederickson, M.D., from the NJ/ Pennsylvania ROCAP put together a series of four events throughout 2011. In an interview with Dr. Strauss, he said, “the programs were received very positively by all of the ECPs who attended. Everyone expressed a desire for more events in the future.”

“The positive impact of the NJ/Pennsylvania ROCAP ECP Connect events clearly demonstrates the need for further development of regional ECP programming. As a result, ECPs will gain more vital opportunities for professional and personal growth, while AACAP will gain new leaders!”

NJ/Pennsylvania ROCAP used a variety of different formats to keep the events fun, informative and distinctive. The first event in August 2011 introduced ECPs to various child and adolescent psychiatrists from the region. Mentors presented a short synopsis of their careers and then answered questions from attendees. Amy Rowan, M.D., Randall Gurak, M.D., and David Ellis, M.D., served as mentors representing private practice. A number of ECPs attended, some already engaged in private practice and others considering a private practice career option. The mentors provided an overview of the range of private practice options and career paths in the community. The meeting was interactive with time to ask questions that ranged from practical matters, such as buying malpractice insurance, to work-life issues, such as treating peers of one’s children.

The focus of the second event was peer mentorship. Alex Strauss, M.D., an early career psychiatrist, met with other ECPs to discuss his training in the field of sport’s psychiatry and concussion management. He described in detail the latest evaluation and treatment recommendations for concussion, including the complexities of working with a multi-disciplinary team, neuropsychiatric complications, and their management.

The largest NJ/Pennsylvania ECP event of the year was a career mentorship day. This event included a round table discussion with psychiatrists of varying backgrounds and career levels describing their areas of career focus. This was followed by breakout groups with participating senior child psychiatrists being available for 1:1 discussions. This format facilitated individual discussions among possible mentors and senior CAPs without formal presentations.

During the final the NJ/Pennsylvania ROCAP ECP event on January 25th, nine members of the regional organization met with Marilyn Benoit, M.D. The
ECP group was very excited to have the opportunity to meet with Dr. Benoit given her extensive clinical, academic, administrative, and leadership experience. Dr. Benoit provided useful information about her career path as well as her growth within the AACAP that culminated with her being elected AACAP president.

Dr. Strauss was most excited about the regional peer mentorship group that developed as a result of the ROCAP events. The local ECPs collectively decided to continue to communicate through an ECP list serve to provide peer mentorship on a variety of issues. They plan to hold meetings every one to two months to continue face to face mentorship and communication. In Dr. Strauss’ words, “All of the events were well received and we hope to continue to meet regularly.”

The positive impact of the NJ/Pennsylvania ROCAP ECP Connect events clearly demonstrates the need for further development of ECP programming. As a result, ECPs will gain more vital opportunities for professional and personal growth, while AACAP will gain new leaders!

The ECP Committee would like to acknowledge the work of AACAP staff Ashley Partner, as well as ECPs Susan Millam-Miller, M.D., Kayla Pope, J.D., M.D., and mentor Michael Houston, M.D., who were all instrumental in the inception and development of the ECP Connect Program. Special thanks also go to the Campaign for America’s Kids, whose financial support made this possible.

Dr. Haak is a clinical assistant professor for the University at Buffalo. She works in the Child and Adolescent Residency Training Clinic and also treats patients at a community mental health clinic. She may be reached at lezama2@yahoo.com.

Dr. Strauss practices in Marlton, New Jersey, as a partner at Centra, P.C. He can be reached at alexstraussmd@gmail.com.

Dr. Lorberg is an inpatient child psychiatry attending at Massachusetts Adolescent Continuing Care Units (Worcester State Hospital). He is an assistant professor of Psychiatry at University of Massachusetts Medical School and has a small private practice. He may be reached at boris.lorberg@umassmed.edu.

Dr. Frederickson is the medical director of a child and adolescent inpatient psychiatric unit in the Philadelphia metropolitan area. She also supervises general psychiatry residents at Temple University. She may be reached at anne_frederickson@yahoo.com.

In 2013, AACAP will celebrate 60 years. Not many organizations in the public sector, private sector, for profit, or non-profit get to 60 years. While longevity is a proud milestone, it’s 60 years of purpose that matters. We have defined a profession, and in doing this, we have made children’s lives better.

Now it is on to the next 60 years of more achievements and milestones leading the fight to treat, and one day end, childhood mental illnesses. So, we are launching the “60. 60. 60.” challenge.

In celebration of 60 years, we are asking 60 percent of our membership to donate $60. You can donate more – $6/month, or a one-time donation of $600, or $6,000. Or, surprise us!

If we achieve this, at a minimum we raise $270,000 for Campaign for America’s Kids. Those who choose to donate $600, or even $6,000, will help us strive beyond our challenge goal. Remember, whether we reach or exceed this financial goal, the only true purpose of this challenge is strengthening AACAP, which strengthens the child and adolescent psychiatry profession. The real winner: the children and adolescents we serve.
2013
PSYCHOPHARMACOLOGY UPDATE INSTITUTE
The Impact of DSM-5 on Child and Adolescent Psychopharmacological Treatments

SAVE THE DATES!

JANUARY 25–26, 2013
Gabrielle A. Carlson, M.D., Chair
Marriott Wardman Park Hotel — Washington, DC

Register by December 14 at www.aacap.org/cs/psychopharm/2013
to get the early bird rate.
Plus, save $25 by registering online.
Advancing AACAP’s Advocacy Efforts: The Creation of a Political Action Committee

Kristin Kroeger Ptakowski  
Senior Deputy Director and Director of Government Affairs and Clinical Affairs

For two years, AACAP leadership has discussed the creation of a Political Action Committee (PAC) to advance our existing advocacy efforts. As part of Dr. Greenhill’s presidential initiative, Project AACAP, a working group of members and staff explored what a PAC would mean for AACAP, how members would feel about it, and which other similar medical and professional organizations have a PAC. After legal consultation, the working group determined that AACAP would need to create a separate non-profit organization to implement a PAC. Additionally, through member surveys and discussions, we learned that the AACAP membership, the Assembly of Regional Organizations, and Council are supportive of creating a PAC, although survey respondents are also mindful of the risks. Finally, the working group found that there are other similar-sized medical organizations that have established PACs and find them effective; however, these organizations had been initially cautious about their creation.

In June 2011, the working group presented their findings to Council, who then voted to create a PAC through which AACAP can support the campaigns of pro-mental health candidates for Congress. Dr. Greenhill appointed a task force to both examine how AACAP would set up the PAC and educate the membership about this new endeavor. The task force has since reached out to committees and regional organizations of AACAP via conference calls and webinars to speak with members about the PAC and solicit feedback. All survey data collected from the membership and presented to Council, as well as the member webinar, can be found on the members only section of our website: www.aacap.org/cs/members_only/political_action_committee.

How AACAP Will Establish a PAC

AACAP is currently a 501(c)3 non-profit organization, and, by law, can engage in limited lobbying activities. Additionally, 501(c)3 organizations are defined as charitable or education organizations and cannot endorse or oppose a candidate for election or contribute to campaigns. Consequently, to advance our advocacy efforts and form a PAC, AACAP will need to create an affiliated non-profit organization, a 501(c)6, which is classified as a trade association made up of members who share a business interest. All or part of AACAP’s current government affairs activities would rest within this new non-profit organization, as would an AACAP PAC and any other new advocacy activities.

The bylaws of the new 501(c)6 organization will ensure that it is affiliated (“connected”) with AACAP’s current 501(c)3 organization in several ways. First, the organizations will be linked through their elected officers, with AACAP’s Council and the governing board of the 501(c)6 being identical. Second, the two organizations will be linked through membership dues. The portion of your dues that currently supports AACAP’s government affairs programs will be allocated to the new 501(c)6 organization to continue to support these programs, as well as administer the PAC. Your dues will NOT increase to operate this new program!

All AACAP members will have the choice to opt-out of being a member of the new 501(c)6 through your annual member dues statement. If a member chooses to opt-out, their dues will not be used to support any of the government affairs programs within the 501(c)6 and 100 percent of their dues will go to AACAP’s 501(c)3. Because 501(c)6 organizations are geared toward business purposes, any contributions to a 501(c)6 can be written off as a business expense. However, contributions are not considered charitable giving as they are when contributing to a 501(c)3.

Forming an PAC is just one reason to create a 501(c)6 organization affiliated with AACAP. As the Project AACAP working group and the new task force have learned, a 501(c)6 organization will advance our government affairs activities by increasing our lobbying activities and educating AACAP members about candidates running for elections. The creation of a PAC will not impact the existing programs within the Government Affairs Department, such as AACAP’s annual Advocacy Day, our state and grassroots advocacy work, or the various activities through which we educate members of Congress and federal agencies.

If you would like to learn more about advancing AACAP’s advocacy efforts and creating a PAC, please log onto AACAP’s members only site at www.aacap.org/cs/members_only/political_action_committee. You can ask questions in a forum, read past AACAP News articles on the subject, and review all the information collected to date.
Helping Parents and Infants Sleep

Sleep problems are common across all ages but are particularly common in the first year of life. Approximately 45% of all infants are reported to have sleep problems in the second six months of life. Further compounding the situation is that infant sleep problems are associated with a doubling of the rates of maternal depression. The common nature of this problem has led to a broad range of advice and multiple approaches to address the challenge of helping infants and thus parents sleep. While almost all approaches profess variations on techniques to teach babies how to put themselves to sleep independently, they all fall into the broad category of extinction-based behavioral training. These techniques rely upon the infant awakening and then the parent gradually decreasing the parental scaffolding that the child needs to return to sleep. One approach to this is typically done by allowing the infant to awaken and cry, and then the parent providing “controlled comforting” by responding to the child’s crying at gradually increasing intervals of time until they are no longer needed. The second variation has been deemed “camping out.” In this approach the parents start by “camping out” in the child’s room after the child cries, but then progressively desensitizing the child’s need for parental scaffolding by gradually “camping out” at greater and greater distances until their physical presence is no longer needed.

The success of almost all of these programs was reflected in the wide sample of published behavioral approaches to sleep problems that were reviewed by Mindell’s (2006) who “found that 49 of 52 programs led to clinically significant reductions in bedtime resistance and night waking 3 to 6 months later. Secondary benefits included better parent sleep, mental health, and child/parent relationships.”

Despite this extensive literature, resistance to this well documented and quite successful set of approaches has generally lingered, having its roots in the belief that unresponded to crying (pure extinction that few would recommend) might impair the parent-child bond, increase the child’s stress, or even impair future mental health. While neither “controlled crying” nor “camping out” promote crying, they both have elements of allowing the child to awaken and cry (at least some) and thus might be subject, according to some critics, to the same set of concerns.

These questions around long-term impact were addressed by Price et al., in October’s Pediatrics. In their study, they looked at 5-year follow ups (at age 6) of a large cohort of infants (323) who had presented to health providers with sleep problems at age 7 months. At the inception the infant/family units were randomized to either an extinction based behavioral program (a combination of both “controlled comforting” and “camping out”) or to usual outpatient care. The behavioral training was delivered by trained nurses who met with families 1-3 times at infant age 8-10 months.

As expected the infants in the intervention group rapidly responded to this well documented approach. They were able to follow up 5 years later on about 70% of the original cohort, now age 6. They found that there was no evidence of differences between intervention and control families for any outcome, including 1) children’s emotional (P = .8) and conduct behavior scores (P = .6), sleep problems (9% vs 7%, P = .2), sleep habits score (P = .4), parent- (P = .7) and child-reported (P = .8) psychosocial functioning, chronic stress (29% vs 22%, P = .4); 2) child-parent closeness (P = .1) and conflict (P = .4), global relationship (P = .9), disinhibited attachment (P = .3); and (3) parent depression, anxiety, and stress scores (P = .9) or authoritative parenting (63% vs 59%, P = .5).

So for clinicians the picture is quite clear, the behavioral interventions work and there are no adverse sequelae 5 years later. Infants, parents, and clinicians all can now sleep better.


Risk Factors for Suicide in Youth with Bipolar Disorder

Youth with bipolar disorder are at higher risk for suicide than youth with any other diagnosis, with studies reporting lifetime rates of suicide attempts between 20% and 47%. While suicidality in bipolar disorder has been fairly well studied in adults, youth have not received the same focus in the literature. Clinical factors predicting suicide in adults with bipolar disorder include a history of a suicide attempt, amount of time spent and severity of hopelessness and depressed or mixed episodes, panic disorder, and substance misuse. Genetically, a family history increases risk. Demographically, only younger age of onset at illness appears to be predictive. As 65% of adults with bipolar disorder report onset of illness before adulthood, suicide in bipolar disorder is a challenge for the child and adolescent psychiatrist.
In Archives of General Psychiatry, Goldstein et al. report analyses on proximal factors of suicide attempts in youth with bipolar disorder from the Course and Outcomes of Bipolar Youth (COBY) study, a multi-site (Brown, Pittsburgh, and UCLA) longitudinal cohort of over 400 children and adolescents aged 7-17 diagnosed with bipolar disorder using rigorous DSM-IV criteria. Over the 5 years of follow-up from intake, 76 of the 413 subjects made at least 1 suicide attempt; 31 made more than one attempt. Girls were more likely to attempt suicide than boys. Overall, more time spent with depressed mood, mixed mood symptoms, and substance use disorders were the most robust predictors of these suicide attempts. Of 163 total suicide attempts, subjects reported suicidal ideation prior to the attempt 42% of the time. Only 2% of attempts were associated with psychotic symptoms, 5% occurred while the subject was intoxicated. Significant life events preceded 31% of the attempts, with break-ups in romantic relationships and family conflicts being the most commonly reported events. No difference in attempts was noted between bipolar subtypes. Those who attempted suicide were twice as likely to have a comorbid substance use disorder as those who didn’t.

In assessing suicide risk in youth with bipolar disorder, clinicians should pay particularly close attention to the severity of recent depressive symptoms, the presence of more mixed features, family history of suicide attempts, and substance use disorders, even though very few suicide attempts are directly associated with intoxication with substances.

archpsyc.jamanetwork.com/article.aspx?articleid=1206778

Stimulants May Reduce Risk for Cigarette Smoking in Youth With ADHD

Cigarette smoking begins during adolescence for most smokers. About 4,000 youth in the US try their first cigarette each day. Adolescents with ADHD are more likely to smoke, tend to start smoking earlier, and have a higher chance of becoming addicted and having a harder time quitting smoking compared to their non-ADHD peers. Perhaps adolescents with ADHD are more likely to impulsively try a first cigarette. They might even have dopaminergic reward systems that are simply more sensitive to the reinforcing effects of smoking. Some previous studies have suggested that with treatment, youth with ADHD might be less susceptible to cigarette smoking.

Investigators at the Clinical and Research Program in Pediatric Psychopharmacology and Adult ADHD at Massachusetts General try to shed further light on this question in an open-label clinical trial of extended-release methylphenidate (OROS-MPH) for smoking prevention in 154 adolescents with ADHD. A naturalistic sample of 103 untreated youth with ADHD and 188 non-ADHD youth were used as historical comparators derived from previous MGH studies of the treatment and epidemiology of ADHD. After treatment for an average of 10 months with OROS-MPH, subjects with ADHD who were being treated with stimulants in the clinical trial smoked at similar rates to subjects without ADHD and the historical comparators with ADHD who were treated with stimulants. However, the rate of smoking in the clinical trial subjects (7.1%) was much lower than that of the historical comparators with ADHD who were not being treated with stimulants (19.6%). When controlling for conduct disorder and other alcohol and drug abuse, the difference between the clinical trial subjects and the historical comparators with ADHD not being treated with stimulants was no longer statistically significant.

The study openly describes its limitations, including a low number of smokers in the population as well the open-label design and historical comparators, and suggests that further prospective trials need to be conducted to clarify the effects of ADHD treatment (stimulants and otherwise) on smoking behaviors. As clinicians, we can use this information to further inform families about the risks and benefits of prescribing stimulant medications to adolescents with ADHD, recognizing that the potential for reducing smoking behaviors may have powerful implications for public health.


Home Foreclosures, but Not Unemployment, Increase Risk for Child Abuse

Rates of child abuse began to decline in the late 1990s in a clear trend through at least the mid-2000s in the United States. One important factor in this decrease may have been the relatively robust U.S. economy during this time period. Given the economic recession that began in 2007, child abuse experts are concerned that rates of child abuse may reverse the trend and begin to increase. Data regarding this trend has been mixed. Poverty and childhood maltreatment have been clearly linked, but less is known about sudden changes of unemployment, mortgage foreclosures, and cuts in social services due to dwindling state budgets.

A group of child abuse policy experts at Children’s Hospital of Philadelphia examined some of these questions in a report published in Pediatrics. Wood et al. reviewed retrospective data of children admitted to 38 hospitals in a public database linked to unemployment,

continued on page 302
Monitoring of Psychotropic Medications for Children in Foster Care States Grapple with Implementation

Kristin Kroeger Ptakowski
Senior Deputy Director and Director of Government Affairs and Clinical Affairs

In September 2011, Congress passed The Child and Family Services Improvement and Innovation Act, (PL 112-34), which requires state child welfare agencies to develop protocols for appropriate use and monitoring of psychotropic drugs prescribed to children in foster care. The law was established due to the concerns over the increased number of children in foster care who are receiving psychotropic medications. The individual state protocols are in their early stages and are being developed with representatives from state Medicaid and child mental health agencies. This is a critical opportunity for child and adolescent psychiatry involvement on this critical issue.

Last December, a Government Accountability Office (GAO) report showed that in five select states in 2008 (Florida, Massachusetts, Michigan, Oregon and Texas) foster children were 2.7 to 4.5 times more likely to be on a psychotropic medication than children on Medicaid.

The report hailed AACAP Position Statement on Oversight of Psychotropic Medication Use for Children in State Custody: A Best Principles Guideline as the gold standard for monitoring. Since the passage of the legislation and the release of the GAO report, the Agency for Children Youth and Families (ACYF), the federal agency with oversight over the state child welfare agencies, has put out guidance to states on how to establish their systems, recommending the use of AACAP guideline as well as another educational document, A Guide for Community Child Serving Agencies on Psychotropic Medications for Children and Adolescents, created by AACAP’s Community-based Systems of Care Committee (created with support from the Center for Mental Health Services).

ACYF also invited me and AACAP members Mike Naylor, M.D., and Chris Bellonci, M.D., to assist them and other federal agency partners within Department of Health and Human Service to plan a two-day conference to provide technical assistance to states on how to establish these monitoring systems. Each state and several territories brought representatives from Medicaid, child welfare, and mental health together to hear from national experts on how best to begin to implement and maintain the monitoring programs. Other AACAP members who are a part of successful programs in their states were invited to speak and many AACAP members from either state mental health or child welfare agencies also attended. To view the program agenda, go to ACYF’s website at http://www.paltech.com/web/psychotropic/.

The best outcomes for children in foster care are achieved with collaborations at all levels. AACAP Regional Organizations must be at the table during each state’s monitoring program development. As child and adolescent psychiatrists, you are the MOST QUALIFIED to run these programs. AACAP is here to assist both members who are building and maintaining these programs and those who are treating children in the foster care system. If you have any questions or need assistance, please contact me at kkroeger@aacap.org.

News Updates continued from page 301

mortality delinquency, and foreclosure data for the associated areas. Over the years studied from 2000 to 2009, admissions for physical abuse increased by about 1%, and admissions for high-risk traumatic brain injury increased by about 3%. In contrast, all-cause injury rates declined by nearly a percent. The abuse and high-risk TBI admission rates were associated with mortgage delinquency and foreclosure rates. Though these changes in rates were small, they were statistically significant, likely due to the very large samples employed in the study.

The study suggests that housing concerns are a significant source of stress for communities and families and likely contribute to increases in child abuse. Nearly 45% of families with children reported difficulties with stable housing during the foreclosure and housing crisis. It is not entirely clear why unemployment itself was not also associated with child abuse, but the authors speculate this may reflect either gaps in the data or the better available infrastructure for supporting the unemployed relative to those in a housing crisis. Given the incredible impact of child abuse upon childhood psychopathology and the families we see in our offices, knowing more about the risk factors for child abuse increases our opportunities to monitor and intervene for the benefit of our patients.


peditiatrics.aappublications.org/content/130/2/e358
AACAP’s Douglas B. Hansen, M.D.
38th ANNUAL REVIEW COURSE
in Child and Adolescent Psychiatry
& Training Session for the Oral Exams
March 13–16, 2013

Westin Jersey City Newport
Jersey City, NJ (Just Outside Manhattan)
CATHRYN A. GALANTER, M.D. AND
MOIRA RYNN, M.D., CO-CHAIRS

What you will get out of the course:
A. Earn up to 27.25 CME credits
B. A course notebook, which doubles as a great review guide
C. Review of the fundamentals of child and adolescent psychiatry
D. Savings with low rates on registration and lodging within 15 minutes of New York City
E. Prepare for the Oral Exam through simulation exercises
F. All of the above

For more information, visit www.aacap.org or contact meetings@aacap.org or 202.966.7300, ext. 2006
AACAP K12 Physician Scientist Program in Substance Abuse Funded by the National Institute on Drug Abuse

**Yoshie Davison**
Director of Research, Training, and Education

On June 7-8, AACAP hosted the annual retreat for the K12 Physician Scientist Program in Substance Abuse in Palm Springs, CA, preceding the College on Problems of Drug Dependence’s (CPDD) annual meeting.

The NIDA-funded AACAP Mentored Scientist Development Program, established in 1998, provides up to five years of salary support and mentored addiction research training for qualified child and adolescent psychiatrists. The first cohort of seven scholars participated in this program from 1998 to 2003; and the second cohort of five scholars from 2005 to 2009. A third cohort of six AACAP K12 scholars received awards on June 1, 2010, and are now in their third year of the program. The six scholars continue to make significant progress on their research projects that address clinically-important research gaps in the field:

- **Margaret Benningfield, M.D.**, Vanderbilt University Medical Center
  - K12 Research: Neurobiology of Impulsivity, Risk Taking & Reward in Youth at Risk for Addiction

- **Brady Case, M.D.**, Emma Pendleton Bradley Hospital
  - K12 Research: Epidemiology of Adolescent Substance Use Treatment

- **Michelle Horner, D.O.**, University of Pittsburgh
  - K12 Research: The Role of Affective Processing in Etiology of Substance Use Disorder

- **Leslie Hulvershorn, M.D., M.Sc.**, Indiana University
  - K12 Research: Neural Correlates of Emotion Dysregulation in Youth at Risk for Substance Abuse

- **Mini Tandon, D.O.**, Washington University in St. Louis School of Medicine
  - K12 Research: Prenatal Cigarette Exposure and Course of Childhood ADHD

K-12 Retreat Attendees: Mini Tandon, D.O., Leslie Hulvershorn, M.D., M.Sc., Peter Finn, Ph.D., Margaret Benningfield, M.D., Michelle Horner, D.O., Peter Tanguay, M.D., Ralph Tarter, Ph.D., Paula Riggs, M.D., Bennett Leventhal, M.D., Andrea Silva, M.S., Catherine Martin, M.D., Frances Levin, M.D., Susan Weiss, Ph.D., Ronald Cowan, M.D., Ph.D., Greg Tau, M.D., Ph.D., Brady Case, M.D., Anthony Spirito, Ph.D., Yoshie Davison, M.S.W., Bradley Peterson, M.D.
Greg Tau, M.D., Ph.D., Research Foundation for Mental Hygiene, Inc.

- K12 Research: Neural Correlates of Multiple Memory Systems in Adolescent Cannabis Use

The program director, Paula Riggs, M.D., advisory committee members (Catherine Martin, M.D., chair, Bennett Leventhal, M.D., Neal Ryan, M.D., and Frances Levin, M.D.); grants oversight committee representative, Peter Tanguay, M.D.; scholars (Margaret Benningfield, M.D., Brady Case, M.D., Michelle Horner, D.O., Leslie Hulvershorn, M.D., M.Sc., Mini Tandon, D.O., Greg Tau, M.D., Ph.D.; mentors (Ronald Cowan, M.D., Ph.D., Peter Finn, Ph.D., Joan Luby, M.D., Bradley Peterson, M.D., Anthony Spirito, Ph.D., and Ralph Tarter, Ph.D.). AACAP’s director of research, training, and education, Yoshie Davison, M.S.W. and research program manager, Andrea Silva, M.A., attended the retreat.

The retreat included a formal NIH-style “mock Institutional Review Board (IRB)” review of R-level grant proposals submitted by each scholar. The scholars also worked with mentors individually to tighten their research aims and hypotheses for their grant proposals. In addition, Susan Weiss, former, NIDA director of Office of Science, Policy & Communications, presented on NIDA’s portfolio, early career funding opportunities and keys to success, and updates on the National Institute on Substance Use and Addiction Disorders.

AACAP thanks NIDA for their continued support and appreciates the dedication of scholars, their institutional mentors, advisory committee members, and the program director for making the K12 program such a success.
**Catchers in the Rye Award to an Individual**

**Kristin Kroeger Ptakowski**

Kristin is AACAP’s senior deputy director and director of Government Affairs and Clinical Affairs. Through years of steadfast advocacy for AACAP, Kristin has really opened up the world of policy and legislation to the AACAP membership, inspiring a cadre of member advocates. She has tenaciously advanced our Work Force issues and pediatric legislation that promotes better access to treatment for children, adolescents and their families. Past Executive Director Virginia Anthony said of Kristin, “No one better epitomizes ‘saving children’ than Ms. Ptakowski. She is an advocate par excellence. She is adept at maneuvering other advocates in terms of leveraging opportunities.”

**Catchers in the Rye Award to a Committee**

*There was a tie between two committees so both were awarded.*

**Ethics Committee**

This award recognizes the Ethics Committee’s advocacy and ongoing efforts to help guide the professional conduct of child and adolescent psychiatrists and to provide members with ethical standards. Members have lauded the “Ethics and Child Psychiatry” website and the multitude of resources available to the membership. The Committee has developed a Facts For Families page, an ethics curriculum, and a bibliography. It has written many articles on ethics for AACAP News and the Journal. It has rewritten its charge, broadening the scope of the Committee’s activities and responsibilities, including collaborations with many other committees and the development of relationships with other professionals and organizations both domestic and international.

**Psychotherapy Committee**

This award recognizes the Psychotherapy Committee’s advocacy and ongoing efforts to advocate for psychotherapy as a core competence of child and adolescent psychiatry. It has presented more opportunities for a more clinical Annual Meeting program. In addition, the Committee on Psychotherapy has influenced the number of practice relevant clinical presentations in AACAP News and has lobbied for a more clinically focused Journal.

**Catchers in the Rye Award to a Regional Organization**

**Big Sky Regional Council of CAP**

This award recognizes the Big Sky Regional Council’s outstanding efforts to advocate for children and families with mental illness, both by revitalizing the entire Council and bringing together its members. Its efforts are now a model for all regional organizations seeking to revitalize their operations and take their activities to a new level. Its leadership has done a fabulous job rewriting its bylaws, rallying members, revamping its financial system to support all activities, and creating a sustainable and strong infrastructure. Tricia Martinez and Earl Magee agreed, “With a contagious enthusiasm, they have worked together to create a group that is now vital and active.”

**Catchers in the Rye Humanitarian Award**

**Shari and Garen Staglin**

Shari and Garen Staglin are the recipients of the AACAP’s 2012 Catcher in the Rye Award. The award recognizes the Staglins’ tireless efforts to end the stigma of mental illness.

In 1990, the Staglins’ son, Brandon, was diagnosed with schizophrenia and since then they have been leading advocates of mental illness awareness. Starting in 1995, their collective efforts launched the Music Festival for Mental Health. This annual event at their family vineyard in Rutherford, CA, brings together renowned chefs and wineries, top musicians, and leading scientists to raise significant funds and awareness of mental illnesses. In 2008, the Music Festival evolved into what is now IMHRO, the International Mental Health Research Organization.

In the 22 years since, the Staglins have launched multiple organizations all with the mission of raising mental health awareness and fighting stigma, including BringChange2Mind organization co-founded with multiple Emmy, Tony, and Golden Globe Award winner, Glenn Close and others.
Media Page

Garrett Sparks, M.D., M.S.
Resident Editor

Transforming Behavior: Training Parents and Kids Together

By Mary N. Cook, M.D.

384 pages – $69.99 (paperback + CD-ROM)

Is your clinic filled to the brim with families in individual therapy trying to manage their children’s difficult behaviors? That’s the situation in which Dr. Cook found herself when she joined the outpatient clinics at the University of Colorado. Hoping to expand their behavioral program to serve even more families, Dr. Cook used her expertise in parent management and social skills training to establish a time-limited group program for parents and children in an intensive outpatient setting. Transforming Behavior is the manual she and her colleagues developed for easy use by psychiatrists, pediatricians, therapists, counselors, teachers, and parents. The text and CD-ROM include clear instructions, clinical pearls, and family handouts for two protocols: Parenting Approaches for Challenging Kids (PACK), and Mastery of Psychosocial Skills (MaPS).

Watts and the Nightlight

By “Grandpa” Gaston Blom, M.D.
Illustrated by JD Deering

Larch Press, 2012
26 pages – $9.95 (spiral-bound paperback)

Previously the author of seminal texts on working with children who suffer from trauma, neglect, and stress, Dr. Blom embraces his role as Grandpa the storyteller to write a more lighthearted text about a little boy named Henry, who just can’t get to sleep at night after his family moves to a new house. Henry makes a new friend named Watts, a special nightlight who comes to the rescue to scare away the shadows. Both a sweet children’s book and a thoughtful musing on a young child’s need to feel safe, Grandpa Blom successfully blends child psychiatry and his family life with 10 grandchildren and 3 great grandchildren.

Suicide by Security Blanket, and Other Stories from the Child Psychiatry Emergency Service

By Laura M. Prager, M.D., and Abigail L. Donovan, M.D.

ABC-CLIO (Praeger), 2012
115 pages – $37.00 (paperback)

Every year, around 850 families in crisis bring their children to the emergency room at Massachusetts General Hospital. Dr. Prager and Dr. Donovan have drawn from their rich experiences serving these families to write a series of twelve anecdotes inspired by actual visits to the Acute Psychiatry Service. More than just a collection of warm yet honest stories, the authors use these cases to provide clarity about the stresses and conflicts that lead to a family seeking emergent psychiatric care as well as to highlight the various ways that schools and systems of care come up short in caring for children and supporting the families that take care of them. Suicide by Security Blanket even includes a glossary to make this glimpse behind closed doors more accessible to casual readers.

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

Dancing Bear

The sculpted bear dances on my desk, his mass precariously balanced on one foot. Despite his strength, it only takes a jiggle to topple him.

With his head thrown back and arms reaching towards spirits unknown, he seems poised between two worlds. Inuits believe he is interchangeable with man.

His joy is captured by a local artist in smooth, green serpentine for future generations to see, generations who may no longer divine what a polar bear used to be.

The polar bear dances no more but his legacy lives on locked in a case of museum glass through which children stare and ask “How can a bear be happy in there?”

Diane Schetky, M.D. from her new book: Dancing Bear and Other New Poems, 2012. Dr. Schetky is retired and lives in Maine.

THE DIAGNOSTIC PROCESS

By Chuck Joy, M.D.

establish an adequate if shallow rapport talk about the weather, the purpose of the visit after all what is a child psychiatrist but a specialist in relating with

identify strengths
what can the patient do
where will subsequent skill development represent progress

identify strengths
the parent or guardian, you’ll get as far as they can take you who helps them, what gifts do they bring and other professionals, how many are already deployed what are their various levels of effectiveness

take a deep breath maintain your focus, the distractions are endless choose a label from the list of constructs sometimes it’s new, yours will be the first, be gentle sometimes simply recognize what everyone is telling you

Individuals interested in submitting poetry should e-mail Poetry Coordinator Charles Joy, M.D., at crjoy1@gmail.com.
The second edition of this highly regarded autism assessment offers the convenience of a screener and the power of a diagnostic tool. Completed in just 15 to 20 minutes, the SRS-2 identifies social impairment associated with autism spectrum disorders (ASDs) and quantifies its severity. It’s sensitive enough to detect even subtle symptoms, yet specific enough to differentiate clinical groups, both within the autism spectrum and between ASD and other disorders.
On the Manure Pile: Fertilizing the Development of Social Skills

Jenna Saul, M.D.

“Our friends are people who make us feel good about ourselves.”
—Michelle Winner

For most of us, when we meet new people and create new friendships we do so without even thinking about it. For individuals with an autism spectrum disorder, this complex process can be extremely challenging and overwhelming. Despite how anxious youth and adults with high-functioning autism may feel about these social interactions, they do want friendships and do want people to be friendly—and not mean—to them.

Many youths receive social skills coaching at school, but this often takes place in a one-on-one situation with an adult. Or it may take place in the form of social stories. These skills, if not practiced in real-time, do not necessarily generalize to better social interactions. I once saw a child who was encouraged by the school’s guidance counselor to spend a day “complimenting others.” The counselor provided him with two examples of what a compliment might be. He then spent one day telling each and every person he interacted with “I like your shirt,” parroting back what he had heard as an example.

Unfortunately, in the rural area where I practice, there are few opportunities for youth to practice initiating social interactions with their peers with the guidance of adults who have skills in supporting them in their efforts. Animal-assisted activities can help children improve their social thinking and social skills. The presence of the animal can facilitate a trusting alliance between therapist and child. The animal relieves some tension and anxiety of learning social skills and interacting with the animal is entertaining and fun. As we move forward with our efforts to develop equine assisted psychotherapy services, it is my hope that our new program will provide a greater number of youth with real opportunities to practice these skills.

I regularly use the animals on our farm as a way to help youth transition to meeting with me in my office. For youth with autism spectrum disorder, meeting with me can create anxiety because it is a change in their schedule from what normally happens. When a family arrives, rather than rushing the child into my office, I often attempt to engage them around the farm. When we have kittens, I may ask a child to observe how the kittens are playing and consider whether they can see any traits or characteristics particular to one kitten or another. “This one is shy” a child might volunteer. Last week, after a challenging session, Joe and I spent some time with the kittens. My next patient arrived early and found us, standing on top of the manure pile, holding some of the kittens. Both of the boys have a history of autism spectrum disorder.

Both of the boys’ families and I have been working on ways to encourage social skills practice. We have been working hard to help the boys think about how we adjust our behavior even when we are not intentionally communicating. We have discussed that most of us want others to have nice thoughts about us. The opposite is also true: we do not want people having weird thoughts about us. I have not yet started working with either of the boys using the horses. But both showed me on this day that it is time to get to work. It was an exciting moment for me, the boys’ parents, and for the boys when they began to interact with one another, all of us standing on a pile of manure!

“Hi, I am Joe” said the first boy. “What is your name?” “I’m Travis” the other boy replied. “I’m 10 years old. How old are you?” Joe responded “I’m twelve.” Travis then extended his hand, and Joe responded by taking it, and the boys shook hands. The most important thing that happened at my clinic for these children and their parents took place outside of my office, on a manure pile!

Each family was able to provide positive feedback and encouragement to their children about this experience, but even more importantly, these two boys experienced success in a social interaction, where they have often experienced rejection.

We will be able to talk about this interaction the next time each of the boys...
comes. I will be able to ask each of the boys how they felt about the other, and to consider their own actions. Did they act in ways to try to make the other boy like them? And do they think the other boy was doing the same thing? It will give me the opportunity to discuss social memory; many children with social skills problems do not appreciate the role that social memories play in day-to-day interaction. How does Joe feel about Travis? And how does Joe think Travis feels about him?

I am looking forward to encouraging both of the boys’ parents to allow me to spend some time with the boys and with horses. Horses are prey animals. They are innately cautious around new people and experiences. I can use this to encourage the boys to think more about how others respond to them, and how their actions affect what the horse thinks and feels about them. I cannot wait for the boys to meet my Appaloosa, Rorschach!

Jenna Saul’s office is in a renovated barn in central Wisconsin. She recently founded HORSES TREAT (Human Optimism Resilience Self-Efficacy & Strength Through Responsive Equine Assisted Therapy) where she provides Equine Assisted Psychotherapy to children and families, and is developing an eating disorders day treatment program.

LETTER TO THE EDITOR

Dr. Wasserman’s letter is in response to the President’s Message, Slow Down and Listen Up!, published in the July/August issue of AACAP News.

Dear Dr. Drell,

I spent a fair amount of time with Bruno Bettelheim after he retired from the Orthogenic School and moved out to the Palo Alto, California area. Although he has been roundly criticized, when he became consultant to our inpatient unit, his message was similar to yours. He kept forcing us to slow down, to listen carefully and precisely to the patient, and then, with Talmudic precision, and try to understand what was said, both in content and in what it indicated about the patient’s world view. This meant having to control our own anxiety and sense of self in the process.

I think this has been an invaluable skill for my work in child and adolescent psychiatry. Children and adults feel understood and are highly connected to the process. Relationship forming is much easier and the patient’s anxiety goes down substantially. Nowadays, 30 years later, I still am asking families to “slow down, because I am trying to listen carefully and understand what you are saying.” Although there are fewer words we do not talk at cross purposes and much more gets done.

On your second subject, it is sad and painful to hear of your medical experience. I concur in your concerns that these skills are being lost. Still, it is up to us oldsters to pass them onto the next generation.

Saul Wasserman, M.D.
Life Member
Palo Alto, California

We always look forward to hearing from members! Letters to the Editor of 250 words or less may be submitted through the National Office to Rob Grant, director of Communication and Member Services at rgant@aacap.org.
A Retirement from Child and Adolescent Psychiatry

Douglas A. Kramer, M.D., M.S.

I thought others who might be retiring, either shortly or decades from now, could be interested in what the experience was like for one child and adolescent psychiatrist. This is a personal description of a seven-month process. I describe my own experience, include some photographs, and hope this catalyzes for others how they approach their own retirement. No advice is offered. Every retirement is unique, every retirement is personal, each person inventing his or her own.

On January 13, 2011, I announced to the chair of Psychiatry my intention to retire. I began telling almost every patient at their next visit. Thus began a seven-month process of saying “goodbye.” For all, it meant ending treatment with me, and for many it meant finishing treatment altogether. I had seen some patients for 20 or more years, others for just a few months. At both extremes, the process felt remarkably similar. With a time limit having been set, some patients worked harder, I worked harder. Dictating notes, returning phone calls, and completing paperwork were pushed to afterhours as each session ran into the next. The experience was intense, but in most cases not overtly emotional.

Although the seven months was stressful, they were very worthwhile, not just for the treatment aspects, but also for me. Almost all of my patients gave me what I believe I had given them—respect, compassion, an interest in who they are as people, some interesting stories from our work together, and genuine good wishes for the future. The stories were true gifts as I often did not remember the events, but I liked and was surprised by what was described. A couple of times, I was even impressed at things I was told that I had done. There were many other heartfelt (tangible) gifts that were thoughtfully chosen. One artist produced a large acrylic painting of a wolf. Another did a beautiful carving of a Tlingit shaman. Over the seven months of saying goodbye, I increasingly had no sense of yesterday or tomorrow, only today existed. That was even true two days before the final day.

I did not begin counting down until the final 100 days, and then only in 10-day increments. I began sending patients copies of their final progress notes. I felt like I was attending six or seven funerals every day, except nobody had died. The final two weeks followed a canoe trip in northern Maine. During those two weeks, I kept having the impression that I was about to fall off a cliff. It was similar to when the world was flat—I knew I would fall off eventually—I could not see the edge—it would likely happen while sailing at night.

The final day, and really most of the final two weeks, I chose the patients and even the times. My final patient was a family, various components of whom I had seen since 1999, long enough to have treated family members from four generations (Kramer 2009). The “parents” were there, more or less from my generation, a little younger maybe, plus all five “children.” One flew in from Seattle, Washington, where she is a nurse about to start graduate school, another from Ft. Lewis where he is a helicopter test pilot in the Army, a third from Jackson Hole, Wyoming, where he is a teacher of special needs children.

The two who live locally were there, one of whom brought her two children. I had treated the older of the two children in the spring for emotional/behavioral issues that appeared related to heart surgery the previous summer when he was three. Seeing him for treatment only happened because I see whole families (Kramer 2008), and this family usually comes in its entirety at Christmas. I noticed changes in the four-year-old’s behavior compared to the previous Christmas. I subsequently saw him and his mother two additional times for follow-up. It turned out that he told his mother the problem in the parking lot prior to the first visit: “Mommy, please don’t let the doctor take me away from you.” He was referring to the separation that occurred when he went to surgery, not the pain and other physical trauma that the wise and experienced child and adolescent psychiatrist had hypothesized. Catching things early, those things being easier to see in a child’s natural environment (the family), and also with three generations present, and helping families learn what to do about those things, can change a whole life and perhaps the course of an entire family.

I became aware after my career ended of the clutter at which my patients for 32 years had to look, a perspective of which I had not been aware. It does not look particularly calming to me. The gentleman in the photograph on the right with blue pants is Carl Whittaker, one of my most beloved mentors.

Patti, my wife, had been waiting patiently during the final interview. We went directly from the office to canoeing on Lake Wingra in Madison. We had a picnic on the lake, watched some ducks, and paddled quietly, which was a perfect way to finish a career, not so much a celebration, more a quiet appreciation of a lifetime’s experience.

There was a retirement party at the Wisconsin Memorial Union for an adult colleague and me. My beautiful wife had a chance to talk with “Zeke” Zeman. Zeke is a retired dairy farmer, and is married to Marilyn, who was my receptionist from Day 1 in Madison—until she retired three and a half years before I did. I had always said I would...
When she did, but I guess it was not time.

Pete Thurlow was there as well. The retirement party was the first day back from a canoe trip for the two of us and three friends on the St. Croix River – the border between Maine and Canada. Pete is a general surgeon. I met him in the early 90’s, having slipped on some ice while filling a bird feeder, breaking ribs and tearing a hole in my left pleura, incurring a pneumothorax. After having placed many chest tubes in 1971-72 as a surgical intern – the big old-fashioned ones – I have been forever grateful, and deeply respectful, of his offering me a choice between a) a chest tube and b) his home telephone number in case I had trouble breathing. (Guess which I chose?) The discussions Pete and I had in Maine are reflected in a recent article (Kramer 2011b), “Some Things Just Take 60 Minutes . . . ” Over the years, he and I have talked about what it means to be a physician (Kramer 2011a), i.e., “a person skilled in the art of healing.”

The final photo shows Elizabeth Woods, M.D., Tim Chybowski, and me. Liz graduated from the University of Wisconsin Child and Adolescent Psychiatry Fellowship in 2010, and we have remained friends. I wrote a column that year about Liz and her two graduating classmates (Kramer 2010). Tim is a pediatrician, and was the pediatrician for our two sons. Both Liz and Tim are the kind of physician I discuss in the “60 Minutes” column. Tim and I shared many patients over my 23 years back in Madison, and remain good friends.

So, 2011 was the year of retirement. It dominated everything the entire year. I saw my last patient on July 29, 2011, after having been in the practice of psychiatry for 11,693 days – from July 25, 1979. Because my career felt complete, it was not difficult to end it. I have been very lucky! I want all young physicians in the Academy feel equally lucky at this stage of their careers and their lives.

References
Kramer DA (2011). phy•si•cian: a person who is skilled in the art of healing. AACAP News 42 (5):240-241

Dr. Kramer is clinical professor emeritus at the University of Wisconsin School of Medicine and Public Health. He is co-chair of the AACAP Family Committee. Comments on any aspect of child and adolescent psychiatry are always welcome: dakrame1@wisc.edu.
Pay Your Dues Online & Check Out What Else You Can Do!

Did you know that the Members-Only section of the AACAP website provides valuable information regarding member issues and can save time and effort by providing you with the tools to manage your account? By logging into www.aacap.org you can:

- Pay dues online
- View/Edit your profile
- Update your Member Directory listing
- Reset your password or change your login information
- Purchase publications
- View reports from Council, the Executive Committee and the President
- View the Staff Directory

Do you have questions about how to use the “Members Only” section of the website? Help is just two clicks away. Go to www.aacap.org, click on Members Only, and then click on Help (no login needed).

If you have questions, please contact AACAP Member Services at (800) 333-7636 x 111, or send an e-mail to: membership@aacap.org.

Need help making your dues payment? Contact us to discuss flexible installment payment options.

Automatic Dues Renewal

Need one less thing to think about? Select the automatic dues renewal option on your 2013 dues notice and let us handle the rest.

Your annual membership fee will be charged automatically to your credit card. Don’t worry—we’ll send you electronic reminders for next year.

Log on to www.aacap.org for more information and frequently asked questions about this new feature.

Kudos!

Paramjit Joshi, M.D., was added to the Psychiatric News Editorial Advisory Board.

Melvin Oatis, M.D., delivered the keynote address on bullying at the National Black Caucus of State Legislatures Conference in September!
Welcome New AACAP Members

Maria Aguiló-Seara, D.O., Philadelphia, PA
Ivan Aldea, M.D., Middletown, RI
Jabeen Ali, M.D., Downers Grove, IL
Polina Anang, M.D., Winnipeg, MB, Canada
Alejandra Arroyave, M.D., Hartford, CT
Jessica Azooz, M.D., Arlington Heights, IL
Raquel Balderas, M.D., Prescott, AZ
Dalia Balsamo, M.D., Miami Beach, FL
Arjun Bansal, M.D., Seattle, WA
Ademola Bello, M.D., Hershey, PA
Anthony Belotto, Potomac, MD
Cesar Berdeja, M.D., El Paso, TX
Catherine Berger, Providence, RI
Joseph Bishara, M.D., Lubbock, TX
Samantha Block, Delray Beach, FL
Elise Bonder, M.D., Shaker Heights, OH
Charles Bongiorno, M.D., Philadelphia, PA
Sarah Bougary, M.D., Pittsburgh, PA
David Braithwaite, Indianapolis, IN
Nick Bryant, M.D., Fort Worth, TX
Zuraima Caldera, M.D., Temple, TX
Melisa Carrasco, Rochester, NY
Kia Carter, M.D., Chicago, IL
Rachel Cash, M.D., Middletown, OH
A. Christine Castater, Simsby, CT
Binu Chacko, M.D., East Meadow, NY
Shin-Bey Chang, M.D., Baltimore, MD
Suzy Chen, Sacramento, CA
Javed Choudhry, M.D., Columbus, MO
Courtney Cinko, M.D., Cincinnati, OH
Rebecca Clendenin, M.D.
San Francisco, CA
Laura Conley-Olsen, M.D., Little Rock, AR
Caitlin Costello, M.D., New York, NY
Maria Carolina Court, M.D., San Diego, CA
Amaris Daniels, Atlanta, GA
Natasha Dasig, FL
Pablo Davanzo, M.D., Northridge, CA
Shalini Dave, Pittsburgh, PA
Inge de Weille, M.D., Webster, NY
Daniela Diaz Jaimez, M.D., Zapopan, Jalisco, Mexico
Swati Divakarla, Burlingtons, MD
Karen Dobias, D.O., Ypsilanti, MI
Paul Duffy, M.D., Sydney, NSW, Australia
Nonso Enekweci, M.D., M.P.H., New York, NY
Happy Eskander, Houston, TX
Pamelynn Esperanza, M.D., Pepper Pike, OH
Narissa Etwaroo, Ocoee, FL
Danae Evans, M.D., Marietta, GA
Mia Everett, M.D., New York, NY
Katherine Fan, M.D., Sunnyvale, CA
Carol Ferro, M.D., Los Angeles, CA
Begum Firdous, M.D., East Meadow, NY
Eric Fombonne, M.D., Portland, OR
Kristin Francis, Rochester, MN
Gabrielle Galler-Rimm, M.D., Makawao, HI
Meredith Gansner, Bloomfield, NJ
Janak Ghehani, M.D., Birmingham, AL
Elena Gherman, M.D., San Antonio, TX
Poonamdeep Gill, M.D., Buffalo, NY
Jack Gills, M.D., Memphis, TN
Dan Giurca, M.D., Youngers, NY
Soudabeh Givrad, M.D., New York, NY
Anna Gonzaga, M.D., Baltimore, MD
Oscar Gonzalez-Pedrosa, M.D., Dorado, PR
Alicia Grattan, M.D., Seattle, WA
Sandeep Gude, M.D., Brooklyn, NY
Sandra Hah, M.D., Orange, CA
Thomas Hartman, M.D., Glenview, IL
Staci Hartman, D.O., San Antonio, TX
Trecia Henriques, Baltimore, MD
Thomas Henry, M.D., Milford, MI
Nathan Herman, M.D., Omaha, NE
Hwa Hoang, M.D., Tenafly, NJ
Fumiko Hoeft, M.D., Ph.D., San Francisco, CA
Russell Horwitz, M.D., Potomac, MD
Shanti Jampani, M.D., Valhalla, NY
Tiana Jarrahzadeh, M.D., Grand Blanc, MI
Daneen Jasin, M.D., Clark, NJ
Nosheen Jawaad, Oakland, CA
Robert Johnston, Charlotteville, VA
Suchitra Joshi, Niagara Falls, ON, Canada
Asiya Kabir, M.D., Flushing, NY
Silpa Kamisetty, M.D., Durham, NC
Chris Karampatsis, M.D., M.P.H., Kalamazoo, MI
Aaron Kauer, M.D., Iowa City, IA
Sean Kerrigan, M.D., Menlo Park, CA
Marianna Kessianim, M.D., Cranston, RI
Christina Khan, M.D., Ph.D., Palo Alto, CA
Shamima Khan, M.D., Austin, TX
Esther Kim, M.D., New York, NY
Kamran Kizilbash, M.D., London, ON, Canada
Caitlin Klaas, Ambler, PA
Anna Kostanecka, M.D., Eden Prairie, MN
Lawrence Krupa, M.D., Beaverton, OR
Sanaz Kumar, Baltimore, MD
Young Kwak, M.D., Jeju Special
Self-Governing Province, Korea
Woo Jin Kwak, D.O., Birmingham, AL
Mercedes Kwiatkowski, M.D., Cincinnati, OH
Laura Lafrati, Buffalo, NY
Kathryn Langham, M.D., San Diego, CA
Clark Lester, M.D., Lexington, KY
Erin Li, New York, NY
Joanna Lim, Buffalo, NY
Enyinne Liquori, Flushing, NY
Paulo Lizano, Bloomfield, NJ
Muruga Loganathan, M.D., Pittsburgh, PA
Selene Luk, D.O., Honolulu, HI
Barbara Maddigan, M.D., St. John’s, NL, Canada
Monwabisi Makola, Dayton, OH
Katharina Manassis, M.D., Toronto, ON, Canada
Matthew Markert, Ph.D., Miami, FL
Rebecca Marshall, M.D., Portland, OR
Sunita Mathew, D.O., Westlake, OH
Kelsey Mcclellan, M.D., Little Rock, AR
Alicia McGill, M.D., New York, NY
Tamar Meidav, M.D., El Cerrito, CA
Garen Mirzaian, M.D., Reno, NV
Mitsuki Mishra, M.D., Durham, NC
Janki Modi, M.D., White Plains, NY
Omer Moghraby, MBBS, London, United Kingdom
Varun Monga, M.D., Omaha, NE
Sonar Moratschek, M.D., Cleveland, OH
Phillip Murray, M.D., Somerville, MA
Nakita Natala, Rochester, NY
Jamie Ng, M.D., Sacramento, CA
Rachel Nguyen, Redlands, CA
Abhishek Nitturkar, MBBS, Bangalore, India
Dele Omiye, M.D., Indianapolis, IN
Nidhi Onyejiaka, M.D., New Orleans, LA
Adewale Oyemade, M.D., Memphis, TN
Kristen Pagel, M.D., Redlands, CA
Mercedes Paine, M.D., Hackensack, NJ
Sang Park, Arlington, TX
Rosangela Parsons, M.D., Silver Spring, MD
Karnika Patel, Staten Island, NY
Smitta Patel, M.D., Los Angeles, CA
Panchajany Paul, M.D., Atlanta, GA
Marilyn Peraza, M.D., Miami, FL
Thuc Phan, M.D., New York, NY
Sara Popkin, M.D., New York, NY
Nabilla Porbandarwalla, M.D., San Antonio, TX
continued on page 316
Welcome New Members
continued from page 315

Michael Przydzelski, M.D., Hanover, NH
Revital Racin, M.D., Newton, MA
Shirley Rajan, M.D., Worcester, MA
Melissa Ramirez, M.D., Scottsdale, AZ
Andres Ramos, M.D., Hartford, CT
Anita Rashford, M.D., San Diego, CA
Jagadesh Reddy, M.D., Rochester, NY
Karim Reed, M.D., Grantham, NH
Stefani Reinold, Killeen, TX
Christian Reusche, M.D., Charleston, SC
Annette Reynolds, M.D., Lexington, KY
Kimberly Riquelme, D.O., Long Beach, NY
Aaron Roberto, M.D., Brooklyn, NY
Christopher Rogers, Broomfield, CO
Kevin Rosi, M.D., Davis, CA
Laura Rubenstein, San Francisco, CA
Jessica Sandoval, M.D., San Antonio, TX
Sarah Savage, Lebanon, NH
Arjun Saxena, M.D., Birmingham, AL
Craig Schiltz, M.D., San Francisco, CA
Rahim Shafa, M.D., Millford, MA
Christine Shapter, Vernon Rockville, CT
Shanique Shaw, Loxahatchee, FL
Amy Shekarchi, San Antonio, TX
Jillian Shellabarger, M.D., Fairborn, OH
Seleena Shrestha, M.D., Chicago, IL
Keenan Smart, Oklahoma City, OK
Chris Snowdy, M.D., Burbank, CA
Rea Somer Kniestedt, M.D., Thalwil, Switzerland
Jessica Stewart, M.D., New York, NY
Samantha Stewart, M.D., Venice, CA
Randy Su, Princeton Junction, NJ
Nidhi Tewari, M.D., Plymouth Meeting, PA
Jayaselvi Thanaeselan, M.D., Bellaire, TX
Michelle Thorpe, M.D., Parsippany, NJ
Alexander Timchak, M.D., Oak Park, IL
Suzette Toombs, Dallas, TX
Reena Trivedi, M.D., Los Angeles, CA
Susan Uyanna, M.D., Valhalla, NY
Jeanne Van Cleave, M.D., Boston, MA
Elizabeth Vannucci, M.D., Germantown, TN
Mini Varghese, M.D., Philadelphia, PA
Milka Vega Perez, M.D., Yauco, PR
Kelley Victor, M.D., Pittsburgh, PA
Anureet Walia, M.D., Omaha, NE
Melissa Wellner, M.D., Severna Park, MD
Claire Williams, Providence, RI
David Wilson, D.O., Morgan, UT
Jie Xu, Philadelphia, PA
Elif Yilmaz, M.D., Philadelphia, PA
Michael Yuan, Indianapolis, IN
Asima Zehgeer, M.D., Farmington, CT

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

November 20-22, 2012
Bangladesh Association for Child and Adolescent Mental Health (BACAMH) 4th Annual Conference and General Meeting
Dhaka, Bangladesh
www.bacamh.org
bacamh@gmail.com

January 25-26, 2013
Psychopharmacology Update Institute
The Impact of DSM-5 on Child and Adolescent Psychopharmacological Washington, D.C.
www.aacap.org

March 7-9, 2013
American Association of Directors of Psychiatric Residency Training
Fort Lauderdale, FL
www.psych.org

March 13-16, 2013
Douglas B. Hansen, M.D.
38th Annual Review Course in Child and Adolescent Psychiatry and Training Session for the Oral Exams
Jersey City, NJ
www.aacap.org

May 9-11, 2013
Society of Professors of Child and Adolescent Psychiatry
Washington, D.C.
emagee@aacap.org

May 18-22, 2013
American Psychiatric Association Annual Meeting
San Francisco, CA
www.psych.org

June 6-9, 2013
4th World Congress on ADHD
Milan, Italy
www.adhd-congress.org

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

Follow AACAP on Twitter!

Stay up-to-date on AACAP’s latest programs, products, and children’s mental health news by following us on Twitter. Visit our Twitter page at www.twitter.com/AACAP to learn more. If you have questions, contact Caitlyn Camacho, Communications & Marketing Coordinator at ccamacho@aacap.org.
AACAP Policy Statement Requirements

Policies should:

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

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

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

*revised 1/2009

AACAP Policy Statement Procedures

Once a final draft policy statement is submitted to the Policy Statement Advisory Committee (PSAC), the PSAC Chair directs that:

- the author(s) is told of what major revisions or minor edits are necessary. After the author(s) has revised the statement, they may resubmit to the PSAC;
  
  OR

- the author(s) is informed that the statement does not meet the criteria for a policy statement.

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

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

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

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

*revised 3/2005
Thank You for Supporting AACAP

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

Gifts Received August 23 to October 31, 2012

$1,000 to $9,999

AACAP Norbert and Charlotte Rieger Psychodynamic Psychotherapy Award

The Norbert and Charlotte Rieger Foundation

AACAP Norbert and Charlotte Rieger Award for Scientific Achievement

The Norbert and Charlotte Rieger Foundation

AACAP Norbert and Charlotte Rieger Service Program Award for Excellence

The Norbert and Charlotte Rieger Foundation

Campaign for America’s Kids

Elizabeth Craig in memory of Kate Plaisier, M.D.*

Virginia Q. Anthony Fund

Alan Axelson, M.D.
American Professional Agency, Inc.
Myron Belfer, M.D., M.P.A.
Clarence Chou, M.D.*
J. Michael Houston, M.D.
Joan Kinlan, M.D.
Maurice Shaw, M.D. and Kailie Shaw, M.D.
Larry A. Stone, M.D. and Marnette Stone

$500 to $999

Campaign for America’s Kids

Norbert Enzer, M.D.
Joan Kinlan, M.D.
Joan Kinlan, M.D. in memory of Kate Plaisier, M.D.

Life Members Fund

Claudia Berenson, M.D.
Martha Collins, M.D., M.P.H.
Carlos Salguero, M.D., M.P.H.

Staff Appreciation Contribution

Yiu Kee Warren Ng, M.D.

Virginia Q. Anthony Fund

Asociación Mexicana de Psiquiatría Infantil (AMPI)
Blanche Baler, M.D.
David Cline, M.D.
Norbert Enzer, M.D.
Anthony Jackson, M.D.
Debra Koss, M.D.
Andres Martin, M.D., M.P.H.*
Kaye McGinty, M.D.
Rachel Ritvo, M.D.
Peter Tanguay, M.D.

$100 to $499

Campaign for America’s Kids

Sumaru Bilge-Johnson, M.D.
Mark Boror, M.D.
Julio Calderon, M.D.
Mr. Carleton and Ms. Bartenstein*
Nancy Collins, M.D.
Deborah Deas, M.D.*
Dell*
Rose Demczuk, M.D.
Martin J. Drell, M.D.
Joseph Drinka, M.D.
Carol Ann Dyer, M.D.
Kate Garrison in memory of Kate Plaisier, M.D.*
Kathryn Kederis, M.D., D.F.A.P.A.*
Elisa Newman, M.D.
Clara Obleada, M.D.
Jose Sanchez-Lacay, M.D., M.P.H.
Jonathan Santiago and Family in memory of Kate Plaisier, M.D.*
Fred Schultz, M.D.
Richard Spiegel, M.D.
Joan Sturgis, M.D.
Fred Thompson*
Jane Wellman in memory of Kate Plaisier, M.D.*
William Wolf* in memory of Kate Plaisier, M.D.*
Fred Schultz, M.D.
Richard Spiegel, M.D.
Joan Sturgis, M.D.
Fred Thompson*
Jane Wellman in memory of Kate Plaisier, M.D.*
William Wolf* in memory of Kate Plaisier, M.D.*
Holly Zapata*

Endowment Fund

Robert Shearer, M.D.

Life Members Fund

Perry Bach, M.D.
Mark Hinshaw, M.D.
Jerome Liebowitz, M.D.
Robert McKelvey, M.D.
John Sikorski, M.D.
Larry A. Stone, M.D. and Marnette Stone

Virginia Q. Anthony Fund

Auril Abedi, M.D.
Nora Acharati* Abimbolda Akanji, M.D.
Chandramouleswa Amara, M.D.
American Psychiatric Foundation*
Kathleen Banks, M.D.*
David Bellian, M.D.*
Anne Benham, M.D.
Bettina Bernstein, D.O.*
Usha Bhatt, M.D.*
Susanne Blix, M.D.
David Block, M.D.
Vijayalaxmi Bogavelli, M.D.
Stephen Brown, M.D.
Patrick Burke, M.D., Ph.D.
Tracey Cornella-Carlson, M.D.*
Elmer Cupino, M.D.*
Denize Da Silva-Siegel, M.D.*
Katherine Daly, M.D.*
M. Downes, M.D.
Gail Edelsohn, M.D.
Leesha Ellis-Cox, M.D., M.P.H.*
Joel Ganz, M.D.
Stuart Goldman, M.D.
Lawrence Greenhill, M.D.
Lawrence Hartmann, M.D.
Lily Hechtman, M.D.*
David B. Herzog, M.D.
James J. Hudziak, M.D.*
Carol Jankowski*
Catherine Jaseikskis, M.D.
Alessandra Kazura, M.D.
Kathleen Kellely, M.D.
Wun Kim, M.D., M.P.H.
Bernard J. Lee, M.D.*
Bennett Leventhal, M.D. and Young Shin Kim, M.D., M.P.H., M.S., Ph.D.
James MacIntyre, M.D.
Klaus Minde, M.D.
Richard Morse, M.D.*
Albert Nafiel, M.D.
Robert Nover, M.D.
Silvio Onesti, M.D.
Joanne Pearson, M.D.
Kristin Kroeger Ptakowski
Timothy Robertson, M.D.
Theodore Shapiro, M.D.
Diane Shrier, M.D.
Sheila Sontag, M.D.
Richard M. Spiegel, M.D.
William Stark, M.D.
Carrie Sylvester, M.D., M.P.H
Harvey Tullin, M.D.
Anna Vander Schraaf, M.D.
David Waller, M.D.
Richard Ward, M.D.
Jack Westman, M.D.
Roger Wu, M.D.
Joel Zrull, M.D.

Up to $99

Campaign for America’s Kids

Auril Abedi, M.D.
Nora Acharati* Abimbolda Akanji, M.D.
Chandramouleswa Amara, M.D.
American Psychiatric Foundation*
Kathleen Banks, M.D.*
David Bellian, M.D.*
Anne Benham, M.D.
Bettina Bernstein, D.O.*
Usha Bhatt, M.D.*
Susanne Blix, M.D.
David Block, M.D.
Vijayalaxmi Bogavelli, M.D.
Stephen Brown, M.D.
Patrick Burke, M.D., Ph.D.
Tracey Cornella-Carlson, M.D.*
Elmer Cupino, M.D.*
Denize Da Silva-Siegel, M.D.*
Katherine Daly, M.D.*
M. Downes, M.D.
Gail Edelsohn, M.D.
Leesha Ellis-Cox, M.D., M.P.H.*
Joel Ganz, M.D.
Stuart Goldman, M.D.
Lawrence Greenhill, M.D.
Lawrence Hartmann, M.D.
Lily Hechtman, M.D.*
David B. Herzog, M.D.
James J. Hudziak, M.D.*
Carol Jankowski*
Catherine Jaseikskis, M.D.
Alessandra Kazura, M.D.
Kathleen Kellely, M.D.
Wun Kim, M.D., M.P.H.
Bernard J. Lee, M.D.*
Bennett Leventhal, M.D. and Young Shin Kim, M.D., M.P.H., M.S., Ph.D.
James MacIntyre, M.D.
Klaus Minde, M.D.
Richard Morse, M.D.*
Albert Nafiel, M.D.
Robert Nover, M.D.
Silvio Onesti, M.D.
Joanne Pearson, M.D.
Kristin Kroeger Ptakowski
Timothy Robertson, M.D.
Theodore Shapiro, M.D.
Diane Shrier, M.D.
Sheila Sontag, M.D.
Richard M. Spiegel, M.D.
William Stark, M.D.
Carrie Sylvester, M.D., M.P.H
Harvey Tullin, M.D.
Anna Vander Schraaf, M.D.
David Waller, M.D.
Richard Ward, M.D.
Jack Westman, M.D.
Roger Wu, M.D.
Joel Zrull, M.D.

Every effort was made to list names correctly. If you find an error, please accept our apologies and contact the Development Department at development@aacap.org or 202.966.7300 ext. 130. Donations that did not get in at press time, will be included in the January/February AACAP News.
COMMENT ON YOUR PRACTICE PARAMETERS!

TIME IS RUNNING OUT!

If you did not have a chance to review the draft and voice your comments at the Member Forum during this year’s Annual Meeting, here is your next opportunity!

The practice parameters currently available for membership comments are:

- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Eating Disorders, James Lock, M.D., Ph.D. and Maria C. La Via, M.D.

- Practice Parameter for the Assessment and Treatment of Youth Involved with the Child Welfare System, Terry Lee, M.D., Rachel Brown M.B.B.S., and George Fouras, M.D.

The parameters are displayed in the “Members Only” section of our website at www.aacap.org. The comment form is found at the end of the parameter. Please send your comments by **January 31, 2013**, to Jennifer Medicus at jmedicus@aacap.org or by fax at 202.966.2891. If you have any questions, please call 202.587.9670.

The practice parameters, published each year by AACAP, represent the collected wisdom, research, and clinical practice in child and adolescent psychiatry. Each year, you are asked to express your views and provide critical feedback to the Committee on Quality Issues as it prepares the new parameters for publication. Your comments are VERY important!
Classifieds

CALIFORNIA
SUPERVISING CHILD AND ADOLESCENT PSYCHIATRIST
County of San Diego
Board certified Child Psychiatrist wanted to serve as Supervising Child Psychiatrist for Child, Youth, and Families (CYF) Behavioral Health and as deputy to the Clinical Director of the Behavioral Health Division of the County of San Diego Health and Human Services Agency (HHSA). Significant administrative/managerial experience required; as well as flexibility, a team approach, and an interest in innovation to provide the highest quality services. This individual will work closely with the manager of CYF Behavioral Health and the CYF leadership team to develop policy, and provide clinical guidance and oversight. This individual will participate with the Clinical Director on the HHSA Clinical Leadership Team. Will provide clinical supervision in a variety of CYF County operated programs.

The HHSA Behavioral Health Division encompasses both Mental Health and Alcohol/Drug Services, and has a budget of approximately $400M. Physician leadership is highly valued.

Submit application and CV online: www.sdcounty.ca.gov/hr
For further information please e-mail: Marshall Lewis, M.D., Clinical Director
E-mail: marshall.lewis@sdcounty.ca.gov
Phone: 619.563.2771
Or
Katie Astor, Assistant Deputy Director
E-mail: katie.astor@sdcounty.ca.gov
Or
Lita Santos, Human Resources
E-mail lita.santos@sdcounty.ca.gov

USA
CHILD AND ADOLESCENT PSYCHIATRISTS
HCA Healthcare
Child and adolescent psychiatry opportunities available in numerous states through a recruiter employed directly by hospitals who are searching. This is NOT A FIRM; please contact for more details. Jobs include employed, private practice, etc.

Current Opportunities Include:

Salem, Virginia:
We offer an employed position through HCA for an IP/OP opportunity (additional program development is desired). Call is 1:16.

Richmond, Virginia:
Well established group practice practicing IP/OP medicine. Hospital based practice located on the Chippenham Campus.

Chattanooga, Tennessee:
Excellent group at Parkridge Valley (108 beds); looking for someone interested in community psychiatry with a desire to develop a practice in complex trauma, mood/anxiety and systems therapy.

West Palm Beach, Florida:
Columbia Hospital inpatient position in Palm Beach County.

Corpus Christi, Texas:
Develop a private practice in addition to providing oversight of 2 busy inpatient units. 16 bed children’s unit and a 16 bed adolescent unit. 1:4 call.

Submit Applications to:
Kathy Kyer
E-mail: Kathleen.Kyer@HCAHealthcare.com
Phone: 937-235-5890
Mail: 3 Maryland Farms, Brentwood, TN
Fax: 937-235-5897
Website: www.practicewithus.com

WEST VIRGINIA
CHILD AND ADOLESCENT PSYCHIATRIST
West Virginia University Charleston, West Virginia
West Virginia University - Charleston Division, Department of Behavioral Medicine and Psychiatry is seeking a full-time, academic BC/BE child and adolescent psychiatrist for evaluation and treatment of child outpatients, coverage of child intakes, follow-ups with residents/medical students, and coverage of pediatric consults. The opportunity involves teaching and supervisory responsibilities. Students include more than 20 residents in either a general psychiatry track or a med/psych track, 30+ medical students, and three PhD psychology interns. Scholarly activity is strongly encouraged and supported. The position includes seeing your own panel of patients, which in some instances will be in collaboration with child psychology faculty. Duties include supervision of residents/medical students on adult services on a regular basis, predominately in resident clinics, and others on an as needed basis as when on weekend third call. You will also give lectures on child and adolescent psychiatry topics and serve as a discussant for case presentation. Administrative duties may develop as academic career progresses.

The successful candidate will join a diverse and interdisciplinary faculty, including general psychiatrists, child and adolescent psychiatrists, addiction psychiatry, geriatric psychiatrists, medicine/neuropsychiatry, psychiatry faculty. Duties include supervision in a variety of CYF County operated programs.

West Virginia University-Charleston Division is the oldest regional medical campus in the United States with approximately 400 clinical faculty providing training and educational oversight to more than 80 medical students and 140 residents. We are affiliated with Charleston Area Medical Center, a non-profit, 838-bed, tertiary referral center. Appointment will be at a level commensurate with experience and qualifications. The position will remain open until filled.

West Virginia University is an Affirmative Action/Equal Employment Opportunity Employer. Women and minorities are encouraged to apply.

Submit Applications to:
Carol Wamsley
E-mail: carol.wamsley@camc.org
Phone: (304) 388-3347
Mail: 511 Brooks Street, Charleston, WV 25301
Fax: (304) 388-6297
Website Address: www.camc.org
Rx Only.
KAPVAY\textsuperscript{\textregistered} (clonidine hydrochloride) extended-release tablets, oral.

Brief Summary: For complete details, please see full Prescribing Information for KAPVAY.

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

**WARNINGS AND PRECAUTIONS**

**Hypotension/Bradycardia**
Treatment with KAPVAY can cause dose-related decreases in blood pressure and heart rate. In patients that completed 5 weeks of treatment in a controlled, fixed-dose monotherapy study in pediatric patients, during the treatment period the maximum placebo-subtracted mean change in systolic blood pressure was -1.0 mmHg on KAPVAY 0.2 mg/day and -0.5 mmHg on KAPVAY 0.4 mg/day. The maximum placebo-subtracted mean change in diastolic blood pressure was -1.0 mmHg on KAPVAY 0.2 mg/day and -0.5 mmHg on KAPVAY 0.4 mg/day.

**Somnolence**
Somnolence was common in patients treated with KAPVAY. Use KAPVAY with caution in patients with a history of somnolence, especially elderly patients, and in those with a history of cardiovascular disease, because it can decrease blood pressure and heart rate. Use caution in treating patients who have a history of syncope or may have a condition that predisposes them to syncope, such as hypertension, orthostatic hypotension, bradycardia, or dehydration. Use KAPVAY with caution in patients treated concomitantly with antihypertensives or other drugs that can reduce blood pressure or heart rate or increase the risk of syncope. Advise patients to avoid becoming dehydrated or overheated.

**Sedation and Somnolence**
Sedation and somnolence were commonly reported adverse reactions in clinical studies. In patients that completed 5 weeks of therapy in a controlled fixed-dose pediatric monotherapy study, 31% of patients treated with 0.4 mg/day and 38% treated with 0.2 mg/day vs 7% of placebo treated patients reported somnolence as an adverse event. In patients that completed 5 weeks of therapy in a controlled fixed-dose pediatric additive to stimuliants study, 19% of patients treated with KAPVAY + stimulant vs 8% treated with placebo + stimulant reported somnolence. Before initiating KAPVAY with other centrally active depressants (such as phenothiazines, barbiturates, or benzodiazepines), consider the potential for additive sedative effects. Caution patients against operating heavy equipment or driving until they know how they respond to treatment with KAPVAY. Advise patients to avoid use with alcohol.

**Abrupt Discontinuation**
No studies evaluating abrupt discontinuation of KAPVAY in children with ADHD have been conducted. In children and adolescents with ADHD, physicians should gradually reduce the dose of KAPVAY in decrements of no more than 0.1 mg once weekly. In children 6 to 7 years old, physicians should be instructed not to discontinue KAPVAY therapy without consulting their physician due to the potential risk of withdrawal effects.

**In adults with hypertension, sudden cessation of clonidine hydrochloride extended-release formulation treatment in the 0.2 to 0.6 mg/day range resulted in reports of headache, tachycardia, nausea, flushing, warm feeling, brief light-headedness, lightness in chest, and anxiety.**

**In adults with hypertension, sudden cessation of treatment with immediate-release clonidine has, in some cases, resulted in symptoms such as nervousness, agitation, headache, and tremor accompanied or followed by a rapid rise in blood pressure and elevated catecholamine concentrations in the plasma.**

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

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

**Patients with Vascular Disease, Cardiac Conduction Disease, or Renal Failure**
Clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, conduction disturbances, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

**Other Clonidine-Containing Products**
Clonidine, the active ingredient in KAPVAY, is also approved as an antihypertensive. Do not use KAPVAY in patients concomitantly taking other clonidine-containing products (e.g., Catapres\textsuperscript{\textregistered}).

**ADVERSE REACTIONS**

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

**Study 1: Fixed-dose KAPVAY Monotherapy**
Study 1 was a multi-center, randomized, double-blind, placebo-controlled study with primary efficacy endpoint at 5 weeks, of two fixed doses (0.2 mg/day or 0.4 mg/day) of KAPVAY in children and adolescents (6 to 17 years of age) who met DSM-IV criteria for ADHD hyperactive or combined inattentive/hyperactive subtypes.

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

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

<table>
<thead>
<tr>
<th>Preferred Term</th>
<th>Percentage of Patients Reporting Event</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KAPVAY</strong></td>
<td><strong>KAPVAY</strong></td>
</tr>
<tr>
<td><strong>0.4 mg/day</strong></td>
<td><strong>0.2 mg/day</strong></td>
</tr>
<tr>
<td><strong>(N=76)</strong></td>
<td></td>
</tr>
<tr>
<td>Somnolence\textsuperscript{1}</td>
<td>31%</td>
</tr>
<tr>
<td>Headache\textsuperscript{1}</td>
<td>19%</td>
</tr>
<tr>
<td>Upper Abdominal Pain\textsuperscript{1}</td>
<td>13%</td>
</tr>
<tr>
<td>Fatigue\textsuperscript{1}</td>
<td>13%</td>
</tr>
<tr>
<td>Upper Respiratory Tract Infection</td>
<td>6%</td>
</tr>
<tr>
<td>Irritability</td>
<td>6%</td>
</tr>
<tr>
<td>Throat Pain</td>
<td>6%</td>
</tr>
<tr>
<td>Nausea</td>
<td>8%</td>
</tr>
<tr>
<td>Nightmare</td>
<td>5%</td>
</tr>
<tr>
<td>Dizziness</td>
<td>7%</td>
</tr>
<tr>
<td>Insomnia</td>
<td>6%</td>
</tr>
<tr>
<td>Emotional Disorder</td>
<td>5%</td>
</tr>
<tr>
<td>Constipation</td>
<td>6%</td>
</tr>
<tr>
<td>Dry Mouth</td>
<td>5%</td>
</tr>
<tr>
<td>Nasal Congestion</td>
<td>5%</td>
</tr>
<tr>
<td>Body Temperature Increased</td>
<td>1%</td>
</tr>
<tr>
<td>Gastrointestinal Vomiting</td>
<td>0%</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>1%</td>
</tr>
<tr>
<td>Ear Pain</td>
<td>0%</td>
</tr>
<tr>
<td>Nasopharyngitis</td>
<td>3%</td>
</tr>
<tr>
<td>Abnormal Sleep-Related Event</td>
<td>1%</td>
</tr>
<tr>
<td>Aggression</td>
<td>1%</td>
</tr>
<tr>
<td>Asthma</td>
<td>1%</td>
</tr>
<tr>
<td>Bradycardia</td>
<td>4%</td>
</tr>
<tr>
<td>Enuresis</td>
<td>4%</td>
</tr>
<tr>
<td>Incontinence</td>
<td>3%</td>
</tr>
<tr>
<td>Tachycardia</td>
<td>3%</td>
</tr>
<tr>
<td>Thirst</td>
<td>3%</td>
</tr>
<tr>
<td>Tremor</td>
<td>3%</td>
</tr>
<tr>
<td>Epistaxis</td>
<td>0%</td>
</tr>
<tr>
<td>Lower Respiratory Tract Infection</td>
<td>0%</td>
</tr>
<tr>
<td>Poliomyelitis</td>
<td>0%</td>
</tr>
<tr>
<td>Sleep Terror</td>
<td>0%</td>
</tr>
</tbody>
</table>

**1. Somnolence includes the terms "somnolence" and "sedation".**

**2. Fatigue includes the terms "fatigue" and "tachyphagia".**

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

**Table 3 Common Adverse Reactions in the Fixed-Dose Monotherapy Trial-Taper period**

<table>
<thead>
<tr>
<th>Preferred Term</th>
<th>Percentage of Patients Reporting Event</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KAPVAY</strong></td>
<td><strong>KAPVAY</strong></td>
</tr>
<tr>
<td><strong>0.4 mg/day</strong></td>
<td><strong>0.2 mg/day</strong></td>
</tr>
<tr>
<td><strong>(N=76)</strong></td>
<td></td>
</tr>
<tr>
<td>Abdominal Pain Upper</td>
<td>6%</td>
</tr>
<tr>
<td>Headache</td>
<td>2%</td>
</tr>
<tr>
<td>Gastrointestinal Vomiting</td>
<td>5%</td>
</tr>
<tr>
<td>Somnolence</td>
<td>3%</td>
</tr>
<tr>
<td>Heart Rate Increased</td>
<td>3%</td>
</tr>
<tr>
<td>Urinary Incontinence</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Taper Period:** 0.2 mg dose, week 8, 0.4 mg dose, weeks 6-8; Placebo dose, weeks 6-8.
Interactions with Tricyclic Antidepressants
If a patient is receiving clonidine hydrochloride and also taking tricyclic antidepressants, the hypotensive effects of clonidine may be reduced.

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

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

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

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

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

Pediatric Use
A study was conducted in which young rats were treated orally with clonidine hydrochloride from day 21 of age to adulthood at doses of up to 300 mcg/kg/day, which is approximately 3 times the maximum recommended human dose (MRHD) of 0.4 mg/day on a mg/m² basis. A slight delay in onset of prapatual separation was seen in males treated with the highest dose (with a no-effect dose of 180 mcg/kg/day, which is approximately equal to the MRHD), but there were no drug effects on fertility or on other measures of sexual or neurobehavioral development.

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

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

Adult Use in ADHD
KAPVAY has not been studied in adult patients with ADHD.

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

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

© 2012 Shionogi Inc, Florham Park, NJ 07932
Last modified 01/2012

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

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

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

<table>
<thead>
<tr>
<th>Preferred Term</th>
<th>Percentage of Patients Reporting Event</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>KAPVAY+STM (N=102)</td>
</tr>
<tr>
<td>Somnolence</td>
<td>19%</td>
</tr>
<tr>
<td>Fatigue</td>
<td>16%</td>
</tr>
<tr>
<td>Abdominal Pain Upper</td>
<td>12%</td>
</tr>
<tr>
<td>Nausea</td>
<td>6%</td>
</tr>
<tr>
<td>Throat Pain</td>
<td>6%</td>
</tr>
<tr>
<td>Decreased Appetite</td>
<td>5%</td>
</tr>
<tr>
<td>Body Temperature Increased</td>
<td>4%</td>
</tr>
<tr>
<td>Dizziness</td>
<td>4%</td>
</tr>
<tr>
<td>Insomnia</td>
<td>4%</td>
</tr>
<tr>
<td>Epilepsiae</td>
<td>3%</td>
</tr>
<tr>
<td>Rhinorrhea</td>
<td>3%</td>
</tr>
<tr>
<td>Abdominal Pain</td>
<td>2%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>2%</td>
</tr>
<tr>
<td>Pain in Extremity</td>
<td>2%</td>
</tr>
</tbody>
</table>

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

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

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

<table>
<thead>
<tr>
<th>Preferred Term</th>
<th>Percentage of Patients Reporting Event</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>KAPVAY+STM (N=102)</td>
</tr>
<tr>
<td>Nasal Congestion</td>
<td>4%</td>
</tr>
<tr>
<td>Headache</td>
<td>3%</td>
</tr>
<tr>
<td>Irritability</td>
<td>3%</td>
</tr>
<tr>
<td>Throat Pain</td>
<td>3%</td>
</tr>
<tr>
<td>Gastroenteritis Vertebral</td>
<td>2%</td>
</tr>
<tr>
<td>Rash</td>
<td>2%</td>
</tr>
</tbody>
</table>

* Taper Period: weeks 6-8

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

Adverse Reactions Leading to Discontinuation
Thirteen percent (13%) of patients receiving KAPVAY discontinued from the pediatric monotherapy study due to adverse events, compared to 1% in the placebo group. The most common adverse reactions leading to discontinuation of KAPVAY monotherapy treated patients were from somnolence/sedation (5%) and fatigue (4%). Less common adverse reactions leading to discontinuation (occurring in approximately 1% of patients) included: vomiting, palpitations, orthostatic hypotension, syncope, decreased or absent reflexes, weakness, irritability and miosis. The frequency of CNS depression may be higher in children than adults. Large overdoses may result in irreversible cardiac conduction defects or dysrhythmias, apnea, coma and seizures. Symptoms of overdose generally occur within 30 minutes to two hours after exposure.

Effects on Laboratory Tests, Vital Signs, and Electrocardiograms
KAPVAY treatment was not associated with any clinically important effects on any laboratory parameters in either of the placebo-controlled studies. Mean decreases in blood pressure and heart rate were seen [see Warnings and Precautions (5.1) in the full prescribing information]. There were no changes on ECGs to suggest a drug-related effect.

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

Interactions with CNS-depressant Drugs
Clonidine may potentiate the CNS-depressant effects of alcohol, barbiturates or other sedating drugs.
Add KAPVAY® to a stimulant—
achieve significant symptom improvement\(^{1,2}\)
- In the add-on trial, KAPVAY\(^{®}\) demonstrated efficacy at \textbf{week 5} (primary end point as measured by the ADHD RS-IV Total Score) with statistically significant symptom improvement seen as early as \textbf{week 2}\(^{1,2}\)

Offer convenient flexibility to your patients
- KAPVAY\(^{®}\) can be administered \textbf{with or without food}\(^3\)
- When KAPVAY\(^{®}\) is added to a stimulant, the dose of the stimulant can be adjusted/reduced depending on the patient’s response\(^3\)

To learn more about KAPVAY® visit kapvay.com

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

KAPVAY\(^{®}\) is indicated as an integral part of a total treatment program for ADHD that may include other measures (psychological, educational, and social) for patients with this syndrome.

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

Important Safety Information
- KAPVAY\(^{®}\) should not be used in patients with known hypersensitivity to clonidine
- KAPVAY\(^{®}\) can cause dose-related decreases in blood pressure and heart rate. Use caution in treating patients who have a history of syncope or may have a condition that predisposes them to syncope, such as hypotension, orthostatic hypotension, bradycardia, or dehydration. Use with caution in patients treated concomitantly with antihypertensives or other drugs that can reduce blood pressure or heart rate or increase the risk of syncope
- Somnolence/Sedation were commonly reported adverse reactions in clinical studies with KAPVAY\(^{®}\). Potential for additive sedative effects with CNS-depressant drugs. Advise patients to avoid use with alcohol. Caution patients against operating heavy equipment or driving until they know how they respond to KAPVAY\(^{®}\)
- Patients should be instructed not to discontinue KAPVAY\(^{®}\) therapy without consulting their physician due to the potential risk of withdrawal effects. KAPVAY\(^{®}\) should be discontinued slowly in decrements of no more than 0.1 mg every 3 to 7 days
- In patients who have developed localized contact sensitization or other allergic reaction to clonidine in a transdermal system, substitution of oral clonidine hydrochloride therapy may be associated with the development of a generalized skin rash, urticaria, or angioedema. Use cautiously in patients with vascular disease, cardiac conduction disease, or chronic renal failure: Monitor carefully and up titrate slowly
- Clonidine may potentiate the CNS-depressive effects of alcohol, barbiturates or other sedating drugs
- Use caution when KAPVAY\(^{®}\) is administered concomitantly with antihypertensive drugs, due to the additive pharmacodynamic effects (e.g., hypotension, syncope)
- KAPVAY\(^{®}\) should not be used during pregnancy unless clearly needed. Since clonidine hydrochloride is excreted in human milk, caution should be exercised when KAPVAY\(^{®}\) is administered to a nursing woman
- Caution is warranted in patients receiving clonidine concomitantly with agents known to affect sinus node function or AV nodal conduction (e.g., digoxin, calcium-channel blockers and beta-blockers) due to a potential for additive effects such as bradycardia and AV block
- Clonidine, the active ingredient in KAPVAY\(^{®}\), is also approved as an antihypertensive. Do not use KAPVAY\(^{®}\) in patients concomitantly taking other clonidine-containing products, (e.g., Cetapres\(^{®}\), JENLOGA)
- Common adverse reactions (incidence at least 5% and twice the rate of placebo) include: somnolence, fatigue, upper respiratory tract infection, irritability, throat pain, insomnia, nightmares, emotional disorder, constipation, nasal congestion, increased body temperature, dry mouth, and ear pain


SHIONOGI INC. © 2012 Shionogi Inc. Florham Park, N.J. All rights reserved. KAP12-PAD-001-00 06/12

Kapvay®
(clonidine hydrochloride)
extended-release tablets
0.1 mg
JobSource (available online at www.aacap.org) is an online recruitment tool used by employers and recruiters seeking qualified child and adolescent psychiatrists for positions around the world. This database reaches the largest group of credentialed specialists in the field.

In the Positions Database, both members and non-members can post available positions, and search for available positions around the world. In the Vitae Database, members can post their curriculum vitae for employers to search. CVs are located in a protected, member’s-only section of the AACAP Web site. Only screened advertisers and recruiters have access.

If you have any questions please contact Adriano Boccanelli, Clinical Practice Coordinator, at aboccanelli@aacap.org